An Examination of the Influences on Health Development Post Conflict:

Angola – in the Transition

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Abstract

This thesis examines the issues that influence health development post conflict. Its aim is to increase understanding of the current issues within the transitional post conflict phase through presenting the experiences of three communities in rural Angola.

Having emerged from nearly 30 years of civil war, Angola remains in a challenging transitional period. This phase of rehabilitation, flanked by efforts of relief and development, is shown to be problematic. This thesis considers the process from conflict to peace and subsequent repatriation of population. It identifies the transitional phase between relief and development projects and the ambiguous linking of theory and practice within literature. Discussion of appropriate health strategies for implementation shows the limitations of the primary health care (PHC) model. Concepts of community participation and empowerment are identified as difficult due to resettlement factors of time and planning.

The methods of research include household surveys (181 completed), interviews, group discussions, and observations of three communities. Comparisons of the two groups of previously identified Internally Displaced People (IDPs) and Returned Refugees (RRs) are made throughout the thesis. A focus on the needs, wants, reality and use of health services reveals community participation and responsibility. The influences of identity (tribe, gender, IDP / RR) and past experiences of refuge, settlement, and education are recognised as impacting to varying degrees, knowledge, attitude and practice towards health services. The research concludes that the post conflict phase is impacted most strongly by community (identity), time and communication.

Acknowledgements

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[1] 'This document has been produced with the financial assistance of the European Union. The contents of this document are the sole responsibility of Laura Patterson and can under no circumstances be regarded as reflecting the position of the European Union'

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Glossary and Abbreviations

Chivundo	staple food made from maize meal (Mbunda language)
Com	community
Communa	town (Portuguese language)
DRC	Democratic Republic of Congo
FGD	focus group discussion
FNLA	Front for the Liberation of Angola
Funge	staple food made from maize meal (Portuguese language)
HIV	Human Immunodeficiency Virus
HHS	household survey
HW	health worker
IDP	Internally displaced person
IOM	International Organisation for Migration
IRIN	Integrated Regional Information Network
MAG	Mines Advisory Group
MoH	Ministry of Health
MPLA	Popular Movement for the Liberation of Angola
NGO	Non Governmental Organisation
PHC	Primary Health Care
PRA	Participatory Rural Appraisal
QIP	Quick Impact Project
ROC	Republic of Congo
RR	Returned Refugee
Soba	village chief (Portuguese language)
STD	Sexually Transmitted Disease
TB	Tuberculosis
TBA	Traditional Birth Attendant
UK	United Kingdom
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNITA	The National Union for the Total Independence of Angola
US	United States
WHO	World Health Organisation

Chapter 1: Introduction

"If a lion is chasing you and you climb a tree, do you build a house in the tree?"
Soba (village chief), Angola.

The quote above, from a traditional Angolan leader, considers the concept of flight from conflict. He asked me, *"when you flee from something like conflict and you find yourself in a place of refuge, do you then make your home and establish your roots in that foreign place?"* The answer can be varied but in this particular instance the leader said, "*No*". He went on to say that his people were not meant for that place and they were to come home and reestablish their lives in their country of origin. With the lion considered dead, the process of reconstruction and development was able to start.

This process of reconstruction can be challenging when considering the concept of health. In order to be healthy, people need to have the opportunity to make choices regarding their own health. This requires certain levels of time, resources, knowledge, infrastructure and peace. The prospect of making informed and positive choices post conflict is limited in any discipline, including health, due to the general destruction of society. Working with the limitations of community disunity, limited personal and community resources, and various levels of international aid, etc. that influence the improvement of health and its systems, is the challenge and the focus of this study.

Purpose of the Thesis

This thesis uses the experiences of post conflict Angola in order to examine important issues for theory and practice in the implementation of health services. Within this, the study focuses on issues of displacement and repatriation, experiences and expectations of health services, transitional development processes and other influencing factors involved in the specific development of health. It is hoped that this thesis will portray the issues being faced in Angola and that the results from the data will generate positive improvements and change as required to assist in the development of health programmes.

The outcome of this study more specifically aims to assist people and agencies involved in the implementation and development of health programmes within a post conflict and repatriation setting. This can be done through promoting a greater understanding of the

communities involved and encouraging better communication processes. In the midst of social change, the voice of the community can be lost, and this study addresses this gap. It gave, and gives, the communities participating in the research an outlet to voice their ideas and thoughts, and it facilitated discussion within each community.

It is anticipated that the final results of this research will identify the expectations for health activities of the population in the study area of Bundas municipality. It will also identify the differing thought processes of previously identified[1] internally displaced people[2] (IDPs) and returned refugees[3] (RRs), and how their past experiences affect their present expectations. It also aims to give the governing bodies of Angola a snapshot of three of their newly resettled communities to improve understanding of some of the issues that are being faced in these areas, and some ideas to assist in the continuation of community health development.

Putting it in Context

The challenges facing countries in a post conflict phase include that of displaced people, destroyed infrastructure, lack of community services, low educated populations, communication breakdowns, landmines and access difficulties, and disunity and fear, to name a few. Humanitarian assistance in these countries deals with these issues on a day-to-day basis, affecting the daily implementation of projects. As peace is established and the community resettles, population groups emerge that are composed of people with many different experiences accumulated throughout the conflict phase. These differing experiences appear to affect personal desires and motivations for the rebuilding of communities, and therefore, the expectation of the services from a humanitarian aid agency.

Government leadership and systems are often newly established within the post conflict stage, giving rise to challenges in the implementation of policies that may be outdated and inappropriate. Limited infrastructure, communication and transportation difficulties, lead to frustrations for rehabilitation.

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[1] 'Previously identified' denotes that the IDPs are now settled back in their area of origin or identified home and are therefore no longer considered internally displaced

[2] Considered as anyone who did not leave Angola during the war. Within the study area everyone was displaced from their home at some stage

[3] Considered as anyone who left Angola during the war and sought refuge in another country

Community projects are designed according to the perceived and identified needs of the population. Identification of whether the area is at a stage requiring relief, rehabilitation or development, affects the planned time frame of the programme and therefore the style of implementation. The project focus and ideas of what is required or needed in the country is influenced by the drive of the donors or overseeing agencies' mandates. This in turn may affect the process of implementation and the end result of the programme, regardless of the expectations of the community.

This seemingly complicated post conflict situation can have a variety of consequences on personal health and health systems. Health needs that arise out of conflict are specifically related to displacement and the resulting physical and emotional trauma. Displacement is shown to have an increased effect on the spread of communicable diseases, and when coupled with limited food resources, can create, enormous health issues. Effective systems are required to deal with these needs appropriately. In many circumstances basic health structures have been destroyed during the period of conflict, experienced staff have left the area, and materials and supplies are limited. Newly resettled areas of return in rural localities have limited or no infrastructure, including the lack of basic water and sanitation facilities. This leads to the potential increase in disease development that would otherwise be generally confined. These issues produce a challenge for those involved in implementing a functioning health system.

Originally the idea and desire to consider this topic for research came from my experiences of working in Angola, attempting to assist the local government to establish adequate health care for the then, small, returned population, and to prepare for the imminent return of thousands of people to the area. The population was initially a majority of previously identified internally displaced people (IDPs) who had either just returned to their area, or were still waiting to move home. Repatriation in the early days, post the declaration of peace in the second half of 2002 and early 2003, was spontaneous and sporadic, depending on the weather and conditions. Villages beyond the main town were very small and basic compared to two years later, at the end of my research phase, when there were newly accessible areas of settlement popping up everywhere, and an aircraft transporting 300-500 people into the area three times a week. These resettled areas were lacking the infrastructure of protected water sources, adequate food provisions, school facilities and health services.

The demand on health services changed dramatically from the initial requirements for a basic health centre, to the need for a referral centre and immediate accessible medical care to outlying areas. This demand gave rise to the implementation of a mobile medical team by the international NGO with whom I was involved, in order to reach other inaccessible areas with health care.

During my involvement in this work, many issues arose regarding the best form and approach for the commencement of health programmes in the area. Feedback from the Angolan Ministry of Health, international health agencies and donors, revealed that the health programmes within the area were effective for the phase that the community was in. There appeared though, to be a balancing act between the implementation of relief and development programmes. The quality of health care was adequate but the process was at times considered very frustrating and limited to the point of occasional ineffectiveness. This transitional phase from conflict to peace, and on to development, gave rise to issues and outcomes that were possibly specific to this particular stage. Concerns arose regarding participation levels, ownership, dependence, expectations and role identification of the community, and implementation actors involved in the process.

Initial observations revealed differing expectations from the population on what the needs of the area were, and how a programme should be put into practice. The population group of IDPs initially appeared more independent and determined to work for what they needed, having often in the past used the services of the local military and others to survive. The returning refugee (RR) population had, in general, been living in established communities in neighbouring countries where access to housing, food, healthcare, and schooling appeared to have been relatively easier to obtain. Motivation of the community to be involved in the growth of their own area appeared to differ depending on the IDP or RR identity. Through general observation and informal discussions, it appeared that returnees from established camps outside of Angola had a higher expectation of health care services and yet were less motivated to be involved in the re-establishment processes in their communities. IDPs, on the other hand, appeared to have a lower expectation of health care services and yet were more willing to assist and invest in the growth of their community.

Questions surrounding issues of the phases of aid, levels of responsibility, donor strategies, repatriation and community participation all led to a desire for a greater understanding of the situation, improved results of the programmes and the general health situation in the area.

A Focus on Objectives

The objectives for the study, as seen in Table 1.1, guided the initial data collection phase and were identified through reflection on my work in the area and on discussion with colleagues. It was essential to initially obtain the communities perception of their priority needs, and then more specifically their requirements within the context of health. The comparison of participants' past experience of health services with present expectations and satisfaction hopefully would identify the motivation for community participation in the current development of health. Observation of the relationship between actors in the implementation process was necessary to understand the issues and management styles. Communication was an identified requirement for effective implementation, and its processes were deemed important to understand. The information was collected using various methods as outlined in Chapter Five.

Objectives:	
1	Identify priority of needs in the community and role responsibility of community and humanitarian actors
2	Identify current health services / activities in the community
3	Identify past experiences of health services in the last 30 years
4	Investigate knowledge, attitudes and practice towards current health services in the community
5	Identify the levels of expectations for health services in the community
6	Explore the levels of participation by the community in developing the health services
7	Identify considerations for improved programme implementation processes for health services
8	Identify methods for improved communication processes between community, government and international agency services

Table 1.1: Planned objectives of the study

The relevance of this study is timely and useful to the many countries that are within this transitional post conflict phase. These countries require effective health services and can learn from the situations experienced within Angola.

The Practicalities of Research

I was able to complete the field phase of this research project during the months of November and December 2004, in Moxico Province, Angola. The local government administration of the municipality was supportive of this study, as were the three communities that took part. The Massey Human Ethics Committee of Massey University New Zealand, considered the research to be a low risk project.

The study was carried out in collaboration with Medair (NGO), an international humanitarian aid organisation who has been implementing multi-sectorial aid programmes in the study area since 2002. I was working with Medair in the role of Primary Health Care Project Coordinator and then Medical Coordinator since the beginning of 2003. I handed over this role in order to focus on two months of field research at the end of my two year term. The European Commission[4] supported the field phase of the research through the funding of Medair's medical programmes in Bundas Municipality, the study area. Medair Angola provided all logistical support and daily resources.

Thesis Structure

This thesis is comprised of nine chapters. Chapter Two describes the country of Angola and its historical path to the present day, and gives an understanding of the issues connected to the study. The chapter considers the concept of health, its place in Angola, and specifically its impact within the study area.

Chapter Three considers, through a review of literature, the process from conflict to post conflict within a country. It outlines the evolution of a complex emergency, its effect on health and the international aid response to the situation. Displacement and consequent

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repatriation of people is considered and the specific outcomes of the process are discussed.

Chapter Four describes the transition from relief to development within the post conflict phase. The chapter presents issues and frameworks for the implementation of health programmes within these settings.

Chapter Five outlines the methodology used in the collection of data within Angola. It also discusses the methods of data analysis and reveals the limitations of the study.

Chapter Six presents the findings from the research in Angola. The data collected focuses on the issues of community needs; past and present health activities; concepts of expectation, participation, and communication; and repatriation. It reveals perspectives on these topics from three geographical communities, traditional and government leaders, health service representatives and NGO / agency staff.

Chapter Seven is a continued discussion of the collected data, focusing on a more condensed approach to the results. It considers both present and past perceptions of responsibility for health and the role allocation of actors within the implementation process.

Chapter Eight allows for further analysis and discussion of the information presented in previous chapters. It examines current thoughts and ideas relating to the results of the data. The correlation of ideas reveals concepts for health development.

Chapter Nine is the concluding chapter and reflects on the initial objectives of the study as presented in this introduction chapter. The main findings of the research are outlined and four points of recommendations are made for the implementation of health programmes within a post conflict setting. The chapter also considers areas that require further reflection and research.

Chapter 2: History and Health in Angola

This chapter explores the social and political journey of Angola through the presentation of its history up to the present. It considers how the historical events impact on, and are responsible for, the current situation today. This chapter also discusses the concept of health and considers its perception and application within Angola. This discussion provides the foundation to this thesis.

Angola is a country composed of 1,246,700 square kilometres with approximately 13,800,000 people (2003 United Nations estimation). As shown in Map 2.1, it is situated on the west coast of the southern region of Africa and has borders in the north, east and south, with Democratic Republic of the Congo, Zambia and Namibia. It is met on the west coast by the Atlantic Ocean, which results in a couple of great surf beaches. The capital city, Luanda, resides on the west coast and has an estimated population of 3.8 million (UNDP 2005).

The industrial development of Angola is said to have only really commenced after the end of World War II. The country has rich agricultural resources with cash crops, the main being coffee, as well as subsistence farms. Industrial resources are also substantial with large oil reserves and diamond mines as well as other mineral resources. External debt was estimated to be US $9.9 billion in 2002 (UNDP 2005).

	HDI rank 2002 (177 countries)	GDP per capita rank 2002 (177 countries)	GDP per capita value (PPP US$ 2002)
Angola	166	128	2,130
Best performer in Sub-Saharan Africa (Seychelles)	35	33	18,232
Worst performer in Sub-Saharan Africa (Sierra Leone)	177	176	520

Table 2.1: Angola Human Development Index compared to worst and best performers in Sub-Saharan Africa (UNDP 2004)

The 2004 Human Development Report (Table 2.1) ranked Angola at 166th with a human development index (HDI)[5] value of 0.381. The gross domestic profit (GDP) is also shown in the table above. No historical information is available to compare previous year's trends as there has been a lack of information collected on the country (UNDP 2004).

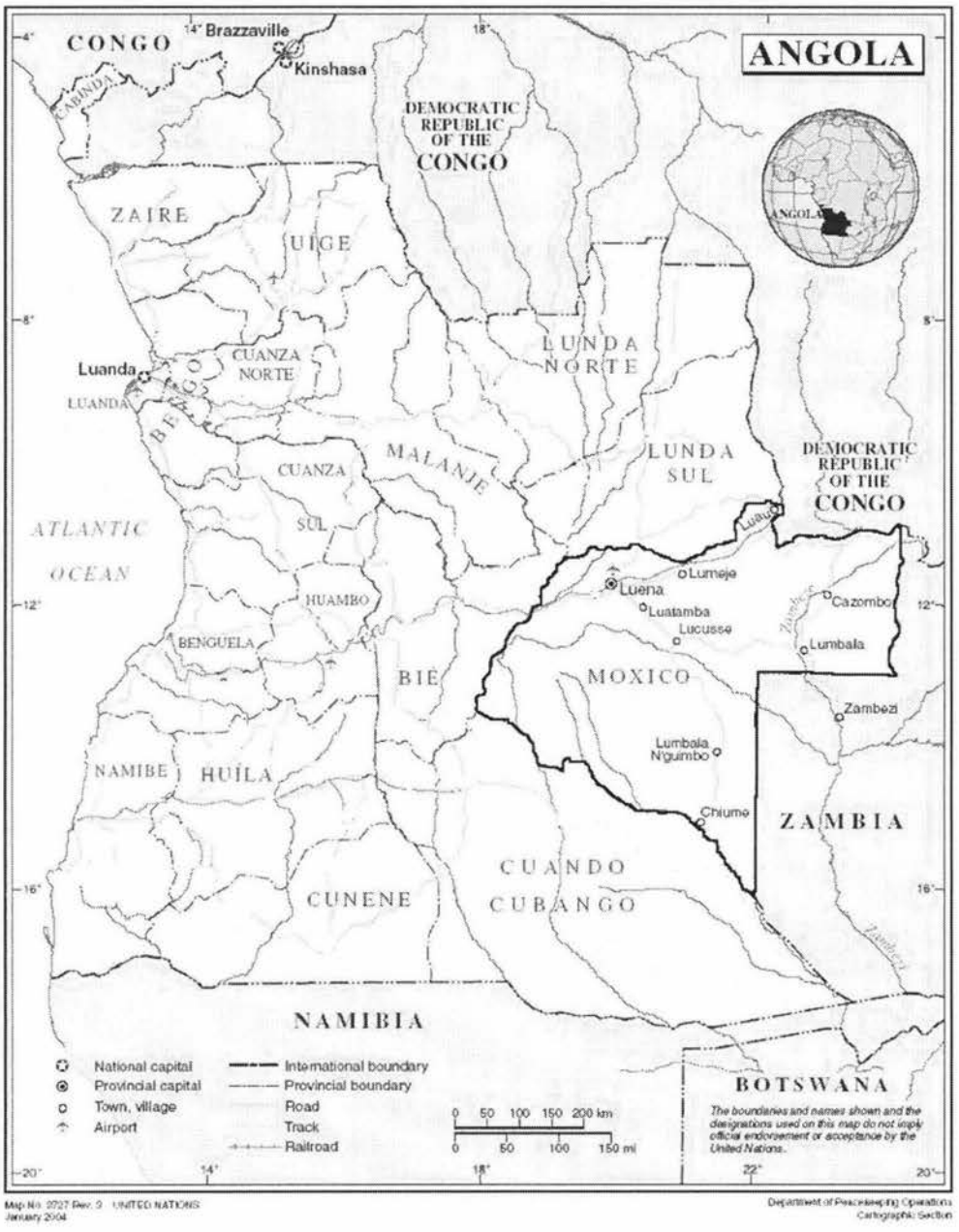
Historical Influences

Angola was named by the Portuguese from the chief of the Kimbundus' Ndongo kingdom Ngola. Seven central African kingdoms, each with its own economy, culture and history, existed prior to Portuguese influence (Wolfers and Bergerol 1983). Currently eighteen provinces make up the country with nine ethno-linguistic groups which can be broken down into around 100 tribal groups. The two main tribal groups are the Ovimbundu and Bakongo. The official trade language is Portuguese and over 60 Bantu-group languages are spoken within the country (The Embassy of The Republic of Angola 2005).

It is thought that Bantu tribes arrived in the area now known as Angola, from West Africa, around the 13th century and displaced the first inhabitants of the Khoisan tribe of hunters and gatherers (Brennan 1987). The Portuguese began exploring the western/central African coastline and arrived in the region of Angola in the 1483. They began to gain power through conquest in 1575 and by around 1625 had gained influence and indirect control through the powerful and dominant Mbundu tribe. Fifty years on, the Portuguese defeated the Mbundu king and gained direct rule over the area (Birmingham 1965).

The kingdoms within the current boundaries of Angola were the first in the African continent to come under European colonial rule in the 17th century. The Portuguese effort to settle inland within Angola was unsuccessful until the 1900s. Their control continued until independence was obtained in 1975 (Birmingham 1965). Throughout the 300 to 400 years of Portuguese influence, intense trading of slaves occurred until its abolishment in the mid 1800s.

[5] HDI combines measures of life expectancy, school enrolment, literacy and income to allow a broader view of a country's development than does income alone.



Map 2.1: Angola with Moxico Province (study area) in dark outline (source: adapted from United Nations 2004).

It is estimated that around four million slaves (30 per cent of all slaves from Africa) were sent from Angolan ports (Brennan 1987:6). Racial and class tension was apparent in the Luanda Capital, resulting in the oppression of native Angolans, although an elitist group of Angolan nationals did evolve with the assimilation of Portuguese (Wolfers and Bergerol 1983).

Internal conflict simmered within Angola and in 1961, erupted with the fight for independence from Portuguese control. Three groups were initially involved. The first, identified as the Front for the Liberation of Angola (FNLA) was based out of Zaire, with the United States of America and The Peoples Republic of China supporting it throughout various stages. The group was dominated by the Kikongo tribe of the once powerful Kongo Kingdom (Brennan 1987).

The second group, the Popular Movement for the Liberation of Angola (MPLA), was also based out of Zaire and then the Republic of the Congo. It was influenced by Marxism, with most of its support coming from Cuba and the Soviet Union. MPLA focused much of their initial recruitment efforts on the Mbundu tribe around Luanda (Brennan 1987).

The third faction, The National Union for the Total Independence of Angola (UNITA), was supported by the United States, South Africa, and later with diamond revenues from controlled mines in the northeast of the country. Its foundations came from Ovimbundu tribalism and initially focused on the Chokwe of eastern Angola. Other tribal groups often mistrusted the UNITA movement due to the historical links of the Ovimbundu with the colonial army (Brennan 1987:14).

Angola gained independence in 1975 under MPLA, who, at the time had the control of the capital. Augustine Neto became the first president of Angola. This led to an intensified civil conflict between the main factions which was deepened through the lack of a coalition government, the loss of Portuguese professionals (through the downfall of colonialism), and increased international military support for the opposing factions. FNLA and UNITA attempted a coalition but MPLA controlled the whole region by 1976 (Brennan 1987:17).

The intensity of this period resulted in unprecedented population death and displacement. As a result of this civil war conflict, the UNHCR 2002 Global Report (UNHCR 2002) stated that it was estimated by the Angolan government that 4 million people were displaced over the 28 year period and an additional one million people died in the fighting. Many people fled to the neighbouring countries of Namibia, Zaire, or Zambia, either staying in organised camps or making their own way in the host country. Others fled to areas of less conflict, usually the capital city of Luanda, or deeper into the bush of their home areas (Hansen 1982).

In general, this displacement was in response to the violence from all factions involved, but with the focus at the beginning of conflict being mainly in the northern areas, the Kikongo tribes were greatly affected. Later, with a shift of the conflict into greater UNITA supported areas, central and eastern Angola, the home of the Ovimbundu became more unstable and created large population movement into Zambia. Human rights abuses were reported from all sides involved (Brennan 1987).

For the people of Angola, the experiences throughout the period of war were very different. Two main people groups evolved, one being the Internally Displaced Person (IDP), namely those that chose or ended up staying within the country; and secondly, the Refugee or Returned Refugee (RR), those who left the country for a significant period and then returned or were in the process of returning. These two groups are sometimes now distinguishable by their language and culture, depending on the amount of time spent in different areas.

Life, for those who took refuge in other countries during the period of conflict, was very different, depending on the area of settlement. Zambia, the predominate area of refuge for the people in the study area, had two organised settlements available. The first to open in 1971 was Maheba Refugee settlement, Zambezi district, where it covered 720 km of previously unsettled land. Bakewell (2000) reported approximately 26,000 Angolans were settled there at one point. Officials expected people to become self-sufficient for food and gave land for agricultural use, although the World Food Programme did supply food when required. Zambian government departments and NGOs provided health and education facilities. Opportunities were also available for apprenticeship schemes, income generation loans, legal assistance, livestock cooperatives, and support and social clubs (UNHCR 2001). The main disadvantage to staying within the settlement area was the restrictions on leaving the area. Permission had to be granted and passes obtained in order to travel beyond the settlement's boundaries (Bakewell 2000). The other settlement was Mayukwayukwa in Western Province, Zambia which had a similar setup.

The restriction of travel within an organised settlement area persuaded many people to self settle along the border within neighbouring countries, some with family and friends in

the area. The area, family support and general opportunities determined if the experience was positive or not (Bakewell 2000).

The intense period of conflict occurred at the height of the Cold War which *Time Magazine Online* described as a *"geopolitical chess match pitting Washington against Moscow"* (Karon 2002). However, since the end of the Cold War, geopolitical explanations have lost a lot of their relevance because more of a focus has been placed on the local conflict and the reasons for its occurrence (Grandvoinnet and Schneider 1998). Brennan (1987) sees the conflict within Angola deeply rooted in the relationships that deteriorated between the ethno-linguistic groups during the slave trade and Portuguese colonial rule. Distrust between the groups was high and these same attitudes were seen to influence the civil war and also current events in Angola.

The armed conflict continued throughout the country between MPLA government forces and UNITA, except for a short cease fire in 1991. It proved unsuccessful, though, after the 1992 elections when rekindled fighting broke out. This 1992 conflict led to the destruction of much of the remaining infrastructure in many of the war afflicted areas. Finally, in November 1994, the Lusaka Protocol was signed between the leaders of MPLA and UNITA. Integration of UNITA troops into MPLA forces was planned and the UN arrived to supervise this process, but it was generally unsuccessful and fighting resumed in 1998. This continued until the death of UNITA's leader, Jonas Savimbi, in early 2002 and subsequently a peace agreement was signed on 4 April, 2002, between the government of Angola and UNITA. Following this cease-fire was an integration process of UNITA troops into either government forces or resettlement into civilian life.

In February 2002, following the cease-fire, access to the formerly inaccessible areas began to improve. By November 2002, due to the large numbers of refugees within their country borders, a tripartite agreement between the governments of Angola, Zambia and Namibia had been signed and subsequently included the Democratic Republic of the Congo (DRC) and the Republic of the Congo (ROC) in December. This led to the official start of, but in reality the continuation with renewed emphasis, on the voluntary return of around 450,000 refugees back into Angola from the Southern African countries of refuge (UNHCR 2002). In 2001, there were approximately 202,000 internally displaced people (IDP) within Angola (UNHCR 2001).

A Migratory People

The movement of population is seen to be an integral part of the history of the country. Originally the pursuit of new land brought people down from the Luunda kingdom[6] in Democratic Republic of the Congo (DRC) into the interior of Southern Africa to what was then uninhabited land (Bakewell 2000). Migration in and around the greater area of central and southern Africa was constant, and only the colonial boundaries created such a defined sense of origin and clear border movements (Papstein 1994). The "scramble for Africa", following the Berlin conference in 1884, created the defined borders of Angola and Zambia and resulted in the divisions to the accessible tribal land (Wolfers and Bergerol 1983:103).

The region is on the historic migration route for people travelling from the north and east which has led to a mixture of populations. The tribal wars, and then the conflict with the Portuguese, resulted in the ongoing movement of people within the area. Historically this movement, resulting in displacement and then possible return, creates a people group with this process interwoven into their concept of home and identity (Bakewell 2000). There remains a constant movement of people between the present day borders of Angola and Zambia (Bakewell 2000; Hansen 1982).

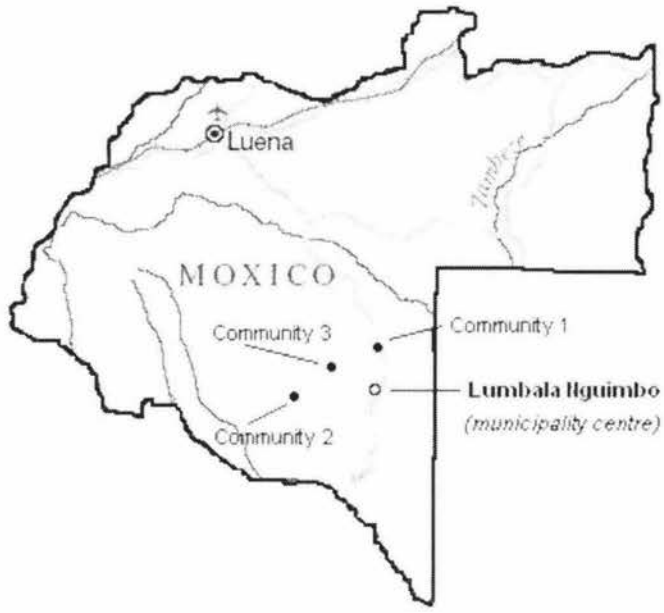
Following the establishment of peace, many people chose to come back to the area that they identified as their home, either an area where they had lived before or a location considered ancestral. In some cases it could be many or just a few years ago that they were settled in the area, and for others they may have never lived there before.

The Study Area

The study area exists in the rural setting of Bundas municipality in the eastern province of Moxico, Angola, which boarders predominantly with the country of Zambia, and partially with the Democratic Republic of the Congo (DRC). During the height of the internal conflict, Bundas municipality suffered greatly from damage to essential infrastructures. The area, with an estimated population of approximately 20-30,000, is isolated and initially

[6] This includes the Mbunda, Luchazi, Luvale and Chokwe tribes who were most prominent in the study area

received little government support following the establishment of peace. Accessibility to and within this municipality was, and still is, extremely limited due to a heavy concentration of mines and the destruction of bridges on the main provincial roads. The area could only be accessed by air at the time of research.



Map 2.2: Moxico Province Angola, the research area (source: adapted from United Nations 2004).

The town of Lumbala Nguimbo, which is the government administration for the municipality, is considered to boast a fluctuating population of approximately 10,000 people. It is currently identified by UNHCR (United Nations High Commissioner for Refugees) as an official area of return for refugees due to its proximity to the Zambian border and the potentially large numbers of people that wanted to return to the area. Medair (NGO), an international humanitarian organisation, commenced work in the area in September 2002, and started planning with UNHCR for receiving returnees as a result of organised repatriation.

A Reception Centre was built and coordinated by Medair, to act as the initial welcoming and processing centre. Returnees stayed for three days and received food and household items to assist in resettling. Health and safety education and medical care were offered. The centre opened its gates in June 2003. Areas of resettlement were dotted around the

municipality (population of approx. 20,000-30,000) and access to some of these places was very difficult. Accessibility was hampered because of land mines, un-maintained roads, destroyed bridges, and flooding during the rainy season. MAG (Mines Advisory Group), an international de-mining organisation, arrived in Lumbala N'guimbo in September 2003 to commence active de-mining and this enabled greater and safer access for all of the community.

Until the end of 2003, the municipality lacked acceptable access to health care, schools, water, and agricultural tools. Since September 2002, Medair has been working with the local government to increase the availability of these services in the Bundas area. The government has active administration offices in the main areas of the municipality, including Lumbala N'guimbo. UNHCR has an office site in the town of Lumbala N'guimbo, and IOM (International Organisation for Migration) set up an operational office mid 2004 to assist in the transportation of returning refugees.

The present process of repatriation continues at the time of this writing[7]. The return of refugees from neighbouring countries, as well as returning IDPs, puts a huge burden on infrastructures that are struggling to be re-established within the Bundas area. Newly accessible areas continue to open up across the country as roads and bridges are de-mined and repaired. The existence of land mines around certain areas creates a problem for resettlement. There is in many cases, no mapping of the mined areas.

Within Angola, and more specifically Bundas Municipality the availability of assistance to the IDP population was limited. Assistance to IDPs was the responsibility of the government, and distribution of food and items for resettlement was limited and sporadic compared to the standard kits and monthly food distribution for returned refugees, who came under the jurisdiction of UNHCR. The presence and assistance of UNHCR in the return process of refugees from neighbouring countries was strong. This difference of assistance to the two people groups created tensions between them which resulted in occasional bouts of conflict within the community. This tension was more apparent within the town setting, with rural areas appearing more unified and compatible in their approach to integration and settlement.

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[7] As of July 2005

The Concept of Health

Comprehension of the concept of health is variable due to factors including cultural, religious, and educational experiences. It can be defined and delimited in many different ways but for the purpose of this writing, the concept of *health* is considered to incorporate the all encompassing holistic wellbeing of the individual and the community as a whole, to whatever level the individual or community considers acceptable.

WHO (1948) defines health as, *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*. This definition, as stated here, is limited as it does not include the spiritual aspect of health, which is necessary for complete health. The concept of the absence of disease, in order to have health, is in general a paradigm of western thought (Woelk 1994).

The classification of health services differs from community to community, but broad international systems are very similar in general and possibly incorporate the following: traditional treatments; clinical curative treatment; prevention; education; and volunteer community trained groups, etc (Sanders 1985), again to whatever level the community considers acceptable.

Angola and Health

The beliefs and traditions of the people within present day Angola is changeable from area to area, due to the large number of different tribes. Within the Bundas area of eastern Angola the traditional concept of health for the Mbunda people is based on an all encompassing spiritual view of life. Three types of sicknesses are believed to exist that can change that sense of well-being. The first is considered 'bad willed', which include common diseases such as measles and leprosy. The second is 'magical sicknesses' which result from witchcraft practices. The third is said to come from 'ancestral spirits'. The traditional healers of these illnesses can be placed into three categories: those that treat disease with herbs and charms, those that divine and treat people, and those who call on the ancestral spirits for answers (Papstein 1994).

My research team defined and characterized a traditional healer as:

> *"a person who has knowledge about traditional herbs and the types which can cure a particular disease. He/she can cure different diseases or infections depending on length of involvement and experience attained in the practice. People can become traditional healers as a result of having worked for a long time with a traditional healer."*

The research team also gave clarity to the role of a witch doctor as:

> *"a person who can cure diseases by detecting the disease and its cause in the patient through supernatural powers. He/she has knowledge to detect witchcraft practices and can have life destructing powers. Most people become witchdoctors by buying these skills from experienced witchdoctors and others by inheriting the skills from family members who die."*

Historically, the majority of the people of Angola depended on traditional healers for health services. Introduction of clinical medicine came with the armed forces and missionaries of the 18th century (Sanders 1985). Health services were nationalised and primary health care (PHC) policies structured around the time of independence, but were not implemented adequately due to the civil war. A health model, with a central focus on the presence of hospitals and doctors, was prominent (Pavignani and Colombo 2001).

Many areas were neglected by the government health department resulting in greater NGO and agency involvement, especially at the beginning of the 1990s in the rural areas. In the late 1990s to early 2002, it was estimated though, that up to 80 per cent of the country was inaccessible for humanitarian aid (Fustukian 2004). UNITAs areas of stronghold were assisted with basic services from their military troops. The ministry of health (MoH) was without strong influence during much of the war period, especially within more inaccessible rural areas, resulting in a variety of implementation strategies and various policies being used. Relationship between the government, and therefore the MoH, and NGOs, was said to be difficult and created problems for ease of implementation. Internal medical resources were extremely limited (Pavignani and Colombo 2001).

The periods of temporary peace in the 1990s allowed for some growth in the health sector. There was international support for a focus on financial management, policy, and general capacity building of the health department. There was an attempt to move from emergency response into the support of the sustainability of the health institution. The success of

these strategies was hampered by lack of coordination of the implementing agencies and the low capacity of the ministry of health (Fustukian 2004).

Throughout the last few years of the war, the uncertainty of peace created a disillusionment of the possibility for reconstruction of the health sector. Energies were put into vertical programmes of health, as the likelihood for further destruction and interruption of the development process was probable, due to the unresolved conflict. Information collected from the development and progress of health systems, and the issues being faced, was limited due to a high turn over of implementing staff and the lack of an established national system. A history of mistrust and rivalry affected, and is said to continue to affect the development of services (Pavignani and Colombo 2001).

Concerns for the country are based on the knowledge that basic health services are limited, HIV/Aids rates are rising (est. adult prevalence at 3.9, 2003), 40 per cent of the population do not have access to safe water, more than one million children do not go to school, and millions of landmines impact on the safety of people everyday (UNICEF 2005). The national health indicators (Table 2.2) show the current estimations from WHO.

National Indicators	
Life expectancy at birth	42.0 / 38.0 (f/m)
Child mortality[8] (per 1000)	243 / 276 (f/m)
Percentage of total life expectancy lost due to poor health (2002)	16.4 / 16.6 (f/m)
Total health expenditure per capita	92 (Int. dollars)

Table 2.2: Angola national health indicators (The World Health Report 2003)

Following the establishment of peace in 2002 the main priorities for the country were identified as, infrastructure, de-mining, security for livelihoods, political reconstruction and training of health and education staff (Fustukian 2004:7).

During the time period of the field research, government driven health policies in Angola were just starting to emerge from various departments and health divisions. These were structured with the input of WHO, UNICEF, other agencies and NGOs involved in health. Prior to the emergence of government policies and during the difficult period of implementing new policies, implementers of health services based their programmes on a

[8] Probability of dying under the age of five years

combination of factors including international standards, local needs, previously existing structures and individual mandates. Within the study area of this research, an attempt was being made to establish a primary health care model which was slightly altered to fit within the needs of the post-conflict setting. The changes were due to the need for emergency health care in some of the outlying areas, because of the time delay in establishing the national programme and the opportunity for crisis if interventions were not put into place immediately.

Fustukian (2004) reports that improvements to the health network within Angola are slow. The lack of adequate numbers of health workers is limiting coverage of programmes. Much of the health funding continued to be allocated through UN agencies or NGOs, which bypassed the government ministries. There was a noted level of under-funding for health programmes in 2004. A recent IRIN Report reflects on the current phase of transition and notes that Angola still has a *"complex mix of humanitarian and developmental challenges"* (IRIN 2005a).

Summary

The historical issues presented in this chapter are integral to understanding the influences on health care in Angola today. Angola is a country of great wealth coupled with excessive poverty. Limited infrastructure in all sectors determines a population with many needs. Conflict has played a big part in the history of Angola creating a legacy of destruction and distrust. This current period of peace is an exciting opportunity for change and development. This process from conflict to the establishment of peace will be considered in the next chapter.

Photo 1:
The flags of The Republic of Angola, Medair and UNHCR.

Greeting the new arrivals at the Reception Centre Lumbala N'guimbo

Photo 2: Recently returned refugees in the first stages of resettlement.

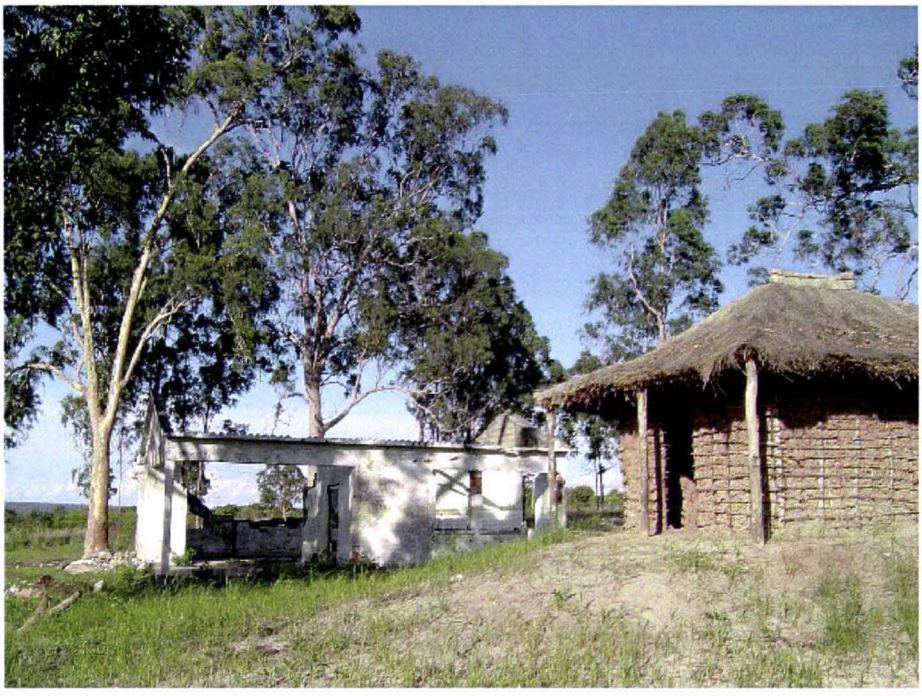

Photo 3: The transitional period, Community 2.

The original health clinic (white building) damaged in the war, with the newly built single roomed clinic building (in foreground). This clinic was not used due to lack of staff and resources. The small population size of the community meant that it was not a priority area for the implementation of services at the time of research.

Chapter 3: From Conflict to Peace

This chapter explores the process from conflict to peace using current and applicable literature. It identifies the different forms of crises, both natural and human induced, with a focus on human conflict situations. It considers the development of the complex emergency and subsequent displacement of population, recognising the impact that this has on health. The post conflict phase is introduced revealing its ambiguity. This chapter shows that the process from conflict to peace is determined by vast influencing factors that are specific to each country involved.

Emergencies

Crises in society that require a response from humanitarian actors are the result of situations that are natural, human induced or a combination of both. Awareness of the cause of the crises is key to determining the response to the disaster and emergency but in the knowledge that each situation is influenced by a number of interrelated variables that affect the reality of each situation (Toole and Waldman 1997).

The focus of this thesis will be on human induced disasters, which mainly result from situations of conflict. To clarify, in comparison, a natural disaster is specifically a disaster that is caused by a natural event. It is a geophysical, weather-related or biological event that includes earthquakes, floods, and droughts and it has damaging effects on the existence of physical structures and human life. These disasters can be acute with immediate devastation or they can be chronic, climaxing to a point of major devastation (PAHO 2000; Toole and Waldman 1997).

Human induced disasters are in most cases the result of conflict. Wallensteen (2002:16) defines conflict as: *"a social situation in which a minimum of two actors (parties) strive to acquire at the same moment in time an available set of scarce resources"*. The resources within conflict can be anything from power to principle and the actors can be farmers to politicians. Conflict can be violent or non-violent and can bring negative or positive change. It exists all the time but it is its manifestation, be it small or large, that can have a negative effect on innocent parties, with the destruction of society (Maynard 1999). Zwi and Ugalde (1989:634) note that there is political violence in most societies but that underdeveloped countries have shown a greater level of violence. Conflict creates displacement of

population as people escape violent wars and atrocities (Rogge 1994). Maynard (1999:30) reveals through the eyes of historians the reality that most historical events, whether political, cultural, developmental or personal, have occurred through violent conflict.

The perception or classification of conflict has changed with the end of the Cold War in the late 1980s. Throughout the Cold War period, conflicts in many areas of the world were considered a result of the fight for power between international factions. International funding to these conflicts was high and is seen to have played a big part in keeping many of these conflicts active, through the support of bad governments or inappropriate aid programmes (Smillie 1998). Since the end of the Cold War, more emphasis has been realised and placed on the cause of conflict from internal country issues (Macrae et al. 1995). Following this period there has seen to be an increase of internal conflicts which are complex and continuously changing (Munslow and Brown 1999; Pavignani and Colombo 2001). These civil wars break down the social structures of communities with the division of family and friends (Wallensteen 2002:133).

Conflict has been grouped into two main types. The first involves government military forces fighting for rights of the people which Macrae et al. (1995:671) label as *"ideological struggles"* and Maynard (1999:30) as *"trinitarian wars"*. The second is based more on decentralised violence with rebellions, revolutions and campaigns often within country borders. Macrae et al. (1995:671) considers this as *"fragmented conflicts"* and Maynard (1999:32) as *"insurgent movements"*. Maynard (1999:33) has also identified a third pattern of conflict called *"identity conflicts"*, more especially identified within post Cold War uprisings. Its foundations often rise from individual groups at community level who have personal missions to achieve. These conflicts result in disintegration of society through distrust and disunion. These categorisations of conflict are considered interrelated and merging at times, and cannot be completely considered independently (Macrae et al. 1995).

The process of peace is generally inconsistent after intense armed conflict and can involve many years of discussion, involvement of a variety of factions, huge demands on resources and a great deal of patience. Within Angola, two peace agreements were signed during the 28 year period of conflict prior to the current 2002 agreement; one in 1991 lasted nearly a year and the other in 1994 lasted four years (Wallensteen 2002). Without

complete integration, the peace did not last. This cycle of war and peace can occur readily in unstable countries as has been seen over the last two decades in the Democratic Republic of Congo, and Liberia (Macrae et al. 1995).

Complex Emergencies

Active conflict, depending on its manifestation and severity, can lead to what is considered as a *complex emergency*, defined by Duffield (1994:38) as *"unprecedented levels of abject poverty, political insecurity, conflict, state disintegration and population displacement"*. The use of this term evolved in Africa in the late 1980s and is generally considered to be the result of political issues and therefore has an effect on all aspects of society, from culture to economy (Duffield 1994). Tsui (2003:36) identifies complex emergencies as a *"total or considerable breakdown of authority"*. As quoted by Duffield in Munslow (1999:209) it can be considered a *"neutral metaphor for civil war"*.

The outcomes of disorder and destruction from forms of conflict have been considered similar to the outcomes of natural disasters. The difference between the two is that the complex emergency involves the deterioration of society whereas in a natural disaster the society structures remain intact (Duffield 1994:38). Duffield (1994) comments that specific responses are required to the situations. He criticises international relief efforts for not identifying the differences between these two circumstances and therefore inappropriately responding to them. Tsui (2003:35) argues that the differences are not always clear and the aftermath of both of these situations are similar and can be the cause or effect of each other, thus being interlinked. He does identify though, that there are differences in the *"immediacy, duration, scope, and political complexity"* of the crises which leads to a variety of responses.

Emergencies and Health

Both complex emergencies and natural disasters create death, population displacement and damage to infrastructure. Tsui (2003:34-35) notes that worldwide, over three million people have died within the last two decades from natural disasters, compared to five million within the last decade from complex emergencies.

An acute natural disaster has an immediate impact on health including death and injury. Table 3.1 shows the direct effect of earthquakes, high winds, floods and tsunamis. These

events are followed by general disruption to the health system through the destruction of facilities and infrastructure. The damage to water supplies and food sources has a long-term detrimental impact on the society, including outbreaks of communicable diseases from unsanitary living conditions (Toole and Waldman 1997). Other common health problems identified include social upheaval, population displacement, climatic exposure, and mental health issues (PAHO 2000:2-5). The long term effects of the process of reconstruction can be laborious and slow, especially in an underdeveloped country that has had limited infrastructure to start with, and this has a huge negative effect on health (Burkle 2003).

Effect	Complex emergencies	Earthquakes	High winds	Floods	Flash floods / tsunamis
Deaths	*Many*	*Many*	*Few*	*Few*	*Many*
Severe injuries	*Varies*	*Many*	*Moderate*	*Few*	*Few*
Increased risk of communicable diseases	*High*	*Small*	*Small*	*Varies*	*Small*
Food scarcity	*Common*	*Rare*	*Rare*	*Varies*	*Common*
Major population displacements	*Common*	*Rare*	*Rare*	*Common*	*Varies*

Table 3.1: Public health impact of selected disasters (Sphere Project 2004:257)

Toole and Waldman (1997:283) also recognise that complex emergencies create severe public health consequences, which are a result of destruction of infrastructure through population displacement, food scarcity, and the collapse of basic health services. Table 3.1 also outlines the impact of these emergencies on personal health. Landmines have a long term detrimental effect on community health, causing physical harm as well as emotional stress due to their unknown locations. The breakdown of the infrastructure of roads, communication, housing and food sources all have a major negative effect (Zwi and Ugalde 1989). The end result of this is excess mortality, with the severity of the emergency again being relevant to the negative effect.

Table 3.2 reveals a more detailed breakdown from Table 3.1, of the direct and indirect effects of complex emergencies on public health. The direct effects are personal while the indirect effects are the impact on the community infrastructure and daily activities of life.

Direct Effects	Indirect Effects
Injuries / Illnesses	*Population displacement: internally displaced and/or refugees*
Deaths	*Disruption of food*
Human rights abuses	*Destroyed health facilities*
International Humanitarian Law violations and abuses	*Destroyed public health infrastructure*
Psychological stressors	
Disabilities	

Table 3.2: Direct and indirect effects of complex emergencies (Toole displayed in Burkle 2003:56)

Alongside the physical health problems of conflict and disaster, trauma and psychological stress is manifested through a number of different symptoms. Baron et al. (2003) identify that most people focus their energies on survival within the emergency phase and the effects of trauma are not identified immediately. Depression, confusion, denial, guilt and anxiety all create stress which the body deals with in different ways, including disorders of behaviour, development, sleep, intestine, eating, speech and many more. The personal trauma of one member of the family has an effect on the whole family (Zwi and Ugalde 1991:209). Baron et al. (2003) comment on the effect that culture has on the diagnosis and manifestation of trauma and stress, revealing that the outcomes are variable all over the world.

Populations that have experienced conflict and have been displaced from their homes are vulnerable, not only to physical ill health, but also psychologically and socially in their rights as citizens, their voice, and power in the community (Banatvala and Zwi 2000). The vulnerable people of conflict are typically the women, children and aged. Women are often the victims of rape and violence throughout war (Zwi and Ugalde 1991). This gender based violence is an increased risk and stress reality for women (Baron et al. 2003).

Conflict and disaster is a major disruption to the effective growth of a national health system and the development and implementation of health policies (Bornemisza and Sondorp 2002). Initiatives at all health levels are lost, especially in the area of primary health care and more specifically preventative services like immunisation and antenatal services (Toole and Waldman 1997). Resources that would normally be used to maintain

and improve the primary health system are placed into emergency response programmes (Zwi and Ugalde 1989). Health workers are known to be targeted with offensive treatment due to their work in assisting particular communities involved in conflict (Zwi and Ugalde 1991).

The similarities of the effect on health between a complex emergency and a natural disaster are quite clear. But there are differences that are linked to the original causes of the crises and, as seen in Table 3.2 include the abuse of human rights and the violation of international humanitarian law, leading to forms of psychological stressors based on distrust and fear of sectors of society. Within a natural disaster this outcome is not directly present. The breakdown of the foundations and structure of society is what makes a complex emergency so complicated and therefore challenging for rehabilitation and development.

Displacement

Displacement of population is an outcome of disaster and it occurs frequently throughout the world. Figures reveal that there were 2,900,000 refugees and asylum seekers[1] and 12,009,000 internally displaced people within the region of Africa in 2003 (International Federation of Red Cross and Red Crescent Societies 2004:193,200).

Displacement often involves loss of belongings and livelihoods, depending on the nature and severity of the situation. Exiled refugees generally have only what they are wearing or carrying, leaving them vulnerable and completely reliant on assistance from others (Simmonds et al. 1983).

The destruction of housing and infrastructure, as a result of a natural disaster, creates the need for immediate aid response in order to cater for the basic needs of these populations. A greater number of people are forced to leave their homes due to violence and fear of injury and death. Baron et al. (2003:243) list some violations that these people suffer including: *"torture, rape, abductions, sexual violation, war wounds, deprivation of basic needs, ethnic cleansing, persecution and harassment, loss of home, loss of loved ones, premature death and genocide"*. The psychological effects for both IDPs and refugees include anxiety and fear for safety and future provisions. Bennett (1998:11) considers that

[1] By country of origin

the decision of where to go is influenced by the *"proximity of international borders, urban centres; the location of family, clan and community members; financial resources; and the kind of help available from national or international bodies".*

Throughout the period of conflict the population can oscillate between the area of conflict and the area of refuge. It is considered that community cohesion and cultural identity is retained at a much greater level if displacement occurs as a community group (Baron et al. 2003). When peace is established the process of return becomes viable as a permanent option and complete repatriation can occur.

In a study of African refugees and IDPs between the years 1964-96, it was seen that the average displacement for refugees lasted for 11 years compared to 6 years for IDPs (Schmeidl 1998:29). The issue of refugees is in general another area considered lacking in adequate research and information especially within the African region (Sorenson 1994).

Internally Displaced People (IDPs)

Internal displacement of people during a period of war is a common reality and is considered to generally occur at the same time as the flight of refugees rather than in place of (Schmeidl 1998:26). The choice to remain within the boundaries of a country during conflict can be a premeditated or an uncontrolled decision, resulting in a variety of outcomes. Choices are made in consideration of available resources and assistance and can be individual or community led (Bennett 1998). One man in the survey area, commented regarding leaving Angola during the war, *"we had the desire to go to Zambia but we were blocked and taken back to Lumbala* (Angolan town)" (male, IDP, focus group discussion, Community 2).

A definition that effectively describes the internally displaced person (IDPs) has not been realised internationally (Schmeidl 1998). Classification is made when the internal displacement of a population is forced. Within the setting of their own country, IDPs are internal citizens and therefore remain under the responsibility, care and protection of their government. This can be a difficult situation if it is the government that has been responsible for the initial displacement (Norwegian Refugee Council 2002) and can leave the people unprotected and vulnerable (Zwi and Alvarez-Castillo 2003).

The UN, under the Office of the High Commissioner for Human Rights (UNHCHR), has 30 guiding principles on internal displacement to ensure assistance and protection for IDPs. Within these principles, IDPs are defined as,

> *"Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border"* (UNHCHR, Guiding Principles 1998).

The Global IDP Survey which was created by the Norwegian Refugee Council in order to collect international information on IDPs also uses this definition (Ludlam-Taylor 1998).

Assistance to IDPs is given by different organisations working within the country but, due to the internal conflict, many of these organisations are restricted and therefore not accessible to those in need, (Schmeidl 1998) although Ludlam-Taylor (1998) discusses how access has increased with improvements in NGO implementation strategies. NGOs and international agencies require government permission to be involved in the assistance of IDPs (Baron et al. 2003; Rogge 1994).

IDPs are forced to relocate to areas of greater safety, often fleeing to stay with family and friends in neighbouring villages. They also access camps, towns, cities, or areas deep in the bush. In most cases this displacement involves danger in travel, lack of food and resources, and a greater susceptibility to disease (Global IDP project and Norwegian Refugee Council 2002).

It is noted that most international actors perceive IDPs to be people in need who are defenceless against protecting their home. People can also become internally displaced through choosing to actively move from their home area. This could be a result of chronic social issues and other outcomes of war but these situations are not often seriously considered and would benefit from more attention and research internationally (Bennett 1998:11).

The UN agency UNHCR (United Nations High Commissioner for Refugees) who works so closely with refugees, is not mandated to assist in the care of IDPs and there is often the feeling that IDPs have been disregarded (Rogge 1994). Cohen (2000) discusses the

positive effect that the Guiding Principles can have on the protection and treatment of IDPs. It is acknowledged though, that these principles are not binding and it will take international effort to ensure that they are achieved. Time and training is seen as required before the full effects will be felt by the IDPs themselves.

There is much discussion and literature on the protection of IDPs and the acknowledgement that international response to the issues involved has at times been unsatisfactory (Ludlam-Taylor 1998). The Global IDP Project and Norwegian Refugee Council (2002) on internally displaced people acknowledges an improvement in the collection and analysis on information which assists in the process of improved response but states that the data still remains inadequate and practical application is limited.

A recent IRIN (Integrated Regional Information Network) Africa English report outlined that internal displacement is a current neglected humanitarian issue, especially in Africa. The report went on to say that, *"displaced people lacked basic support, were destitute and often subjected to abuse"* and that the UN was assessing and putting more effort into the issue (IRIN 2005b).

External Refugees

People who are forced from their country into asylum elsewhere are considered refugees. The term *refugee* was first thought to be used in 1685 in reference to the French Huguenots who left after the Revocation of the Edict of Nantes (TIERE 2000). The 1951 UN Refugee Convention, article 1, defines the term *refugee* as,

> *"(any person who) ... owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it"* (UNHCR 2000:23).

Experiences of refugees within their host countries are broad and variable. Some choose to stay in organised camps and are assisted with daily needs and health care. Others choose to settle independently (if allowed) within the host community and access services as able (Rogge 1994; Toole 2003). Once people leave their country borders and become refugees they may be officially recognised and make use of organised settlement areas in

the host country or they may settle independently, many times with friends or family. The differences within the communities and settlements depend on the country and assistance given. Some organised settlements may provide all services and basic needs while others promote a more permanent setup with a focus on independence, encouraging land development and agriculture (Simmonds et al.1983).

One of the largest agencies working for the assistance and protection of refugees is the UNHCR (United Nations High Commissioner for Refugees), a division of the United Nations. UNHCR's official involvement in this programme began in 1950 and their mandate is to *"lead and co-ordinate international action to protect refugees and resolve refugee problems worldwide"* (UNHCR 2005).

Many agencies regard refugees as an important people group. Sorenson (1994:177) considers refugees within Africa as integral to development. Assistance to the needs of refugees is the focus of many NGOs, some specifically targeting their work to encompass just refugees, and others working for the total population which includes people with refugee status. Many groups apply international mandates to control standards and assist in the care of these identified people groups (Rogge 1994). An internet search[2] using the term *refugee* reveals an array of agencies and organisations actively involved in the protection of refugees. Many are not only web based, but are actively involved and are internationally recognised for this work.

Both positive and negative effects are experienced by the host country from the presence of refugees within their borders. In some cases, there occurs positive economic gain for an area and in others, refugees are seen to be a drain on already stretched resources and services (Sorenson 1994).

Due to the assistance that they received during exile, many refugees develop a level of dependency. Rogge (1994:35) notes that refugees who are given the opportunity to live in their area of refuge with the same lifestyle as they did prior to displacement, maintain self-sufficiency. Those that live in organised settlement schemes that do not promote self-sufficiency are in danger of becoming dependant on the system. Simmonds et al. (1983:196) see that relief programmes form dependency due to the long time frame in the

[2] completed on 13 June 2005

refugee scenario. They consider offsetting the possibilities of dependency through encouraging self-reliance in the participation of families in the programmes that are being implemented, and particularly within health care.

This quote classifies the refugee and internally displaced person,

> *"There is little difference between the displaced and the refugee, save the fact that one remains in his or her country of origin, while the latter crosses a recognised international boundary. Both have been stripped of their livelihood and are in imminent danger of loss of life. They are poor, malnourished, vulnerable to disease and unable to survive without outside help. What difference there is tends to lie in the fact that the refugee is more visible and more likely to attract the attention of the international community"*
>
> *(Eritrean Relief Association 1983, in Adelman and Sorenson 1994:74)*

The Eritrean Relief Association (1983) identify that refugees and IDPs are similar in many ways, both groups having been displaced. They also note that the difference between the two groups is in the response from the international community, revealing the limitations for the protection and assistance to the IDP. This issue is still relevant over ten years on.

Displacement and Health

Beyond the health issues that have been outlined for complex emergencies and natural disasters, is the recognition more specifically of the effect of displacement on the health of the population. Throughout the period of conflict the health issues of refugees and IDPs are considered similar. The physical and mental health issues as already discussed are relevant and even more pronounced for many displaced people (Zwi and Ugalde 1991; Baron et al. 2003). Displaced populations are in general considered more susceptible to communicable disease, nutritional deficiencies and injury (PAHO 2000; Toole and Waldman 1997; Toole 2003). The effectiveness of a primary health care (PHC) initiative is seen to be lost through population movement due to the whole disruption in community cohesion and support (Toole and Waldman 1997).

IDPs are often considered worse off than refugees due to the lack of protection and provision of services which refugees can access under international law (Burkle 2003). The trauma and abuse of IDPs is identified within many countries (Zwi and Ugalde 1989). They therefore have difficulty in accessing health services, food and water and there is often limited opportunity for NGOs and agencies to reach these communities due to danger and conflict. IDPs may also suffer more conflict related injuries due to their proximity to the fighting (Toole and Waldman 1997; Toole 2003).

In comparison, for refugees, the trauma of leaving their country of origin under pressure is seen to have an effect coupled with not knowing if and when they can return (Zwi and Ugalde 1989). Settlement camps may or may not provide adequate services. Substandard health care, food, housing, water and sanitation can be a reality for refugees (Zwi and Ugalde 1991:210). Rogge (1994) notes though, that the level of care and the services available within the host country settlements are often much better than their home country. This can cause problems when opportunity for return is possible, and can create difficulties for reintegration. Zwi and Ugalde (1989:636) also note that services can be better in the area of refuge but they reveal that the services can be *precarious,* noting the results of a study of Afghan refugees in Pakistan which showed an increase in infant mortality compared to their home statistics. The effects that the cultural and language barriers of the country of refuge have on health must also be considered.

The Humanitarian Response

The humanitarian response to these emergencies requires at some point emergency and relief intervention, with efforts toward development and sustainability of community systems. The immediate response for natural disasters and complex emergencies is often considered or misinterpreted as the same for both types of emergencies. The relief efforts of a complex emergency though, can be much more complicated than a natural disaster due to the long term process of destruction of society, thus reducing the effective reconstruction of the communities involved (Tsui 2003).

This process of relief and emergency assistance is seen to involve the provision of very basic life-supporting needs (Walker et al. 1994) within a short term timeframe, with often high intensity spending which can be donor initiated (Fagen 2003). It can have the tendency of being *"top-down, donor dependant, inflexible and hierarchical"* (Buchanan-

Smith as cited in Ross et al. 1994:5). Emergency aid is seen by Ginifer (1997:4) as primarily to *"preserve life or lessen suffering"* which, in health, is the focus and outcome of the reduction of morbidity and mortality (Burkle 2003). The response to complex emergencies and natural disasters requires flexibility (Tsui 2003).

Zwi and Ugalde (1991) agree that the response to emergencies requires immediate care for the needs of those affected. This includes medical treatment and the provision of the basics of life. They see ongoing assessment and evaluation of these interventions as essential. Attention to trauma and addressing mental health issues take a longer period of time but also needs to be considered within this initial phase of response. Baron et al. (2003), with their focus on trauma interventions, also acknowledge the need for basic emergency interventions prior to the psychosocial and mental health issues that may need to be given attention.

Tsui (2003:37-53) identifies six key elements for response to emergencies. In brief these are: the effective assessment of needs and the organisation of the actors' response; adequate staff and resources; effective use of organisations, tools and stock; adequate and available funding; effective information management networks; and continuous evaluations of efforts. The focus or intensity of the use of these elements is varied depending on the type and history of the emergency. Within conflict, this response is limited, with coordination difficulties between fighting factions and physical danger zones.

A specific health response to an emergency is often restricted by the lack of staff, finances and historical data which can hamper effective assessment of the situation. The traditional use of epidemiological data for assessment (detailed and specific health data) is not possible due to time and the fact that a lot of data has often been destroyed (Burkle 2003; Banatvala and Zwi 2000). This determines the use of a form of rapid assessment which quickly identifies the impact of the emergency on public health (Burkle 2003; Toole 1999).

Zwi and Ugalde (1991:211) identify that heath workers have a key role in opposing and overcoming violence through advocacy and the promotion of circumstances that are democratic and egalitarian. This can be done through using their professional roles to influence policies and action. On a more simple level it can be seen to be achieved through providing care and creating techniques to promote health to its fullest potential.

The disruption to public health that occurs from an emergency is revealed in Figure 3.1. It shows the initial upward trend of the disruption being reduced as the initial health needs are taken care of. The doted line shows a potential increase in problems as the process goes into the rehabilitation phase. This resurgence in public health disruption is due to the difficulty that can occur in the restructuring of the health system for normal levels of public health to occur (Burkle 2003).

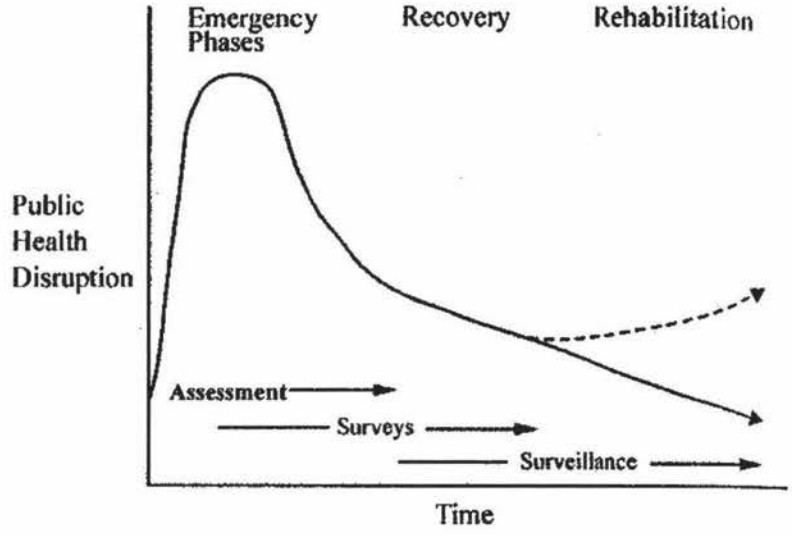

Figure 3.1: Emergencies and the disruption to public health (Burkle 2003:60)

Voutira and Harrell-Bond (2000), in their discussion on successful refugee settlement, acknowledge the importance of identifying the huge variables that affect displaced populations. The effects of past experiences and the many different ways that each entity deals with these do not allow for homogenous grouping and interventions.

Introducing 'Post Conflict'

A search of literature revealed that the use of the term *post conflict* is limited within published material. *Conflict management* is a much more commonly used term, but the consideration specifically of the phase after the resolution of conflict, appears ambiguous and limited. This has led to the use of literature that refers to conflict but not so easily the term *post conflict*. Availability of working documents on the World Wide Web is greater

than published books, revealing a current focus on the topic and the ongoing development of its concepts which have yet to be condensed. The term *post conflict* is used literally here to describe exactly that - *post* conflict, beyond the phase of conflict.

The emergence of a country from conflict can be laborious or abrupt depending on the nature of the cause of conflict and the length of time incurred. There is a definite transition phase that occurs from the reduction of conflict through to the complete establishment of peace and ongoing opportunity for development (Macrae 1995). Waters et al. (2004) see this phase as key to sustaining peace as well as the reconstruction of infrastructure. This phase may include times of intermittent conflict but the main source of the unrest is considered over (Macrae 1997).

Macrae (1995:4) outlines three defining factors for this phase of post conflict:

1. *the signing of a formal peace agreement*
2. *a process of political transition by elections, a negotiated or military transfer of power*
3. *a perception among national and international actors that there is an opportunity for peace and recovery*

Beyond these three points is also the issue of *increased levels of security* (Macrae et al. 1995:671). These factors may not all occur at the same time and are considered to be of varying importance within each country situation.

This concept can also be called 'conflict resolution' which Wallensteen (2002:8) defines as a situation where... *"the conflicting parties enter into an agreement that solves their central incompatibilities, accept each other's continued existence as parties and cease all violent action against each other".* This definition reflects the concepts of Macrae (1995) and within Angola, all of these factors were to some extent implemented with the signing of the peace agreement in April 2002, and the integration of the rebel troops into government recognised forces. Internationally and nationally there was recognition of a new phase of development post war.

Conflict resolution goes beyond the absence of war, and incorporates all the values of peace building and integration. The key to the transitional period post conflict is to prevent

conflict arising again as the nation rebuilds itself (Macrae et al. 1995). A post conflict country has certain characteristics. Angola, as an example, shows a country with limited infrastructure, corruption at many levels, and limited policy implementation (Bornemisza and Sondorp 2002).

The type and length of conflict impacts on the establishment of peace and therefore on the process of reconciliation. The process has a period of transition, between the actual end of conflict (which may not be completely defined), and the resettlement of a country, requiring implementation of the desired policies and controls that are essential in order to have a functioning society. This process involves return of people to their home areas, rebuilding of infrastructure, setting and implementation of policies across all sectors, reinforcement of leadership, emphasis on training and up-skilling etc. The list goes on and on depending on the severity of destruction across all levels of society (Wallensteen 2002).

In reality the definition and use of the term *post conflict* is not clear cut, due to the unsettled nature of the conflict to peace phase. Kreimer et al. (1998) discuss The World Bank's view on the concept of the post conflict framework. In trying to define it, they focus on the definition of a country in conflict and identify the post conflict requirements for it. A clear definition of the actual concept is not given. Other authors, (de Zeeuw 2001;Macrae 1995; Munslow and Brown 1999) evading a direct definition, also describe the scenarios that may define a country or just avoid the use of the term (Wallensteen 2002). Bornemisza and Sondorp (2002) state that post conflict is defined as *"after a complex political emergency has ended"*, but they also give characteristics of the country scenario.

A review of The World Bank's involvement in post conflict situations reveals diverse inputs and time frames within each setting. Kreimer et al. (1998) acknowledge the influence of socioeconomic characteristics, and time and intensity of conflict, on the needs of the areas. The defining of an ideal time frame is therefore not possible. The unstable nature of the conflict areas, where peace is not an instant establishment, determines a process of development which is influenced by so many variables.

The Process of Repatriation

The process of return or repatriation of the displaced person to their area of origin occurs informally (spontaneously) as well as in an organised and official manner, with

international involvement and controls (Rogge 1994), and should always be voluntary (MSF 1997). Rogge (1994) comments, that the increase in people seeking refuge can be a subsequent pressure to repatriate these people. This pressure can result in forced repatriation to areas that are not ready and able to cope with a return of people. Sorenson (1994:179) describes a feeling of insecurity that returnees may have when faced with integrating back into a country and system that may have persecuted or oppressed them.

This process of movement is, and has been, constant over the ages of time, people moving between countries due to disaster, from either war or natural causes. Depending on the extent of the repatriation, entities involved in the process can include: the displaced people groups, governments, NGOs, UN agencies, other international agencies / human rights groups, etc. (Zwi and Alvarez-Castillo 2003). Repatriation is seen as key in encouraging and creating stability within a country post conflict, but returning back 'home' is not always considered the best option, and other possibilities include complete integration to the host community or migration to another country (MSF 1997; Sorenson 1994:178).

Other influences on successful repatriation include the willingness of refugees to return, cooperative or uncooperative governments, overwhelming or limited assistance to the repatriation process and reestablishment issues (Rogge 1994). Exile has historically been perceived as temporary but Rogge (1994) comments that with the change in the source and form of conflict, expectation for permanent refuge is often sought. The desire to return is variable.

On return to their country of origin refugees are generally processed through 'transit' or 'reception' centres. UNHCR is responsible for this process and utilise humanitarian partners to organise and implement the programmes. These centres vary from place to place, but standardly provide food and implements for resettlement, education and medical services. For the returnees, this can be a positive time of commencing the reintegration process but Rogge (1994) notes that it can also be intimidating and overwhelming for some who just want to go home.

Reintegration back into their home area for both refugees and IDPs is a process dependant on many factors. It involves political, social and economic reintegration which

has a compounding effect on all areas of their new lives (MSF 1997). Depending on the length of time they have been out of the country, returnees will have to adjust and cope with issues including: lack of services, limited agriculture and industry, loss of identity, different language, culture changes, different school systems, and changes in types of housing, etc. (Rogge 1994). Rogge (1994:35) states that *"reluctant migrants seldom make successful settlers"* and it is important to get this process right.

Experiences in Ada Bai, with the return of refugees from Sudan in the 1990s, were of people who had been dependant on aid for many years. Access to health care, food, clothing and items like soap, was free and constant, provided through humanitarian assistance in the areas of refuge. The outcome showed that there was a lot of disappointment experienced during the period of return to their home areas as the provision of these items was not to the same level or standard. A scheme was started using programmes that combined participation with benefits in order to assist in the resettlement phase. Programmes like food for work are considered within this to enhance attitudes of self help and community development (Hammond 2004:194).

The repatriation process within Cambodia started in 1991 and needed to be completed by 1993, prior to the elections. UNHCR refers to this repatriation as its largest and most complex due to large numbers of people returning, as well as the impact of the political influences on the whole process. The process was deemed a success by UNHCR, determined by the financial backing and political developments that occurred in Cambodia (Eastmond and Ojendal 1999).

The returning population to a post conflict area brings with them the health issues from their area of refuge. Migration and movement allows for contact levels that fuel the introduction or spread of particular disease processes which may not have existed previously at an identifiable level within the community of return. Fagen (2003) notes, that the return of population to areas that have been affected by war is difficult due to the lack of services available. There are often high expectations placed on agencies to provide essential needs as well as a focus on long term development goals. UNHCR often finds it is difficult to achieve the desired results of a project within the set timeframe.

Summary

This chapter identifies the different forms of crises and the humanitarian response to them. It reveals that complex emergencies have different impacts on the health of the population than those affected by natural disasters. Complex emergencies deteriorate the social structure of society creating difficult scenarios for the humanitarian response. Population displacement is an outcome of these emergencies and the experiences of people are seen to be very different. The biggest impact of displacement on health is the increase in vulnerability towards disease and psychological trauma. The end of a conflict driven emergency, with the establishment of peace, is also a complicated phase. The concept of post conflict remains ambiguously defined leading to confusion over the style of programme implementation. The next chapter address this issue of the transition between relief and development, and considers the health strategy for it.

Chapter 4: The Transitional Phase - Post Conflict

> *"Better 'development' can reduce the need for emergency relief; better 'relief' can contribute to development; and better 'rehabilitation' can ease any remaining transition between the two"*
>
> (Buchanan-Smith and Maxwell cited in Ross et al. 1994:1-2).

This chapter presents the transitional period from relief to development within the post conflict phase, linking the development of health in this process. The quote above, from Buchanan-Smith and Maxwell, identifies rehabilitation as the transition between relief and development. This chapter discusses the discrepancies involved within the process of rehabilitation. It reveals strategies for the implementation of health systems. It introduces international guidelines for health system implementation and uses the breakdown of the guidelines to steer the discussion. As discussed in Chapter Three, *post conflict* literature specific to health is limited therefore making the review slightly problematic.

Between Relief and Development

Humanitarian assistance is implemented according to need, the mandate of the implementers, the donor guidelines, and government policy. The use of terminology like relief, emergency assistance, peace building, rehabilitation, and development all impact on the perceptions and understanding of the style of response. Beyond the initial response to the complex emergency and aftermath of a natural disaster, comes the greater clean up process and rebuilding of society. This aftermath of conflict and disaster brings a hopeful phase of reconstruction and development. The issues evolving out of the transition from the end of conflict through rehabilitation and into the development phase is well documented and discussed within published and web-based written material. A focus on this transitional phase when peace is restored is considered here.

The transition from war to peace through to development is seen as involving social, economic and political transformation in order to achieve *"citizen security, rule of law, more equitable distribution of resources, functioning markets, responsive and effective governance, an active civil society, and basic trust"* (Fagen 2003:197). After a natural disaster it is possible to commence most pre-disaster activities, both social and economic, with some limitation due to infrastructure damage. In a post conflict situation this is not as

easy due to the enormous destruction that has occurred on all levels of society, - socially, politically, physically and economically (Kumar 1997).

The transition between relief and development or the *gap theory* as it is also called, is considered by many to be an issue of the past. It is relevant to discuss it here though, as it gives background to current thinking for the implementation of aid in a post-conflict setting. Through the literature review on this topic it is apparent that the issues surrounding the linking of relief and development were a hot topic in the mid 1990s (Macrae et al. 1995; Ross et al. 1994; Smillie 1998) Beyond this though, discussions and publications on this topic continue to occur due to ongoing discrepancies and the complexness of the process. This is important for the relevance and improvements of practice.

There is often confusion and ambiguity in linking the concepts and responses of the relief and development processes (de Zeeuw 2001; Duffield 1994; Longhurst 1994; Toole and Waldman 1997; van Damme et al. 2002). I have already discussed in Chapter Three, the initial humanitarian response through the process of relief and emergency aid. Consideration of the process beyond this requires an understanding of some of the terminology in use.

The model for relief, as already discussed, is often based on natural disasters where it is considered to be separate to the work of development. As complex emergencies evolved more and more out of political and internal conflict, the differentiation between relief and development changed and throughout the 1990s the concept of the relief-to-development continuum was formed (Munslow and Brown 1999). In general, emergency and relief programmes are considered as short term, high impact projects that respond to the immediate need of the population. Relief programmes are often put together in a hurry to acknowledge or answer a need which Banatvala and Zwi (2000:102) describes as "ad hoc". They also describe a *"tension"* between the initial relief programme of saving lives, and the implementation of a health system that will be sustainable and effective in the long term. The balance of time versus quality in the implementing of relief projects is difficult. Acknowledgement is made that some short term projects may create problems for establishing peace or local government (Banatvala and Zwi 2000:104).

The term *rehabilitation* creates confusion when used for both situations of disaster and conflict. Within disasters, rehabilitation is generally thought of as the restoring of infrastructure to its pre-disaster state. De Zeeuw (2001:5) confirms this in his definition which is, *"assume the ability to restore a society to its previous condition"* although he acknowledges that this definition is difficult to use within a post conflict phase where the previous state of the society which is often responsible for the conflict, may not be desirable to attain again. The concept of *rehabilitation* can also be substituted with the term *reconstruction*. But when considered in the light of post conflict, is restrictive considering the lengthy timeframe of many conflicts and the limitations of the pre-existing structures (Kumar 1997:2). The concept of rehabilitation is seen by Macrae et al. (1995:680) as a term that *"implies a re-evaluation of the goals of relief and development in an unstable world"*.

It is necessary post conflict, not to go back to the conditions that created the crisis, but to move on to new things. Kumar (1997:2) sees that this basically involves the restoration of relationships at all levels of society, psychosocial healing, and the reforming of policies. De Zeew (2001:5) seems to take this thought to another level when he considers *transition* as a term which *"presupposes a certain direction to which development is geared"*.

The concept of development is broad and variable. Traditionally, development has been defined by many within the modernisation theories of the 1950s, as a progressive concept based mainly on economic terms (Macrae et al. 1995). Cowen and Shenton (1996) give an array of definitions from other writers but conclude that a set definition cannot be given due to confusion over the use of the term and its large, encompassing concept. They feel that development *"defies definition...because of the difficulty of making the intent to develop consistent with immanent development"* (Cowen and Shenton 1996:438).

Duffield (1994:38) defines development as a *"normative process of becoming: a series of interconnecting movements leading from poverty and vulnerability to security and well-being"*. Ginifer (1997:4) sees it in a similar light, as seeking to *"change the underlying conditions of life"*. Practically speaking, development can be seen as *"long term, evolutionary, with emphasized decentralised and participatory approaches"* (Buchanan-Smith cited in Ross et al. 1994:5). Development is generally thought of as involving long

term programmes, with fundamental concepts of ownership and capacity building. Rehabilitation is considered the linking phase in between.

Within the Oxfam Handbook (Eade and Williams 1995) the principles of development and relief work are outlined and discussed. The concepts of both terms are seen to be fluid and interrelated and are not referred to separately within the discussion. They are both seen to be without boundaries in order to transform lives and societies through various people-centred programmes.

Participants in the Conflict Research Unit International Seminar (de Zeeuw 2001) emphasised the recognition of post conflict rehabilitation as a process with interrelated and long term approaches. Development strategies take time to implement and Fagen (2003) comments that relief programmes are sometimes still needed until this process has been established effectively. Pavignani and Colombo (2001) noted that at the signing of the peace agreement in Mozambique in 1992, relief activities were scaled down and the focus for donors became developmental.

Duffield (1994) discusses thoughts from UNDP (1994, Position paper of the working group on operational aspects of the relief to development continuum) commenting that due to the high expenditure of relief there was concern that it would overshadow development.

We can see from this discussion that the concepts of relief, rehabilitation and development are at times inconsistent and ambiguous. They also appear variable depending on the context and approach to the situation. To free themselves from the inconsistency or possibly to add to it, Sondorp et al (2001:967) consider the use of *developmental relief* as a term to describe *"humanitarian relief activities which have a longer-term development perspective in mind"*.

The process of relief and development within modernisation theory is considered linear (Macrae et al. 1995; Ross et al. 1994; Smillie 1998). The concept of a *continuum* from relief to development is seen as a definitive separation of the two concepts of development and relief, with different parties involved in the implementation processes. Within this continuum, when disaster or interruption occurs in the development process, the

interruption is dealt with as a separate issue and then the process of development is able to continue (Ross et al. 1994; Smillie 1998).

The causes of the interruption are, in most cases, a result of political issues and are tied to underdevelopment (Macrae et al. 1995:673). This theory of a continuum is seen to be problematic as the boundaries of relief and development are constantly merging and the concepts can not be seen as individual and self-contained, resulting in continuous linking between the two concepts (Smillie 1998). There is also seen to be a discrepancy between theory and practice. The unstable nature of the post conflict phase means that the continuum doesn't have a chance to work with ongoing disruptions to the process (Kreimer 1998:2). Due to this inadequacy the continuum model has become discredited and many consider that there is a need for a new approach incorporating relief, development and peace building (de Zeeuw 2001; Pavignani and Colombo 2001).

Dabelstein (2001) presents nine lessons from over 50 evaluations on the aid response in Afghanistan. Lesson six (Dabelstein 2001:5) states, *"the relief-rehabilitation-development transition requires delegation of authority, flexibility and strengthened monitoring"*. In Afghanistan, it was found that there was a lack of consistency between relief, rehabilitation and development, within the delivery of aid. The reasons for these problems were based on framework differences, new governments, time and planning differences, high staff turnover, donor issues, and funding limitations.

Therefore the linking of the concepts of relief and development are considered essential to ensure that the issues are dealt with as part of the big picture and not just ignored as separate problems. Rehabilitation has been considered by some as this link between relief and development (Macrae et al. 1995). But Macrae et al (1995) also infer that this link creates problems for practice. The actual objectives of relief and development are quite different and therefore the ease of rehabilitation making a smooth transition between the two is seen as difficult.

Ross et al. (1994:6) discusses that some situations can not be categorised with a defined approach of one type of intervention or another, but that participation with the community is necessary to find the most appropriate intervention required. To have a successful transition, strategies need to be based on the specific situations of the countries involved.

This transitional phase post conflict remains relatively undefined and changeable. This discussion reveals that there is no clear understanding and therefore no concrete universal strategies for implementation within the transitional phase from relief to development. Limitations exist even in the agreement of the existence of this transitional phase. Acknowledging the inconsistencies in international understanding of this situation, the considerations for implementation post conflict will be made discussed.

Considerations for Implementation

> *"It is difficult to persuade battered and impoverished populations to trust investments leading to future rather than present benefits when war has taught them that survival depends on taking everything one can from what is immediately available"*
>
> (Fagen 2003:199).

Current literature documents some discussion surrounding the issues of implementation of aid within a post conflict phase. It focuses on the changing factors which influence the success or failure of a project. As previously discussed and outlined within this literature review, the factors include, types of conflict, repatriation, and the understanding of the relationship between relief and development. General introduction of other factors affecting implementation is given here including actors, policies, and resources. All of these are considered within the framework of health. Due to the variability of these factors within country settings, it is impossible to produce a finite list. The following overview of the literature only touches the surface in outlining the issues involved. The detail that is discussed here is adequate to give the views surrounding the topics that are the focus of this research.

Munslow and Brown (1999) see that a change is required in the way that relief and subsequent development is implemented if there is to be effective transition. Issues for implementation within the post conflict setting are identified specifically as coordination; time (Ginifer 1997); resources (Duffield 1994); and entity agendas (Fagen 2003).

Strategies for Health

Health models and frameworks give guidance to the structure and process of a health programme. The range of models is broad including those clinically focused, spiritual, self

help, and community based. The need and individual situation determines the model implemented. The use of guiding principles ensures that adequate standards are employed with these models. Frameworks provide the bigger picture for the implementation of models.

Waters et al (2004:6) presents a framework to consider the strategies and tools for health system rehabilitation in a post conflict setting. This framework, in Figure 4.1, outlines what is described as a *"basis for analysing the rehabilitation of health systems".*

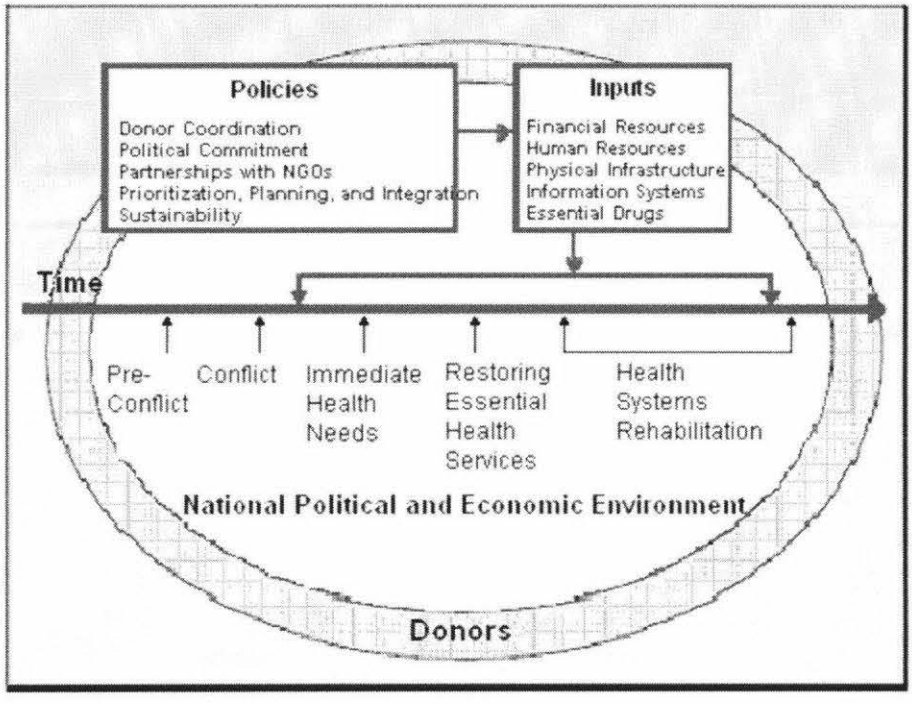

Figure 4.1: A Framework for Post Conflict Health Systems Rehabilitation (Waters et al. 2004:6)

As seen in this framework (Figure 4.2), the three approaches for rehabilitation of health are:

1. *an initial response to immediate health needs*
2. *the restoration or establishment of a package of essential health services*
3. *rehabilitation of the health system itself*

The two key factors which are seen to be integral within this plan are *inputs* (resources and physical structure) and *policies* (actors and donors) (Waters et al 2004:9).

Coordination and partnership of donors and NGOs; government strategies; effective management process and sustainability of health services constitutes *policies* (Waters et al. 2004:12). Effective rehabilitation requires resources, or *inputs*. These can be pre-existing, donated from outside sources, or obtained from within the country. They include, according to Waters et al. (2004:9-11), finances, staff, infrastructure, information, and medical resources. The time line in the centre of the framework reveals the inputs required. The three main approaches are interrelated and should occur simultaneously within this timeframe; with anticipation of future needs during the response to immediate needs.

There are a number of different frameworks and models that are applicable to the post conflict phase. Consideration of all of them is too big for the scope of this study, but the underlying principles and standards are important to recognise. Humanitarian aid is guided by minimum international standards. Outlined in the '*Humanitarian Charter and Minimum Standards in Disaster Response of the Sphere Project*' of the Sphere Handbook (Sphere Project 2004:249) are the *minimum standards in health services*. The international non-governmental community of agencies sees these guidelines as the lowest standards of health care to be implemented. They give guidance on the best practice for the implementation process. The interpretation or implementation of these standards allow for the use and promotion of the most appropriate system for the benefit of the community (Sphere Project 2004).

The guidelines of the Sphere Project are based on two main principles:

1. *That all possible steps should be taken to alleviate human suffering arising out of calamity and conflict.*
2. *That those affected by disaster have a right to life with dignity and therefore a right to assistance.*

The Sphere Project also has eight common standards that are incorporated under specific sectors. These eight standards cover: participation; initial assessment; response; targeting; monitoring; evaluation; aid worker competencies and responsibilities; and supervision, management and support of personnel (Sphere Project 2004). Specifically targeting health, the section on *health systems and infrastructure* has a further six standards relating to the implementation of health services (see Table 4.1):

1	**Prioritising health services:** *All people have access to health services that are prioritised to address the main causes of excess mortality and morbidity.*
2	**Supporting national and local health systems:** *Health services are designed to support existing health systems, structures and providers.*
3	**Coordination:** *People have access to health services that are coordinated across agencies and sectors to achieve maximum impact.*
4	**Primary health care:** *Health services are based on relevant primary health care principles.*
5	**Clinical services:** *People have access to clinical services that are standardised and follow accepted protocols and guidelines.*
6	**Health information systems:** *The design and development of health services are guided by the ongoing, coordinated collection, analysis and utilisation of relevant public health data.*

Table 4.1: Six standards of health care (Sphere Project 2004).

The six standards outlined here cover the main issues that need to be considered in the design and implementation of a programme. In order to be usable in all areas the principles are considered applicable to all forms of traditional services. Toole (2003) suggests that due to the differing levels of aid being delivered by a variety of NGOs and agencies, the standards should be used as a guide to ensure that certain levels are achieved. Ife (2002:17) argues that the defining of minimum standards within a discipline is difficult because of the diversity of cultures and countries. This, he comments, can lead to a standard that is acceptable for one area but unacceptable for another. Banatvala and Zwi (2000) note that the standards don't necessary improve the quality of aid but they do assist in guidance and a measurement for evaluation. Ife (2002) identifies that the standards need to be attainable and desirable, but that some communities find them confusing as they are inappropriate for their situation. He also notes that the attainment of minimum standards is generally limited.

The structure of the following discussion on the post conflict health response will be guided by the outline of these six standards but it is acknowledged that the points made do not attempt to reflect the Sphere Standards to their entirety and are just a tool to guide discussion:

1. Prioritising health services

- *All people have access to health services that are prioritised to address the main causes of excess mortality and morbidity (Sphere Project 2004).*

Classifying the needs of a population is not easy due to individual area requirements resulting from the type and severity of conflict experienced. Requirements often include major social infrastructure such as schools and hospitals; essential facilities for housing and training; personal effects such as food and clothing; and social challenges including communication, trauma counselling and community unification. These issues are expected to be addressed at the same time as possible repatriation of the population and removal of land mines. The list is endless and all of them affect health.

As already discussed, individuals are directly affected through conflict related morbidity, mortality and psychological stressors, which lead to major public health consequences (Banatvala and Zwi 2000; Bornemisza and Sondorp 2002; Macrae 1997; Toole and Waldman 1997; Waters et al. 2004). Identification of the biggest causes of death and injury is needed to ensure effective prioritisation (Sphere Project 2004).

A guideline used in prioritisation of healthcare is *"the greatest health benefit is provided to the greatest number of people"* (Sphere Project 2004:259). This is based on equal access and rights to services for the whole population, including vulnerable groups. This guideline can be difficult to implement when population groups are settled in small numbers and spread out around different areas. This scenario is common post conflict, with newly settled areas opening up and population movement occurring with repatriation.

As discussed in the emergency response section, effective assessment is the key to the identification of needs (Burkle 2003; Tsui 2003) and is crucial for the post conflict phase. Clear identification of what the community expects from the international response is a requirement within this (Banatvala and Zwi 2000:102). Toole (1999:21) notes that assessments are only useful if they impact the actual implementation of the project and that they must be credible, otherwise the process is a waste of time. A rapid needs assessment takes approximately seven to ten days to complete, but during this time an immediate response to some needs may be required. Effective assessments require good communication and observation skills in order to identify and prioritise a response. This

can be difficult post conflict, due to limited area access, initial funding, language barriers and safety issues (Toole 1999).

The assessment phase identifies the most appropriate system or facility required within the health structure. The system should follow the plan of the government and not a previous emergency programme initiative (MSF 1997). International actors often flow through from relief work into the post conflict phase with a tendency to continue implementing short term projects and objectives (Waters et al. 2004).

The process of peace and change can take up to a decade (Fagen 2003). To ensure appropriateness of the programmes requires constant reassessment of goals and objectives. Inappropriate health care can be detrimental to the overall health of the population by increasing the spread of disease through bad practice and creating dissatisfaction of services and therefore distrust (Banatvala and Zwi 2000:102).

2. Supporting national and local health systems

- *Health services are designed to support existing health systems, structures and providers (Sphere Project 2004).*

The term *health system* is defined by WHO (2000) as,

> *"the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health".*

Health systems, as defined by WHO above, require certain inputs to be effective. Limitations within the post conflict phase reduce the effectiveness to the improvement of population health. Post conflict situations reveal the destruction of entire infrastructures, from buildings, materials, staff, education systems, transportation, communication, and preventative services. This destruction has a huge effect on community health and its programmes. Various influences constantly change the boundaries of the health system, requiring ongoing revision and analysis of the situation (Hill 1997).

Local health systems need capacity to respond to immediate needs. If the required services are inadequate they may need input from temporary vertical programmes. These independent parallel services outside of government programmes are not recommended unless there is no accessible adequate care under the national health system as they can create dependence and raise expectations for national services (Sphere Project 2004).

Beyond the emergency response, the rehabilitation of pre-existing services is considered a priority, following with the expansion of services in areas previously lacking adequate health care (Macrae 1997; Waters et al. 2004). This focus of rehabilitating pre-existing systems involves structural work to facilities, training of staff, and provision of medical supplies materials (Sondorp et al. 2001). MSF (1997) outlines the restoration of the health system after repatriation, and identifies the reinstating of curative services as of highest importance. Following this are the integrated and prevention focused programmes.

The priority for rebuilding is dependant on the severity of damage and need of individual areas. Van Gennip (2004) sees that rapid restoration of basic health services is needed as this allows the community to become established in the reconstruction process. Quick Impact Projects (QIPs) can be effective in the initial stages where assistance is required for a population to survive but they are not effective as the only type of programme. In the 1990's, QIPs were seen to fit into the continuum from relief to development and were used extensively by UNHCR in the 1990s. Evaluations of these projects recognised the limitations of community participation and appropriate need identification (Smillie 1998:5). As Banatvala and Zwi (2000) point out, some short term, high impact health projects can increase conflict and confuse the political interventions. They can also undermine long term projects and sustainability. Ginifer (1997:6) notes that short term programmes are ineffective in the long run and do not assist to resolve issues of conflict that may be still underlying in a post conflict society.

QIPs implemented in many countries, including Mozambique and Cambodia in the 1990s, were initially seen as successful in uniting the community to participate in rapid repair of infrastructure and facilities, therefore improving the community as a whole. These projects required large amounts of funds and resources to be successful. The success in Cambodia was limited, mainly associated with timing problems concerned with inadequate planning and land allocation. The end result was one of mixed feelings from implementers.

Some felt that there was success in many of the projects, seemingly filling the need gap, others saw more harm than good come from the inadequate planning and usage of large amounts of funds and resources (Smillie 1998).

Following thirty years of conflict, peace was established formally in Mozambique in 1992, allowing for the rehabilitation phase of the health system to begin. Within Mozambique the success of the phase was also mixed. The use of QIPs left a legacy of both sustainable and unsustainable health programmes. Visibly, there was new infrastructure including clinic buildings but the national health system was unable to sustain them. Much of the country's sectors were dependant on external support for a number of years after the initial international response (Fagen 2003).

Afghanistan went into the post conflict phase in 2001, following 20 years of conflict. The health system at that stage was barely functioning. The following year saw the implementation of a system that contracted health services to the NGO, with a focus to restore or develop basic health services. This ensured the implementation of basic health packages to the population while the government was able to develop other areas of the health system. Initial success of the health delivery was the focus, with short, medium and long term goals (Waters et al. 2004).

Health policies, as referred to in the WHO definition of health systems, are required for effective coordination and planning. As with any government policy, they are dependant on the ability or opportunity to be written and then implemented appropriately. In many cases, especially in a post conflict or post emergency phase, the reality of effective implementation or existence of policies is limited due to restructuring of government offices and departments. This restricts the establishment of an effective health system (Bornemisza and Sondorp 2002).

Staff are an essential resource in a health system. It is recognised that the system of health is complex and requires experienced professional staff to implement the programme and to ensure adequate planning and coordination (Banatvala and Zwi 2000; Sondorp et al. 2001). Decisions for practice need to be based on actual knowledge and implemented effectively with adequately trained staff (Toole and Waldman 1997). This requirement for qualified staff can lead to a drain on the limited number of professional

staff from government programmes into internationally funded ones. Many times the remuneration packages are more favourable from an international agency or NGO and this can lead to problems for the development of ministry of health programmes (Cliff 1993).

3. Coordination

- *People have access to health services that are coordinated across agencies and sectors to achieve maximum impact (Sphere Project 2004).*

Many different groups are involved in the transitional process post conflict and respond to humanitarian crises in different ways. Aid is delivered through a variety of entities including the UN agencies, NGOs (international and national), church/faith based mission organisations (not always identified as NGOs), human rights groups, and governments. This large number of actors can be effective in order to cover all of the needs but there can be difficulties in maintaining adequate communication and coordination between the groups. Fagen (2003) believes actors within this post conflict process have a long way to go to get it right and understand the most productive way of doing things. Humanitarian aid is complex and problematic; there is an ongoing need to gather evidence of effective practice in order to improve implementation strategy. This will only happen through the coordination of actors within these programmes (Banatvala and Zwi 2000).

Government

International agencies are required to work in areas of post conflict due to government inefficiencies which is an understandable outcome of conflict (Bornemisza and Sondorp 2002). Governments are often insecure at this time, with weak policies and control. Central governments need to be empowered through programmes of aid and not bypassed, while also ensuring that ownership and participation is built at the community level to ensure success (Banatvala and Zwi 2000). Van Gennip (2004) also mentions the bigger picture of inter-governmental coordination and the need for this in order for coordination to happen effectively.

NGOs

The level of involvement by NGOs and their status in the implementation of aid has changed over the last decade. Defining the roles of actors within the post conflict setting was considered by Fagen (2003) as easier to undertake prior to the end of the Cold War. Generally it was seen that UNHCR worked with refugees, UNDP with governments in

development projects, and relief agencies and NGOs were involved with reconstruction and relief or development. In the 1980s it became more common for aid money to be given through NGOs rather than the government of the area (Cliff 1993) and the late 1990s saw more development based NGOs getting involved in emergency relief projects. The boundaries of these organisations, including standard NGOs, has spread and merged due to greater opportunities through access, funding, experience, and the requirement to respond to greater needs. This can be seen as a positive thing, but unfortunately again, due to lack of unity and understanding between the actors, means that it can have a negative impact on the delivery of aid (Fagen 2003).

NGOs and agencies have their own mandates and philosophies which define who they are and how they work. These can conflict with government policies and more specifically with ministry of health (MoH) guidelines for practice. This was experienced in Mozambique where NGOs did not want to follow MoH policy and chose instead to set up parallel health programmes and structures (Cliff 1993).

An example of coordination in action within the health sector is Mozambique. The challenge for health development was exacerbated due to the return displaced populations, lack of coordination between players in the rehabilitation process and slow policy formation. Coordination and planning ahead for the development of services with government and NGO input was seen as crucial for the success of the system (Waters et al. 2004). One of the main issues identified for the limited success of the humanitarian response in Mozambique, was the lack of government involvement and control over the projects (Fagen 2003).

Difficulties arise in planning a system adequately. An implementing NGO can have an effective programme within a specified area but this must be compatible with the national programme in order to be sustainable. If there is limited government initiated policy for practical application and organisation then there is a period of frustration trying to build something for which there are no national guidelines. This can be a difficult process for the NGO and later has a roll-on effect for the government when the handover phase is initiated (Sondorp et al. 2001). Coordination between the actors is therefore seen as vital and designation of power within this is required to ensure smooth relations (MSF 1997; Sondorp et al. 2001; Waters et al. 2004).

Good management systems, international guidelines and evaluations should be used to improve outcomes (Banatvala and Zwi 2000). Accountability and transparency of agencies and actors within this is required for success (van Gennip 2004). Toole (2003) identifies the acceptance of quality aid rather than quantity.

NGOs are often considered influential due to their resources but Cliff (1993) also notes that NGO staff are often times young and inexperienced which can lead to problems. Rogge (1994) also identifies this limitation of experience of some NGO personnel, especially when working within complex situations involving repatriation and refugees. Another factor to consider is the high turnover of staff within these situations which results in loss of *memory* from learned experiences within the organisation and area (Sondorp et al 2001).

Donors

Another major influence on implementation is the source of funding for aid programmes. The donation of funds comes from a range of sources including UN agencies, governments, banks, private, churches, community groups and charities. Each of these donors have their own mandates, policies and guidelines for how the money should be spent and for the outcomes. Programmes are often written in order to align with these requirements. The focus can be put on a particular area of need if this is where the donor's attention is at the time, sometimes regardless of the true priority of need on the ground. Giacaman et al (2003) saw this in effect within an aid project in the Occupied Palestinian Territories where the donor preference was put ahead of the actual need in order to obtain the dollars. Fagen (2003:198) sees this role of donors as a *"daunting challenge"* as they can and do use power to greatly influence a particular area. Waters et al. (2004:13) see that donor agendas can *"undermine the cohesiveness of a national health policy"*.

In reality donors have a lot of control over the direction and focus of a project that they are investing in. Projects can be solely donor-driven and with this power donors are able to influence policy. For example, within Mozambique, confusion was created due to the inconsistency of donor-driven health services (Cliff 1993). Fagen (2003) notes that donor initiated programmes are less sustainable.

Knowledge is seen as essential to the transition from relief to development (Munslow and Brown 1999). Zwi and Alvarez-Castillo (2003:24) state that *"NGOs are not often funded to reflect, analyse and learn"* and this leads to the loss of knowledge and limits the opportunity for effective evaluation and therefore evidence based practice.

International priority of expenditure on relief projects is a concern for longer term development programmes (Duffield 1994) and these concerns have been heard recently regarding the 2004-05 tsunami fund allocations (Epstein 2005)[1]. Access to funds depends on the nature of the need. Competition for funding is a fact on the field, especially concerning disasters requiring relief aid. The phase of rehabilitation and reconstruction also requires a lot of monetary investment (Waters et al. 2004). Donors are able to change their areas or specific programmes of interest as desired (Cliff 1993).

Ginifer (1997) identified a general cut back of spending on development and its reallocation into relief in the early to mid 1990s. For post conflict development, Van Gennip (2004) sees that donors need to ensure that their policies are not still set according to the cold war standards, and that there must be a clear link with other countries and agencies for coherence.

4. Primary health care

- *Health services are based on relevant primary health care principles (Sphere Project 2004).*

Public health is defined by WHO (1998) as,

> *"A social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention".*

Public health is the umbrella concept for the overall promotion of health. Within this, primary health care (PHC) models are often used and are thought most appropriate to the situations of complex emergency and post conflict (Sondorp et al. 2001). The PHC model is founded on principles of empowerment and participation which look to respond, promote, and restore health through community initiatives (van Damme et al. 2002). It

[1] One example of many

incorporates health services from the community level right up to referral hospitals (Sphere Project 2004).

Community PHC is also called community-based health programs (Khor and Lin 2001) and community involvement in health (CIH) programmes (Oakley 1989). Community involvement in health was an initiative of WHO and was identified as a process between the government and the community to develop health care services. It involves the right and responsibility of each to participate in development (Oakley 1991).

Van Damme et al. (2002) see the concepts of PHC as part of development and emergency medical assistance as pertaining to medical emergencies, but they also acknowledge that many situations are in between these two frameworks. They conclude that within 'non-development' and 'non-emergency' situations there is no set strategy for the implementation of health services. For this transitional phase, the planners are told to be creative and flexible and to find the balance between PHC and emergency assistance (van Damme et al. 2002).

The PHC programme in Zimbabwe was once seen as the result of a successful transition from a curative system to a community based preventative programme (Woelk 1994). The success was put down to three things: the improvement of socio-economic conditions, community participation, and an appropriate system based on real need. Woelk (1994) comments though, that in reality a true system of PHC had not been developed but instead it was an extension of basic health services. The government support for the initiative was seen to have been lacking thus resulting in a less that adequate outcome of the true principles of the programme. This issue of national support, as well as community cohesion and participation, resource availability and time restrictions are all limiting factors for success. Woelk (1994) concludes that where poverty, inequality and disempowerment are in existence then the success of PHC is limited.

Loewenson (1999) sees that the differences in expectations from the community and the provider for levels of participation in the development of the health service, leads to limited outcomes, resulting in a need to consider realistic goals. During the establishment of the PHC programme in Ethiopia, within a temperamental conflict phase, the actual needs of

the community were not identified correctly, leading to failure of the overall project results (Kloos 1998).

Sanders (1985) outlines the PHC system as implemented in China and Cuba, with the inclusion of village health workers (VHWs) as a driving force of the programme. VHWs were responsible for a variety of skills, from cleaning and health promotion to diagnosing and treating patients, depending on their training and experience. It was found that VHWs were successful in representing the needs of the people and led positive social change within their communities. The programme involved people with a variety of abilities including those who were illiterate and non-educated. The VHW scheme, as implemented in Zimbabwe, uses concepts of participation, ownership and empowerment at the community level (Woelk 1994).

Problems that affect this scheme occur when the community is unable to financially support the worker or where health policies are dominated by professional capacities. An initiative of this type requires large community support to be effective, and conflict, previous or present, affects this cohesion (Sanders 1985). Attempts have been made to bring VHWs within official MoH roles as Sanders (1985) saw in Botswana, but this resulted in the person being alienated from a true representation of her/his community and so rendered the role dysfunctional. In Ethiopia, policy promotions of prevention and equitability did not improve or promote participation within the PHC programme (Kloos 1998). It was found that a general anti-government attitude influenced the society's responsibility negatively, and affected participation.

Private health initiatives, under which a vertical NGO programme could be classified, are seen to be damaging to the PHC values of participation and ownership through relieving the community of the responsibility of health (Kloos 1998). The sustainability of such projects within a rural setting in a developing country would be interesting. A doctor is often highly respected within developing countries due to her/his ability to *miraculously* heal or treat someone. This can also be attributed to historical events where the doctor is deemed as all powerful and a hierarchical system of health is emphasised. The misplaced admiration for this role can be detrimental to community based health initiatives (Woelk 1994:1031).

Within the United Kingdom (UK) more and more emphasis is being placed on preventative and educational services, recognising that this is an effective way of preventing disease (Smithies and Webster 1998). Within the rural setting of Africa (for example) the cost for programmes like this are relatively low compared to structural ones, but are time consuming.

'Bottom up' approaches involve programmes that are initiated and developed from the community level. 'Top down' reveals programmes planned and coordinated in a definite management style from outside of the community setting. Confusion between the approaches of 'bottom up' or 'top down' strategies causes project management problems on the ground which leads to a potential lack of community participation and therefore autonomy and ownership (Chambers 1997; Ginifer 1997). Laverack and Labonte (2000) also see this as a problem for health promotion projects. Top-down strategies are successful in reducing morbidity and mortality rates but are considered useless in sustaining the health initiatives. Vertical programmes can also have this effect. This failure is considered due to of the lack of action and planning by the community, in effective training, and a conflict of identified needs between community and health professionals (Oakley 1991). Involvement of people in their own development is a process which requires continued action, and within post conflict situations this can be difficult. Issues with PHC show that even though participation and ownership is expected from the 'bottom', the programme has to be implemented to some extent from the top (Kloos 1998).

Munslow and Brown (1999:208) identify a *change of approach* which is required for the transition from relief to development. This change involves concepts such as capacity building, empowerment and community ownership. They warn that these concepts focus on the local community and therefore have the potential to leave the government out of the picture. This empowering of society, if not done correctly, can be detrimental to the building up of peace and integration in a post conflict area where the government system may still be finding its feet.

Community empowerment can be defined as,

> *"a social action process that promotes participation of people, who are in positions of perceived and actual powerlessness, towards goals of increased individual and*

> *community decision-making and control, equity of resources, and improved quality of life"* (Wallerstein 1993:219).

'Participation' joined the development jargon book in the 1950s when it was realised that the failure of development programmes lay in the fact that people weren't included in the process (Rahnema 1997). Again, with the shift away from the modernisation theory in the 1970s, there was a search for alternatives to practice and a re-examination process continued in order to make people, rather than economics, central to development (Oakley 1991). It is now seen as necessary that the community be involved in all aspects of their development, from conception to implementation, and through onto evaluation. This participation leads to empowerment, ownership and the building of capacity through its practice (Rahnema 1997).

Participation can be seen as a tool in order to achieve a set outcome or it can be the outcome itself through the process of action (Oakley 1991). Laverack and Labonte (2000) see it more as a means to an end in regard to the process of health behaviour change. When considered as a means or a tool, participation can be defined as, *"a way of harnessing the existing physical, economic and social resources of rural people in order to achieve the objectives of development programmes and projects"* (Oakley 1991). This is also my experience of participation in the post conflict setting.

Community participation as outlined by Oakley (1991) is seen to be interpreted in three ways: contribution (voluntary work or assistance); organisation (cooperatives and groups); and empowering (management and action). Within this is the knowledge that people need to be considered as the subject of projects rather than the objects. Eade and Williams (1995:21) state, *"unless development and relief projects are seen as part of the broader social and political context, and respond flexibly to it, they can become a distraction, imposing a set of demands which relate more to development agencies than to the development of people"*.

Participation goes beyond the individual level and refers to the community as a whole. Within the United Kingdom, due to the changes in the perception of community where cohesion is not defined by area, the concept of participation is advanced through groups and organisations. This brings power to the people involved and can influence policy and

allocation of resources. This use of groups can be well adapted to the post conflict phase, especially within new settlements and periods of transition where communities are not cohesive (Smithies and Webster 1997). This was effective in the programme of health construction in Uganda and Sierra Leone where it was noted that the community did not get involved in the construction work until there was social coherence. This was led by the introduction of health committees (Mitchell 1995).

A principle for participation is that projects should be structured over the long term, not just to achieve a set objective (Oakley 1991). Laverack and Labonte (2000) also consider that when bottom-up programmes are used then the time frame should be longer in order to be implemented effectively. The building of community empowerment takes time and although well established communities may only need six to twelve months, two to seven years may be required for those which are less established (Laverack and Labonte 2000).

Freire (cited in Rahnema 1997) discusses the issue that communities who are in transition or show some form of dependency, are possibly not able to identify clearly their circumstances or have the means to deal with it. Wallerstein (1993) suggests empowerment and educational approaches should be used when involved in the implementation of development so that the core issues that create ill-health are dealt with. This, within the transitional period of post conflict, can be difficult, again due to time constraints.

Challenges to the concept of community empowerment come from individual perceptions. If one person thinks that another is to be empowered, then s/he is revealing that the person is currently disempowered. This infers that one person may hold some sort of key for another's empowerment. When related to the NGO / recipient relationship this can create unequal relationships where one is seen as more important than another. A problem with the participatory approach is that it can coerce participation from a community that may not identify with the objectives of the programme, and the failure of the project falls onto the community (Rahnema 1997). These tensions are considered able to be resolved through correct design of the plan. This is done simply through involving the community in all aspects of the programme (Laverack and Labonte 2000).

This involvement can be achieved through the use of PRA (participatory rural appraisal) which is a very popular approach to development and incorporates the principles of participation. The basic idea of PRA is that people identify and achieve their own priorities (Chambers 1997). The methods of PRA take time by allowing the community to approach their needs in a way that is appropriate for them, as well as obtaining a response that is applicable to the situation. Application of PRA to relief or the transitional period is therefore limited due to the previously discussed issues of time within the post conflict setting.

Chambers (1997) comments that the concepts of participation are included in proposals and evaluations, but many times are not actually implemented on the ground. The true success of participation is criticised as limited. NGOs are seen as trying to professionalize a community based programme in order to achieve recognition and further financial gains (Rahnema 1997). Often there is a lot of talk about participation but in actual fact no action and little contribution given specifically to desired health outcomes (Dudley 1993; Loewenson 1999; Oakley 1991).

Concepts of non-participatory development are within projects that are identified by donors and central government to achieve a certain purpose in a certain time frame. This planning often leaves no room for community participation as the project is already planned and budgeted for (Oakley 1991).

Smithies and Webster (1998:60) consider community empowerment through involvement and self help as a way to build confidence and skills leading to improved overall health and the decline of apathy. It raises awareness of personal health issues and assists in decision making regarding these concerns. It creates sustainability and develops responsibility and commitment towards the subject and system of health. Strengthening of social networks and cohesion is also seen as key for effective empowerment and therefore health (Wallerstein 1993).

Mitchell (1995) sees participation as an action in health development and describes the positive impact that the process of the construction of a health unit can have on a community. Problems in practical participation occur because of limited skill levels available in the community, particularly within the health sector. Post conflict this is further problematic with a greater loss of skill and experience through periods of war.

Communities also struggle to maintain physical buildings or equipment that is specialised and this leads to problems of sustainability (Mitchell 1995).

Expectations of the population for health services relate in part to the accurate identification of need but also require the consideration of past experiences. Loewenson (1999) discusses that these expectations indicate how a population will contribute to health development, and need to be created realistically.

The primary health care model is effective for health development but is recognised to have limitations post conflict. It requires two way recognition and support between the government and the community in order to be successful. It has been shown to require a community that is unified and empowered, although it also develops these attributes within the community as it is formalised. Acknowledging that post conflict geographical communities are often disempowered and divided, the use of committee groups as a starting point for community is promoted. The programme is shown to successfully use illiterate and non-educated people which promotes empowerment.

There is confusion in the approach to PHC due to some aspects of the programme having specialised roles, thus requiring outside involvement in a predominantly community based programme. The effective balance of this approach is critical post conflict, to limit dependency and promote empowerment. The time factor is seen as a difficult part of PHC, where the focus is required on the long-term. Preventative programmes and participation initiatives are time consuming and therefore can be limited in the transitional period, often being short to medium term focused and usually donor driven. Through the effective implementation of a PHC programme, community empowerment is achieved creating awareness of health and developing responsibility for it.

5. Clinical services

- *People have access to clinical services that are standardised and follow accepted protocols and guidelines (Sphere Project 2004).*

The adequate number of health facilities for the population is important to ensure that effective care is given and that resource allocation is sufficient. Included within this is the training of staff to create and maintain these services (Sphere Project 2004). With the limitations of the community based PHC programme outlined, it is acknowledged that

specialised clinical services are required for the complete health package. This can be incorporated under the PHC programme but is in many places unfortunately considered separate. Improvement of the management of public health has been seen through the use of standardised practice. These processes of international standards include the Code of Conduct for the International Red Cross and the already mentioned Humanitarian Charter and Minimum Standards in Disaster Response (Toole 2003).

6. Health information systems

- *The design and development of health services are guided by the ongoing, coordinated collection, analysis and utilisation of relevant public health data (Sphere Project 2004).*

Regular reporting, collection of epidemiology data and ongoing health surveillance ensures that the health needs of the community are evaluated, potential issues are identified early and therefore negative health impacts reduced. The development of health information systems is essential to an effective health system but this process evolves when the system is more established. It is recognised important though to commence the implementation of these processes as early as possible in the relief phase (Sondorp et al. 2001).

Discussion

All of these concepts are very positive for health development, but in the light of a post conflict setting discrepancies are revealed. The union of post conflict transition with community health initiatives including participation is shown to be difficult.

On reflection of Waters et al. (2004) framework, there are many issues that arise through the consideration of other literature. The framework time line is logical but the linking of the different approaches to health, considering short, medium and long term goal is shown to be problematic. Linking the initial response to immediate needs is a challenge, especially if the approaches are coordinated by different agencies or NGOs. Implementation of community based owned and operated health systems are not discussed within this framework and neither is the consideration of actual time spent within the framework continuum. Dealing with immediate health needs and at the same time as focusing on the future is ideal but practically the combination of these concepts is hard to achieve effectively.

The first integral concept of Waters et al. (2004) framework considers *policies*. Included within this is coordination which between the actors of aid is critical to the success of any programme. Within the Sphere guidelines, this concept is a key and underlies all of the other standards presented. The transitional period brings a change in implementers, governments and communities, creating an even greater need for coordination and partnership. The frustrations have been shown regarding the balancing of individual donor and agency mandates with that of the government and community. Within community based PHC initiatives the coordination is delicate due to the focus on community ownership of the programmes but with some specialised input.

It has been recognised that policies to guide practice can often be very slow in evolving, especially when coordination is required from a number of actors. This slows down the process of implementation while discussions are held or work continues, only to be changed later in the phase as a new policy is implemented.

The second integral concept of *inputs*, as outlined by Waters et al. (2004), are recognised throughout the literature as essential to effective post conflict health development. Relief requires experienced staff to implement much of the programme; it also requires costly materials and specialist equipment. This high input also exists in the transitional phase, especially in an area that was previously inaccessible due to the conflict. At the establishment of peace, the opportunity for reconstruction of the system is possible but costly. Linking this with community empowerment and participation is difficult due to time factors and the still repatriating population.

Sustainability of programmes post conflict is essential for the transitional phase. This signifies the success of the transition between relief and development. Sustainability has not been discussed directly here, but is reflected in the ability of the health system to continue beyond the focus of the immediate need. The sphere guidelines promote this through the focus on national systems and community based initiatives. Adequate information systems affect the long term quality and sustainability of a health programme. New systems require a high input of supervision to get them functioning effectively and can be a challenge to promote when immediate need response is high.

Restoration of services in an area that has been void of health services coupled with the actual establishment of new services take much time and resources, often far beyond just rehabilitation. Within this post conflict phase, funding is sometimes allocated 'just for rehabilitation', and in an area where there were originally no health services, then it is impossible to rehabilitate nothing.

Linking of the Waters et al. (2004) framework with the concepts of PHC are somewhat difficult due to the time variable, community cohesion and limited levels of leadership at community level as well as policy formation level. The time period to implement such a system would depend on many factors within the country of implementation. The focus is very much again on a clinical 'western' system of health, which may not be appropriate for all areas.

Summary

The impact of the phase of reestablishment post conflict, throughout repatriation and into development, on personal health and health systems, is extreme in many cases. In order to achieve the transition from relief to development, the implementation approach must be considered and incorporated early in the planning stage. The community approach that is central to development is revealed as most applicable to this scenario. Within health development the linking of relief, rehabilitation and development initiatives are shown as possible but challenging when using the PHC framework. Finding the balance between the needs of the community, the donor cycle, the staffing allocation etc is a challenge post conflict and one that does not come with any easy answers. Incorporating development principles of empowerment and participation has been shown to create ownership and responsibility. Within post conflict this is deemed difficult due to the presence of many variables, outlined in the previous chapter, that affect this transitional period. The Sphere guidelines provide a set of standards to ensure that the basic health needs are addressed. These standards guide international actors in the development of healthcare and in the evaluation of services. The reality of this transitional process, as experienced in Angola, will be presented later in this thesis, with the next chapter outlining the methodology for the collection of that information.

Chapter 5: Methods of Research

The process of research involves many factors that impact the implementation of a well planned methodology. This chapter reveals the research process as experienced during the data collection period. It presents the background to the field research phase and the design of the methods of research that were implemented. This chapter discusses the methods of data analysis that were used, and outlines the limitations of the research.

The Research Team

The casual employment of a research team gave assistance to the translation and collection of data. The team comprised of myself as the research coordinator, one research assistant, two translators, and two data collectors. I advertised these positions in the main town and, through interviews, selected five people for the available positions. The team members were chosen according to their communication skills, previous experience and education, and general appropriateness of tribal affiliation, gender, social status (Nichols 1991). I taught and guided the team in the methods of research and data collection over a period of five days. Training included role-play, practical activities and the theory of research (Babbie 2001).

Design and Approach

Approach

In consideration of the objectives of the study, the design of the research was based on a mixed methods approach, thus incorporating the applicable methods of both qualitative and quantitative data collection and analysis. From the quantitative perspective, this included the consideration of variables and their values, use of measurement and observation techniques and numeric analysis. From the qualitative perspective, this involved recording of personal experiences and consideration of social patterns through the use of participatory and empowerment strategies (Creswell 2003).

The mixed methods approach uses what Creswell (2003:16) describes as a *sequential* procedure which allows for one method to develop or describe the outcomes of another

method. In this case a quantitative method was used in the form of a traditional survey[1] and then followed on with a qualitative approach of group discussions, interviews and observations, in order to, in a sense, qualify and obtain a deeper understanding of the variables.

The concepts of participatory appraisal were considered vital for a balance of responses from participants and the second more qualitative approach allowed for that. Foundational to a comprehensive study was the opportunity for the communities to tell their story and express their own reality of the situation (Chambers 1997). Methods of survey are at times constrictive, detailed and upfront, and it was desired that the communities had the opportunity to feel that they were a real part of the research and were owners of the outcomes of the issues discussed through having their voices heard.

Sampling

The limitations of access to the surrounding areas due to transportation, weather predicaments, and security issues (landmines) resulted in a restriction of the communities accessible for research. A random sample incorporating all communities in the area would have been ideal but this was not possible. This restriction resulted in the need to choose a clustered sample based predominantly on field accessibility constraints which can be described as a sample of convenience (Lohr 1999; Hansen et al. 1993). Within this limitation it was desired that communities chosen were as representative as possible of the population in the area. I chose three such communities for the study according to their: accessibility; safety; government permission; and finally demographic data (population makeup and numbers). One village was composed of predominantly returning refugees, another of previously identified internally displaced and the third was considered a mix of the two groups, but the proportions were not equal. This has resulted in a selection bias as the sample does not represent accurately the total population in the larger area (Lohr 1999).

The use of a purposive sample for this study is not at all detrimental to the effective answering of the objectives or the drawing of conclusions from the outcomes. The outcomes are, in fact, satisfactory as they give a snapshot of the reality of the health situation for three real and complete communities. The research results do not attempt to

[1] The household survey incorporated both qualitative and quantitative questioning formats

reflect accurately the entire population, but the experiences learnt here can be applied as appropriate to other localities.

Instruments

The methods of data collection included: household surveys; focus group discussions; village mapping; priority needs rating techniques; interviews; observation and demographic data. Informal discussions with the community allowed for initial exploration of the subject. My work experience in the area also gave me a background understanding of the general community.

The municipal government office gave permission to undertake the research, as did the community leaders. All participants gave verbal consent to be involved in the study. The household survey forms were tracked by number and no personal names were taken. Interviewees consented to the use of their titles in order to clearly establish the voice of the interview.

House to house surveys

The research objectives guided the design of the house-to-house survey. The section headings of the survey were: general personal and household information; current health activities; current household health; past general activities; and past health activities.

The survey included both open and closed ended question formats, allowing for a variety of responses throughout the survey which reflects the mixed method approach (Creswell 2003). Discussions with the research team, who represented the tribal groups being studied, ensured that the questions were appropriate. The survey format was then translated into Mbunda, the most common and prominent language of the tribal groups in the area. Mbunda to English was chosen rather than the national language of Portuguese, due to the low number of people in the area who understood Portuguese proficiently. Also, after advertising for the position of translators, no applicants were fluent enough in English and Portuguese to enable them to complete the research, and my grasp of Portuguese was too limited to undertake it effectively.

Having previously worked in the study area I had an understanding of some of the key words in Mbunda and, more importantly, some idea of the physical expressions (culturally

specific hand, posture and facial movements) of the language, allowing me to *absorb* some of the responses. Participants appreciated attempts that I made with the local language, for greetings, thank yous and farewells (Leslie and Storey 2003).

Translation discrepancies within the survey were identified and adjusted through the retranslation of the Mbunda version back into English, using a different translator. Finally, the survey was trialled in a nearby community. The survey was designed to take approximately 30 minutes but the first few times took over 1 ½ hours. The research team revised, refined and shortened it over three trials. The survey time was reduced to approximately 45 minutes which was still too long, but as the questions became familiar and the data collectors more skilled in learning to curb long conversations on each topic, the time reduced and took around 25 minutes per form.

The concept of family in the Bundas area is expansive and variable. Many households are made up of members from a number of different families, and houses are congregated together to share common buildings, especially in the current phase of resettlement. To alleviate the difficulty of deciding what the boundaries of a family were and were not, a household was defined as "the total number of people cooking and eating together out of the same pot"[2]. It was observed that most households share one pot of the traditional food *funge*[3] or *chivundo*[4]. This was seen as a very clear definition and there was never any real problems arising out of the classification.

The data collectors from the research team visited each household and whoever was available at that time was asked if he or she would be able to answer the questions of the survey. An adult member[5] from every household within the study area completed a survey form. Most people were out planting and working in their fields in the morning hours due to the time of year (November / December). As the day became hotter, people would return home to eat and rest and would then be more willing to participate in the survey. Due to this, completion of the house-to-house surveys was achieved after the hours of 1400.

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[2] Adapted from GOAL Angola (international NGO) who used and found this definition effective in surveying
[3] Portuguese word for staple food made from ground maize and or cassava and combined with water until a hot, thick consistency is achieved
[4] Mbunda word for Funge
[5] Over the age of 18

The research team completed 181 surveys, which represents the total number of households present at the time of the commencement of the study in the three communities. Of these 181 respondents, ninety-one (91) were women and ninety (90) were men. The surveys represent approximately 955 people of the population of Bundas municipality.

The translation team, on completion of the surveys, translated the information into English. This was then checked and corrected before being compiled and analysed.

Focus group discussions

The use of focus group discussions allowed for expansion of the issues brought up in general discussions and in the household surveys. It also gave the opportunity to observe the interactions and expressions of participants as they discussed the topics (Nichols 1991). A list of prompting questions and topics were compiled, translated and cross-checked into Mbunda, to be used by one of the research team members to facilitate the discussions. A mixed group of men and women in a nearby village participated to trial these questions, and necessary changes were made prior to being implemented.

In the study areas, the *Sobas*[6] were asked to gather 15-20 men and women from different families throughout the area. The makeup of the people attending the discussion groups was not structured, and allowed for whoever was willing to participate. This followed with Babbie's (2001) comment that focus groups are unlikely to statistically represent any set population due to the methods that are undertaken in choosing the attendants. The main purpose of the group was for discussion and exploration of the topic rather than definition.

The observed cultural practice of male dominance within a group of men and women influenced the separation of male and female discussion groups, in order to allow for full participation from attendants. Dividing the group into internally displaced people (IDPs) and returnee refugees (RRs) was considered, but it was the voice of the women that I wanted to capture and to give opportunity for discussion of topics that may not be comfortably discussed in a mixed group.

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[6] Portuguese word for the village chiefs / traditional leaders

A female researcher facilitated the women's group and a male, the men's group. One person from the research team was responsible to make observations of the group during discussions and to tape record the interactions for later transcribing. On return to the field base, the group discussions were then transcribed from the dictaphone and translated into English. The translations were then checked and the information compiled.

Table 5.1 reveals the focus groups attendance level from each of the three communities involved in the study. The total number is displayed in the left of the column with the breakdown of IDPs and returnees in brackets. Represented are one male and one female group from each of the three study areas, totalling six completed discussion groups.

variable	***com[7] 1***	***com 2***	***com 3***
	total (idp/rr)	*total (idp/rr)*	*total (idp/rr)*
female	58 (0 / 58)	11 (4 / 7)	12 (7 / 5)
male	45 (0 / 45)	10 (6 / 4)	17 (10 / 7)

Table 5.1: Community attendance to focus group discussions

Village mapping

Each group discussion started with the mapping of villages. Participants were encouraged to draw a map of their current area in blue or black and to identify areas of importance and people of influence in the community. When completed this was discussed and then participants were asked to draw new priority needs, services or people in the colour red or green. This activity encouraged the group to think about issues that were to be discussed, and stimulated thinking towards the future. It also gave a snapshot to the researcher about how the group viewed their community. The group participants were encouraged to join in and take turns adding to the map. In most areas one or two people were nominated by the group to use the pens and the rest of the group told them where to draw. A large piece of white paper was used with large marker pens, the results of which can be seen in Picture 5.1.

[7] 'Com' is an abbreviation for 'community' and com 1,2,3, represent the three communities surveyed

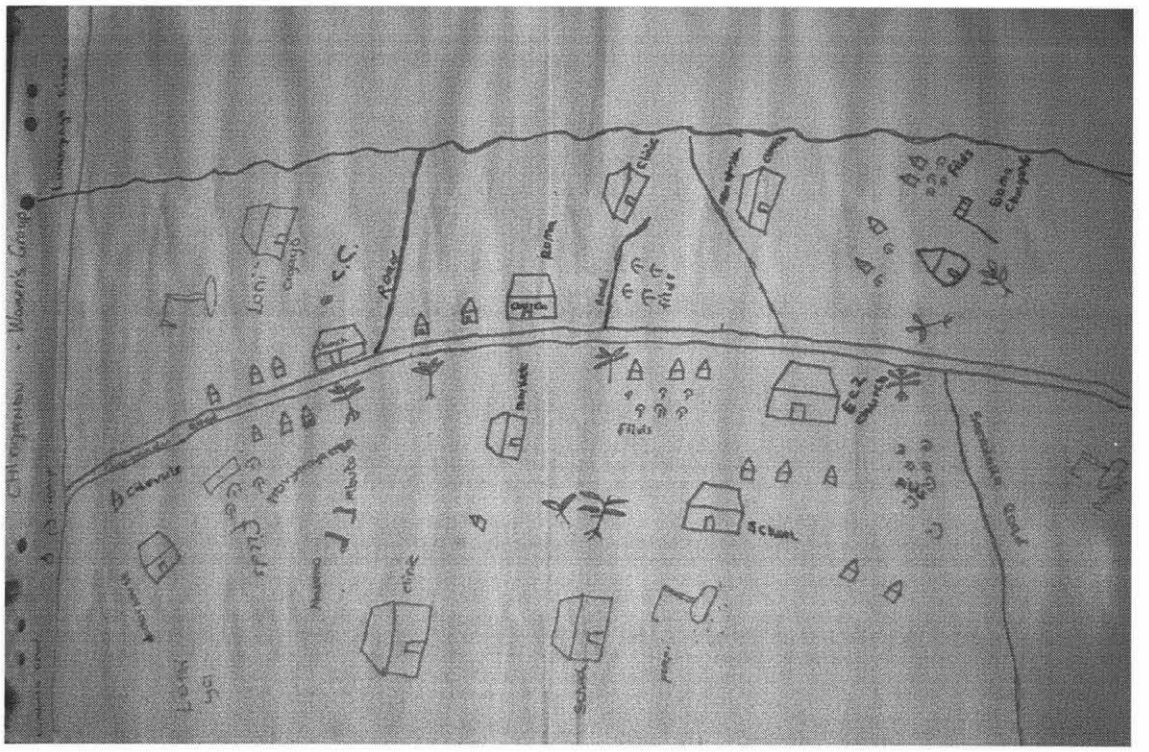

Figure 5.1: Example of village mapping (women's group, Community 1)

Priority rating

A technique of card elimination was used to assess the priority needs of the community. Six needs were identified generally in the municipality through observation, informal discussions and NGO information sources. These needs were: water; health; food; transport; seeds and tools; and education. The research team each drew pictures of these priorities and the illustrations most recognised within the cultural setting were chosen for use on the cards. Participants eliminated each priority card against all of the other priority cards and the results were charted on a matrix. Through alternating volunteer participants from one side of the focus group to another, ten people completed the process from each group. Once all participants had taken part, this technique revealed the priority ratings of each need within the gender groups and in the community.

Interviews

The research assistant and I completed twelve in-depth interviews. Key informants from each community included an area administrator, *Sobas* and health workers. At the town centre of Lumbala Nguimbo, interviews were completed with the director of the referral health centre, the government health representative, and NGO and UNHCR

representatives. The individuals chosen for interviews represented specific groups, and with their knowledge of particular areas within the community it made them essential people from which to gather information from (Babbie 2001).

Interviews focused on the topics of: health activities; participation; communication; expectation; responsibility; and integration. The dictaphone was used to record all interviews except with the government health representative as it was not permissible by the government office. Each interview involved two members of the research team, one to control the recording and take notes on discussion and observations, and the other to lead the interview questions. On return to the field base, interviews were transcribed from the tapes and, if required, translated into English, with checks completed on all translation work.

Observations

Continuous use of general observations in the field reinforced and sometimes challenged other forms of collected data. Observations were mainly qualitative in nature through the gaining of impressions or the learning of a process of action (Babbie 2001). Each member of the research team wrote down their observations at the end of each community visit. These notes included a list of prompting questions as well as opportunity for general notes and feedback. Regular discussions with the data collection team expanded on issues and developed understanding. Recorded observations from my own previous experiences while working in the area proved invaluable for a perspective on the issues being covered by the study. I also kept an informal *journal* of some field experiences, especially of the time spent in the specific study communities (Leslie and Storey 2003). Reflection on this journal brings back many of the feelings and realities of various situations which I consider invaluable.

Demographic data

Demographic data was gathered from the local government to reveal population numbers and settlement areas. Information was also obtained from implementing NGOs, to be used as a balance to this data. Population data from the focus areas for the study was collected within the survey format. Due to the currently very mobile population, the numbers are variable but still reflect fairly accurately the numbers, makeup and population movement.

Questionnaires

It was originally planned that questionnaires would be formatted and sent to health centres who were involved with Angolan refugees in Zambia, to gain a different, more objective perspective of the services provided. This approach proved difficult due to the limited access back to Zambia and the sudden intense focus on repatriation during that time period. Many of the health services in Zambia, who were dealing with the departing refugees, were stretched to capacity with the health screening requirements that each refugee had to complete prior to leaving. Resources appeared limited and the logistics of getting the questionnaires delivered to very specific areas was challenging. In the end, time constraints prevented this process from happening and the questionnaire was removed from the data collection methods.

Bundas Municipal – The Study Area in Focus

The government Administrator of the municipal capital town permitted the research team to access the three communities. The traditional and government leaders of the three areas received messages requesting a meeting to discuss the research programme. Community 1 was accessible, 35kms (45 minute drive) away from the research team's base in the main town, via a tar-sealed road in fairly good condition. As the research team, we were keen to camp in the area in order to gain a greater experience of the community, but, after discussion with the *Soba* and due to its easy access, we chose to visit the area on a daily basis and return home to the main town in the evening.

Community 2 was much less accessible, 85kms away on a very sandy, bumpy road, requiring a vehicle in 4WD for the majority of the way and potential vertebrae realignment on arrival. Due to the shortage of accessible vehicles, the first visit was combined with the mobile medical team's vaccination programme in the area. The research team completed the majority of household surveys, carried out an interview, and camped one night. The second visit two weeks later involved just the research team, with the group discussions being held, and again we camped for the evening.

Community 3 was fairly accessible, being only 35kms away from the main town, but the road was unsealed and sandy in places, thus slowing down the travel time. An initial visit to have a meeting with the *Soba* and commencement of household surveys was followed by a return visit to the area. We were dropped off by a vehicle and camped for four days in

the community. Some of the research team had to return later to the area to complete an interview.

Process of Analysis

It is recognised that the sample area, due to its selection based on *convenience*, has limitations for analysis. With the selection of only three villages for the data collection, the variability is reduced compared to a sample representative of the whole population. This, and the limited number of participants for a comparative study, makes it difficult to conduct a true statistical analysis on the compiled data (Babbie 2001).

Greater analysis of this data would possibly lead to problems including manipulation to obtain results, rather than a revealing of the truth of the situation as discovered through the research process. This analysis limitation, therefore, prevents the use of identifying the statistical significance of the data and promotes more qualitative reasoning. Babbie (2001) discusses tests of significance of data results and concludes that they can potentially be dangerous as they take away from the focus of the bigger picture that the data is revealing. A statistically *insignificant* result may have a big impact in a different form (possibly neutral) and may in reality be very significant to the situation. Due to these considerations, the statistical level of significance of the data will not be measured or discussed.

The focus of the analysis on the household survey data is variable-centred. The two main variables of IDPs and RRs are compared to the three communities. This reveals differing patterns of thought and experience, and shows how the study topic is affected (Fielding and Gilbert 2000).

Due to the access constraints, the communities surveyed had a smaller IDP population group than had been anticipated. The result is a 40 (22%) to 141 (77.9%) comparison, which in percentage is possibly reflective of the proportions in the overall population at the time of research, but due to the sampling error is not representative.

The idea to compare the responses of the two people groups of IDPs and RRs is potentially statistically limited, due to the possibility of influences within the individual village settings which could change the participants' perspectives, rather than their

answers being based on their identities as past IDPs and RRs. Comparison of the clear cut IDP and RR results within the individual community variables reveals potential community biases and clarifies this influence of the community setting upon the IDP and RR results. The relationships between the three communities are observed for differences and themes.

In the household survey the combination of open and closed questions allowed for a mixed array of answers. The questions with a set of optional answers allowed for easy analysis of the responses and a clear outcome. More difficulty arose in deciphering the responses from open ended questions and classifying them into set categories, but when accomplished gave more depth to many of the answers.

The presentation of the results is given with the priority being on the flow of information, thus resulting in a very mixed arrangement in the data results. Many quotations are used from interviews and group discussions in order to capture the true response from the people involved.

The Constraints

My affiliation with the NGO created potential for the community to perceive me as representative of the organisation and therefore possibly impact upon their responses. My previous work in the larger demographic area and the fact that there was limited NGO input in the vicinity also added to this issue. As the research team, we took great efforts to ensure that we had no NGO identity on us (t-shirts, caps, etc), and when dropped off by a NGO vehicle (all had prominent stickers on the doors) it was parked in an inconspicuous area or it dropped us off and returned later for pick up.

In general within Angola, the air is thick with suspicion. Each member of the research team ensured that we introduced ourselves very carefully, stating that we were working with the support of an NGO to collect information from the community but that we did not represent this entity. It was made clear that, as a research team, we were not implementing any projects in the area and that the information collected was to be given in part to the NGO, the government, and used in a university study. Some people needed confirmation through further explanation on why we wanted to know their opinion, what we are going to do with the information, and that the government knew that we are asking questions. Participants

appeared to understand the reasoning well, on explanation, and were very keen to share their experiences.

The dictaphone brought an interesting response and at times aroused greater suspicion until its use was demonstrated. All interviewees and discussion groups consented to its use except for one government representative, which resulted in a limitation on the detail and quantity of data collected from the interview, as the research assistants were not used to recording information quickly in a written format. My inability to speak the local language of Mbunda was a potential limitation on the interview process but the training and the translation quality of the research team compensated for this.

An observation from one of the members of the research team revealed that participants with limited or no education found a few of the questions within the household survey difficult to answer. These included open questions that required the respondent to critically observe an issue and consider future strategies for improvement of their community. He felt that the thinking involved in being able to answer these questions appropriately was beyond the comprehension of some of the respondents. Consideration of this issue was made but periodic checks on the responses that had been collected within these formats revealed that the answers were adequate and revealed reasonable understanding. The research team subjectively considered the overall study population to be *willing*[8] to participate in the study. Non-response was not an issue for the household survey.

It was identified right from the start that the participants involved in the study were of differing backgrounds. Initial observations revealed that people internally displaced during the war would possibly have a lower level of formal education than those who chose to leave the country and use the educational services of their host country. Results of the survey revealed that 45.9 per cent of the 181 people surveyed stated that they had received no formal school education. Of these 83 people (45.9 per cent), 44 per cent were those who considered themselves, at one stage, to be refugees and 52.5 per cent were IDPs. There were no constraints experienced due to the gender of the participants. No effort was made to have either female or male participants, but as presented earlier, the final representation was even (91 / 90).

[8] Against: not willing; a little willing; and very willing.

The presence of government officials and their military aide in one area disrupted a focus group discussion, and it was observed that the group was uncomfortable with their presence in the area while they were discussing various topics. The group discussion was quietly postponed until the officials had left the community. The attendance results from Com 1 (see Table 5.1) are very high for a focus group. This was the first community in which we held the group, and because of the enthusiasm of the community to attend the discussion, it was difficult to reduce the size and create disappointment. The results of both the men's and women's group were very positive, in that the overly large numbers did not appear to impede discussion or reduce participation, and the long transcription notes show some interesting outcomes.

Due to the remoteness of the chosen area for fieldwork, time delays were almost expected in travelling around the area. Access to and from the study areas was achieved through the United Nations passenger service under WFP (World Food Programme) and was all within the planned time frame. Access from the field base to the study areas was achieved via land cruiser and at one stage, due to the lack of vehicle fuel, a bicycle trip was planned, but at the last hour was not required as a fuel flight arrived. The NGO was very happy to assist in transportation needs of the research team. Safety concerns mainly that of land-mines and vehicle accidents were taken into consideration and the security policies of the area-based implementing NGO were rigorously adhered to and no undesirable incidents occurred.

The phase of data collection was an enjoyable but fairly intense period of the research project. To ensure that the surveys were completed appropriately and accurately required that I made constant assessments and checks with the research team. Beyond the structured approach to the research, though, was the opportunity to stop, listen and spend time absorbing a piece of the reality, culture and lives of the communities that we had an opportunity to be involved with, and this was considered an enormous privilege.

This chapter has described the research process as experienced in Angola. A research team accessed three communities and collected data using a combination of qualitative and quantitative methods. This data has limitations due to the convenience sampling of the communities but it reveals the reality of three individual communities and their experience

of war and post conflict in Angola. The following two chapters present the results of the research.

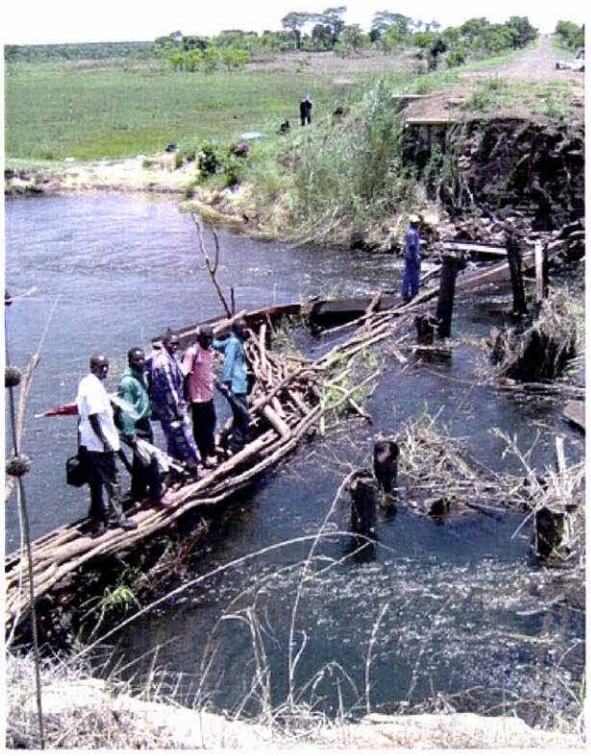

Photo 4: The research team.

Crossing the river to access Community 1. Most bridges in the area were destroyed during the war making access very difficult, especially via vehicle.

Photo 5:
Village mapping.

Community 3, Women's focus group.

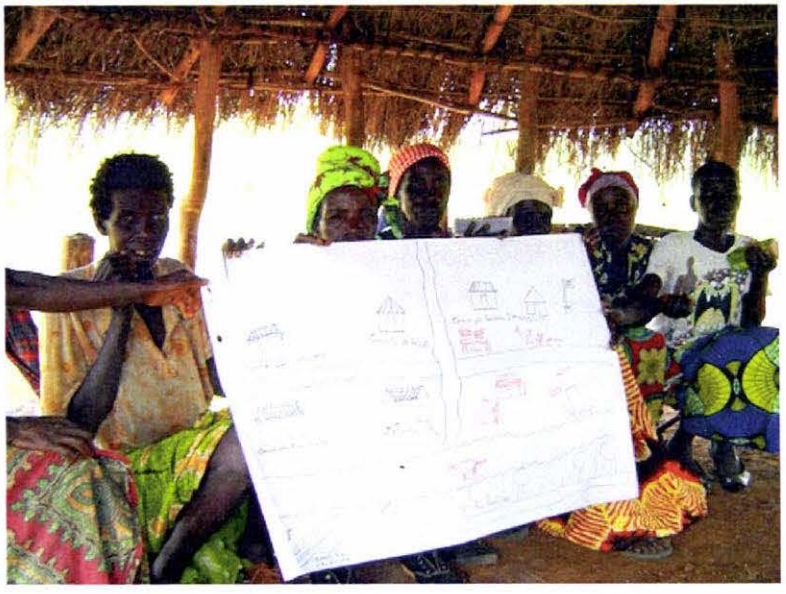

Photo 6: Inquisitive children during data collection in Community 3.

Chapter 6: The Reality of Life and Health in Rural Post Conflict Angola

The experiences of Angola portray the reality and issues involved in the development of health within the post conflict context. This chapter outlines the findings from the period of field research and describes these results considering the needs, wants, reality, and use of health services. These themes reveal some of the reality of life and health in Angola at the time of field work and they portray the issues previously outlined in this thesis. This chapter commences with an overview of the general profile of the respondents which gives background and reality to the data. Presentation of the quantitative data in table format uses specific subject variables against a breakdown of the respondents into their geographical communities[1], and within these communities the identified subgroups of previously identified[2] internally displaced people[3] (IDPs) and returned refugees[4] (RRs). The voices of the respondents are carefully documented in order to reflect as accurately as possible their true meaning. Some comparison and interaction between the variables occurs within this chapter but takes place in more depth within the discussion and the conclusion chapters.

Community Profile

To gain a general profile of the region and the communities, a household survey collected background information. Responses from the IDP and RR groups identify differences between life experiences which affect current knowledge and attitudes. The data reveals that some people spent a long time in Zambia, while others a much shorter period. The influence that the time spent in Zambia has on knowledge, attitudes and practice is relevant to consider. In comparison, the influence of the current settlement area is possibly less relevant due to the probable shorter time period in the new settlement. I consider that influence from time spent in refuge during the period of war, is stronger than from current experiences since the establishment of peace.

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[1] The three communities are represented as Community (Com) 1, 2 & 3.
[2] 'Previously identified' denotes that the IDPs are now settled back in their area of origin or identified home and are therefore no longer considered internally displaced
[3] Considered as anyone who did not leave Angola during the war. Within the study area everyone was displaced from their home at some stage
[4] Considered as anyone who left Angola during the war and sought refuge in another country

The proportion of IDP and RR populations within each community is revealed in Table 6.1. This shows the ratio of IDPs and RRs against the total number of respondents from the household survey as 22 to 77.9 per cent respectively. Within each community the breakdown of IDPs to RRs is revealed, with Community 1 made up of predominantly RRs, Community 2 with a greater proportion of IDPs, and Community 3 with a greater proportion of RRs. The proportional composition of these groups within each community has an effect on the outcome of responses for the community as a whole and the consequences of this will be discussed further within Chapter Eight.

variable	***com[5] 1***	***com 2***	***com 3***	***total***
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*
idp	9 (8.1)	9 (60)	22 (40)	**40** (22)
rr	102 (91.9)	6 (40)	33 (60)	**141** (77.9)
total *n/181 (%)*	**111** (61.3)	**15** (8)	**55** (30.3)	**181**

Table 6.1: Proportion of IDP and RR populations in each community and the total respondents of the household survey (HHS)[6]

As seen in Table 6.2, the overall combined mean number of people per household is 5.2. The household[7] (HH) sizes ranged from one to twenty members. The household survey therefore represents 954 people within three communities.

variable	***com 1***	***com 2***	***com 3***	***combined***	***idp***	***rr***
	n/111 (mean)	*n/15 (mean)*	*n/55 (mean)*	*n/181 (mean)*	*n/40 (mean)*	*n/141 (mean)*
population	623 (5.6)	81 (5.4)	250 (4.5)	954 (5.2)	203 (5)	751 (4.1)

Table 6.2: Mean number of people per household and total population represented by the household survey (HHS)

The proportions of children to adult female and male household members are revealed in Table 6.3 where the results appear fairly evenly represented. Noticeably, the 15-45 years male group from Community 2 is higher than the other communities, whereas the IDP / RR breakdown is more even, although the reason for this is unknown. Females over the age of 45 in Community 1 represent a smaller group than the combined mean percentage, though it reflects the lower RR group of which it is primarily composed of. The RRs have a lower older population overall which could be attributed to the early stages of repatriation,

[5] Abbreviated for 'Community' within tables
[6] Bracketed abbreviation at the end of each table title and quotation indicates source of information
[7] Defined as the total number of people eating out of the same pot

as families may choose to establish their homes prior to bringing elderly relatives back to resettle.

variable	com 1	com 2	com 3	total	idp	rr
	n/623 (%)	*n/81 (%)*	*n/250 (%)*	*n/954 (%)*	*n/203 (%)*	*n/751 (%)*
<15years female / male	382 (61.3)	41 (50.6)	139 (55.6)	562 (58.9)	109 (53.7)	453 (60.3)
15-45 years female	106 (17)	11 (13.6)	41 (16.4)	158 (16.6)	32 (15.8)	126 (16.8)
15-45 years male	67 (10.8)	15 (18.5)	30 (12)	112 (11.7)	25 (12.3)	87 (11.6)
>45 years female	30 (4.8)	8 (9.9)	22 (8.8)	60 (6.3)	17 (8.4)	43 (5.7)
>45 years male	38 (6.1)	6 (7.4)	18 (7.2)	62 (6.5)	20 (9.9)	42 (5.6)

Table 6.3: Age and gender distribution of the household members (HHS)

Tribal affiliations are represented in Table 6.4 with IDPs showing a greater proportion of *Luchazi*[8] and fewer *Mbunda* compared with the RR group. This question within the household survey allowed for multiple affiliations, although the majority responded with one tribal group. Other tribes identified beyond the table results were (in order of greatest combined percentage), Nkangala (5), Umbundu (3.9), Makoma (1.7) and other (1.7). Comparison of these percentiles with national data is not possible due to limited statistical country information.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*	*n/40 (%)*	*n/141 (%)*
Luchazi	40 (36)	6 (40)	15 (27.3)	61 (33.7)	16 (40)	45 (31.9)
Mbunda	34 (30.6)	2 (13.3)	19 (34.5)	55 (30.4)	10 (25)	45 (31.9)
Chokwe	24 (21.6)	5 (33.3)	8 (14.5)	37 (20.4)	5 (12.5)	32 (22.7)
Luvale	8 (7.2)	1 (6.7)	2 (3.6)	1 (6.1)	2 (5)	9 (6.4)

Table 6.4: Top four affiliations of tribe (HHS)

Comparisons between the levels of education[9] obtained by females (Table 6.5) and males (Table 6.) shows a much higher achievement rate from the male group. It is revealed that 60.4 per cent of women compared to 31.1 per cent of men respondents received no formal schooling. No women achieved above year nine and within the IDP women's group only 21.1 per cent obtained education and this amounted to between one to four years. Within the male group the outcomes are more even but the RR group achieved a higher education level. Overall comparisons between combined female and male IDP and RR groups show that 52.2 per cent of IDPs and 44 per cent of RRs received no formal

[8] Italicised words depict a direct reference to relating table
[9] Levels of education are represented by *Years* (ie. Level 2 equals Year 2)

schooling. RRs received a higher level of education overall with 18.4 per cent achieving between five to nine years compared to five (5) per cent of IDPs.

A look at the breakdown of the individual communities shows that those with a higher proportion of RRs to IDPs have a community with a higher level of education. Explanation for this higher level for the RR group is related to the greater provision and access of educational services within organised settlement areas in Zambia. Of the 141 RRs, 59.6 per cent identified that they stayed in an organised settlement for the greatest period of their time in the host country.

variable	***com 1***	***com 2***	***com 3***	***combined***	***idp***	***rr***
year	*n/56 (%)*	*n/9 (%)*	*n/26 (%)*	*n/91 (%)*	*n/19 (%)*	*n/72 (%)*
0	33 (58.9)	8 (88.9)	14 (53.8)	55 (60.4)	14 (73.7)	41 (56.9)
1-4	16 (28.6)	1 (11.1)	10 (38.5)	27 (29.7)	4 (21.1)	23 (31.9)
5-9	6 (10.7)	0	2 (7.7)	8 (8.8)	0	8 (11.1)
10-12	0	0	0	0	0	0

Table 6.5: Level of education obtained by females (N=total number of women) (HHS)

variable	***com 1***	***com 2***	***com 3***	***combined***	***idp***	***rr***
year	*n/55 (%)*	*n/6 (%)*	*n/29 (%)*	*n/90 (%)*	*n/21 (%)*	*n/69 (%)*
0	18 (32.7)	3 (50)	8 (27.6)	28 (31.1)	7 (33.3)	21 (30.4)
1-4	25 (45.5)	1 (16.7)	13 (44.8)	39 (43.3)	12 (57.1)	27 (39.1)
5-9	12 (21.8)	2 (33.3)	6 (20.7)	20 (22.2)	2 (9.5)	18 (26.1)
10-12	0	0	1 (3.4)	1 (1.1)	0	1 (1.4)

Table 6.6: Level of education obtained by males (N=total number of men) (HHS)

Rates of literacy (Table 6.7 and 6.8) have an effect on community rehabilitation and development and the types of implementation methods appropriate within the community. The combined results for *illiteracy* were 32.2 per cent of men compared to 68.1 per cent of women. IDP women revealed higher rates whereas IDP men's rates were lower than their RR counterparts. RR results showed greater variety, with the inclusion of English and French. The total population of Community 2 indicated a very low literacy rate, compounded by the complete illiteracy of the women's group. The combined total of females and males who could write at least one language was 49.7 per cent in comparison

with official Angolan statistics that state that the literacy rate[10] of the combined population was 49 per cent (The Embassy of the Republic of Angola 2000).

variable	*com 1*	*com 2*	*com 3*	*combined*	*idp*	*rr*
	n/56 (%)	*n/9 (%)*	*n/26 (%)*	*n/91 (%)*	*n/19 (%)*	*n/72 (%)*
0	36 (64.3)	9 (100)	17 (65.4)	62 (68.1)	14 (73.7)	48 (66.7)
1-4	20 (35.7)	0	9 (34.6)	29 (31.9)	5 (26.3)	24 (33.3)
5-8	0	0	0	0	0	0
Portuguese	6 (10.7)	0	3 (11.5)	9 (9.9)	3 (15.8)	6 (8.3)
English	2 (3.6)	0	0	2 (2.2)	0	2 (2.8)
French	0	0	0	0	0	0

Table 6.7: Female written literacy rates (N=total number of women) (HHS)

variable	*com 1*	*com 2*	*com 3*	*combined*	*idp*	*rr*
	n/55 (%)	*n/6 (%)*	*n/29 (%)*	*n/90 (%)*	*n/21 (%)*	*n/69 (%)*
0	17 (30.9)	3 (50)	9 (31)	29 (32.2)	5 (23.8)	24 (34.8)
1-4	29 (52.7)	2 (33.3)	15 (51.7)	46 (51.1)	13 (61.9)	33 (47.8)
5-8	8 (14.5)	0	3 (10.3)	11 (12.2)	0	11 (15.9)
Portuguese	22 (40)	3 (50)	11 (37.9)	36 (40)	10 (47.6)	26 (37.7)
English	5 (9.1)	0	2 (6.9)	7 (7.8)	0	7 (10.1)
French	2 (3.6)	0	1 (3.4)	3 (3.3)	0	3 (4.3)

Table 6.8: Male written literacy rates (N=total number of men) (HHS)

With the many tribal groups represented in the area, and the influence of the Portuguese and now the English[11] languages on the process of communication, the knowledge of languages appeared to give advantages for education and employment. The basic communication between people groups requires common language and in consideration of the process of repatriation from different countries, language was seen to be an important variable. The identification of this importance motivated the inclusion of language into the household survey (see Tables 6.9 and 6.10). It was observed generally that RRs were more proficient in English due to their time spent in Zambia which has English as its official trade language, and this is reflected in the table outcomes, but not as strongly as was anticipated. The RR women reflected a lower grasp of the English language than the men. None of the IDPs identified English as a language they spoke. RRs claimed a higher knowledge of the Portuguese language than was expected, with women RRs slightly higher than women IDPs. Community 2 showed high deficiency in Portuguese and English compared to the other two communities, but was also the community with highest

[10] Classification of literacy rate not available
[11] Spoken within Eastern Angola due to the high proportion of returnees from Zambia

percentage of IDPs. The higher percentile results which are not reflected in the tables below indicate the majority of people knowledgeable of one to four (1-4) tribal languages.

variable	com 1	com 2	com 3	combined	idp	rr
	n/56 (%)	*n/9 (%)*	*n/26 (%)*	*n/91 (%)*	*n/19 (%)*	*n/72 (%)*
5-8 tribal	1 (1.8)	1 (11.1)	7 (26.9)	9 (9.9)	1 (5.3)	8 (11.1)
Portuguese	9 (16.1)	0	6 (23.1)	15 (16.5)	3 (15.8)	12 (16.7)
English	2 (3.6)	0	0	2 (2.2)	0	2 (2.8)
French	0	0	0	0	0	0

Table 6.9: Female language speakers (N=total number of women) (HHS)

variable	com 1	com 2	com 3	combined	idp	rr
	n/55 (%)	*n/6 (%)*	*n/29 (%)*	*n/90 (%)*	*n/21 (%)*	*n/69 (%)*
5-8 tribal	15 (27.3)	1 (16.7)	6 (20.7)	22 (24.4)	3 (14.3)	19 (27.5)
Portuguese	29 (52.7)	3 (50)	17 (58.6)	49 (54.4)	14 (66.7)	35 (50.7)
English	5 (9.1)	0	2 (6.9)	7 (7.8)	0	7 (10.1)
French	2 (3.6)	0	1 (3.4)	3 (3.3)	0	3 (4.3)

Table 6.10: Male language speakers (N=total number of men) (HHS)

The coordinators of the NGO identified that there were conflict issues between the two groups of IDPs and RRs surrounding integration and resettlement but that this occurred generally within the main town. Due to a higher level of education and knowledge of the English language it was easier for RRs to get employment. This appeared to induce a certain amount of jealousy between the two groups, and the NGO identified it as one of the triggers for the underlying conflicts. The NGO attempted to alleviate this problem through endeavouring to hire staff representative of both IDPs and RRs. This was not always possible due to the requirement for skills and experience for many of the available positions. The NGO representatives felt that many of the IDPs did not know the job requirements or have the necessary skill levels.

Through focus group discussions the communities identified that there were no problems in the process of integration and settlement between IDPs and RRs. This question was asked within a mixed group of IDPs and RRs which could possibly have influenced a positive response. The response could also be attributed to the rural setting of the communities where small settlements appeared more unified and job opportunities were generally not available.

The vice Administrator[12] and *Soba*[13] of Community 2 noted that there were issues between the two groups of IDPs and RRs resulting from the distribution programme of food and non-food items that occurred in the area. Through the programme of repatriation under UNHCR (United Nations High Commissioner for Refugees), RRs received benefits but IDPs did not. The actual outcome of these underlying issues was not discussed. The government health representative felt there were no problems concerning integration.

One *Soba* identified his role in peace and integration within the community stating,

> *"I do call my people and instruct them what to do, they respond positively and I talk to them about peace. I have not seen any problems. It's the duty of the Soba. If the Soba fails to be open to everybody and work together with the people, they are likely to be scattered. The Sobas' obligation is to unify people together"* (Soba, Interview, Community 3).

Needs and Priorities

There is a vast array of 'need' associated with a post conflict situation. In areas of difficult accessibility, including the three study communities, basic needs were even more pronounced. The requirements for daily life were influenced through the recent return and short settlement period of the population to the area, and the lack of accessible resources and infrastructure. Identified needs could be personal or relate to the entire community. IDPs and RRs returned with very little resources. Most people began to settle and establish their communities with only what they were wearing or carrying.

Respondents, through all forms of data collection, were very clear on identifying their needs, happily listing their wants and desires for the community. One man stated,

> *"If they want our health to improve, we are asking for ..."* (a list followed on) (male, FGD, Community 1) and another, *"...the country can only develop if there are loans"* (male, FGD, Community 3).

The male respondents' reference to *they* in the above quote is an interesting observation and it can only be surmised as to whom he is referring. Consideration of this statement in context would mean that he was talking about either the government or the NGO and it is

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[12] Vice head of the local government administration
[13] Portuguese language for chief, traditional village head

interesting that he did not claim the need for himself but referred to it as another's perception of the needs of his community.

The government health representative commented on the needs of the area by referring to a structural community requirement, saying,

> *"The country, it has been in war for many years. So many things are needed. See from here to Luena you have to use air transport or walking. There are the problems of no bridges"* (government health representative, Interview).

A community in this setting has some very obvious, basic needs of life. Through the technique of card elimination[14], each community identified their greatest immediate need from the six options of: water; health; food; transport; seeds and tools; and education.

From the three communities, the provision of *seeds and tools* at 72.3 per cent of a total of 300, was considered the highest need at the time of the survey (Table 6.11). *Health* came in second at 69 per cent and *education* followed at 61.9 per cent. Noting that the period of data collection was during the month of December, which is the planting season for the region, the positioning of the immediate need for seeds and tools is justified. A closer look shows that Communities 2 and 3 both individually identified *seeds/tools* as their highest need, where as Community 1 identified *health* at 76 per cent. It is also noted that Community 1 was the area where 91.9 per cent of those surveyed were identified as returning refugees who were eligible for the provision of seeds and tools under the repatriation scheme. Communities 2 and 3 had 40 and 60 per cent respectively of returnees, hence a lesser availability of required agricultural implements. The government also provided some level of equipment and seeds but this was not clearly structured and at the time of research Community 2 had not been part of this distribution.

The consideration of needs through the eyes of gender reveals that *education* scored higher for women but fairly even on the community variables. *Food* was ranked higher by men than women, but *transport* was higher for women than men. The men in the three communities rated *seeds/tools* and *health* equal at 72 per cent each and women rated *seeds/tools* and *education* equal at 72.7 per cent each. The women's result was a surprising outcome for me, as the ongoing discussions of the need for health care had

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[14] Six community priorities represented on individual cards. The participants identify their priority from two cards at a time until all are compared, thus revealing a final single priority. See explanation Chapter Five.

been foremost in my mind, and the generalisation that women are concerned predominately with the health of the family created an expectation that this would be the clear priority. This indicated the requirement to consider the health care needs in each area and the community's expectations towards them.

variable	*com 1*	*com 2*	*com 3*	*combined*	*women*	*men*
	n/100 (%)	*n/100 (%)*	*n/100 (%)*	*n/300 (%)*	*n/150 (%)*	*n/150 (%)*
seeds/tools	65 (65)	77 (77)	75 (75)	217 (72.3)	109 (72.7)	108 (72)
health	76 (76)	69 (69)	64 (64)	209 (69.7)	101 (67.3)	108 (72)
education	60 (60)	65 (65)	60 (60)	185 (61.7)	109 (72.7)	76 (50.7)
food	50 (50)	48 (48)	52 (52)	150 (50)	58 (38.7)	92 (61.3)
water	32 (32)	24 (24)	28 (28)	84 (28)	35 (23.3)	49 (32.7)
transport	17 (17)	17 (17)	21 (21)	55 (18.3)	38 (25.3)	17 (11.3)

Table 6.11: Outcomes of identified needs assessment (priority rating technique FGD) (N=total possible responses)

The household survey results collected suggestions (Table 6.12) in an open question format for services that the community wanted to see started in the area. Respondents could make as many suggestions as desired. In comparison to the results of the priority needs ratings where the respondents traded off priorities against priorities, the open questioning allowed for a range of answers. Prior to the completion of the survey, it was considered that *health* would be high on the list as a priority for the community and it is reflected here in first priority throughout each group. S*eeds/tools* came down at fourth equal on the combined list, with overall percentages reflecting quite low, especially in comparison to the results from Table 6.11 where seeds/tools was rated highest priority. The obvious difference with the water variable between IDPs and RRs can be partially attributed to the water result for Community 1 at zero per cent and the lower result for Community 3, both of which have higher IDP numbers, showing that these two communities must have a better water supply than Community 1, and this is in fact true. Community 2 has a concrete well with a lid and Community 3 has a very large fast flowing river (which isn't ideal for drinking but is acceptable in consideration of the priorities in this period of rehabilitation). Schooling was mentioned less by IDPs than RRs.

Fourth on the list for RRs is the need for loans at 17 per cent but this was not mentioned at all by the IDPs. The desire for clubs and grinding mills was low on the list of IDPs compared to RRs. This can be attributed to the fact that the RRs were more exposed to

services and opportunities in their host countries and this in turn affects their expectations and desires for their area of return and settlement.

The subject of *food* in this list was initially disregarded in the report due to its lack of 'service' orientation, but after analysis it was seen to be quite high on the overall list of priorities and so has been included. Its classification as a 'service' is attributed to the food distribution programmes that are operating in the area. The issue of food was comparatively higher from the IDP group and this was represented well in Community 2 which is predominantly IDP. This result is attributed to the fact that RRs receive food distribution for a certain period of their initial settlement under UNHCR guidelines whereas IDPs are not included in this and are considered under government assistance.[15]

Requests for services or assistance for *orphans* came from 5 per cent of RRs and only one response (2.5 per cent) from an IDP. *Other* responses made up 40 per cent of IDP and 54.6 per cent of RRs total responses and included things like markets, bicycles, clothes, roads, oxen, extra curriculum education courses, NGO assistance and more. One comment which reflects the style of many of the responses was from a female RR from Community 1 who, when asked 'what services would you like to see started in your community?' she replied,

> *"Things which are helpful to a human body, a hospital and giving us bicycles"* (female, RR, Community 1, HHS).

On average, IDPs gave 2.7 and RRs 3.1 suggestions per person regarding perceived needs in the community. Discussions with IDPs revealed a more limited approach to thoughts regarding the needs of the community, with suggestions for solutions being visually obvious and concrete. For example, an IDP response, *"...food, blankets, clinic, school"* (male, IDP, HHS, Community 3) compared with an RR response, *"...they should bring us clubs*[16] *so that we can learn tailoring and other skills"* (female, RR, HHS, Community 3).

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[15] Food assistance for IDPs was either nothing or limitedly sporadic under government food for work schemes.
[16] Social groups formed to share and teach things like sewing and animal care etc.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*	*n/40 (%)*	*n/141 (%)*
clinic	75 (67.6)	12 (80)	40 (72.7)	127 (70.2)	27 (67.5)	100 (70.9)
water	60 (54.1)	0	19 (34.5)	79 (43.6)	11 (27.5)	68 (48.2)
school	57 (51.4)	3 (20)	18 (32.7)	78 (43.1)	10 (25)	68 (48.2)
food	14 (12.6)	7 (46.7)	13 (23.6)	34 (18.8)	16 (40)	18 (12.8)
loans	20 (18)	0	4 (7.3)	24 (13.3)	0	24 (17)
grinding mill	9 (8.1)	1 (6.7)	14 (25.5)	24 (13.3)	1 (2.5)	23 (16.3)
seeds/tools	15 (13.5)	1 (6.7)	8 (14.5)	24 (13.3)	7 (17.5)	17 (12.1)

Table 6.12: Prioritised community identified needs (HHS)

The government health representative recognised the impact of an increasing population on the needs of the community. He said,

> *"Many things are needed. The time we first arrived here, there were a lot of military men everywhere, civilians were just few. Now people are many, from the bush and many from Zambia. Things like food, medicines, clothes and holding different training to help people"* (government health representative, Interview).

The most important health services for each area were identified by the respondents from the options[17] of: traditional healer; witch doctor[18]; health clinic; hospital; TBAs[19]; mobile clinic; community activists; and other (with the option to specify) (Table 6.13). This was a question asked in order to get an idea for what was considered as the perceived most important health service and to observe differences between IDP and RR responses. The differing concepts of *health clinic* and *hospital* were clarified with the respondents at the time of survey.

The responses from the IDP and RR groups revealed different levels of importance. The RR response put a greater emphasis on *hospital* services and IDPs had a higher *health clinic* response. All individual communities showed a very different range of responses compared to the combined mean and the IDP / RR variables. Further breakdown of the community variables showed the IDP and RR subgroup responses. In Community 3, this reveals that the high *health clinic* response is a result of the high responses from both (percentages) the IDPs (77.3) and RRs (60.6) groups. The high *hospital* response in Community 2 is made up of a high response from IDPs at 55.6 per cent. The *mobile clinic* response was solely from RRs in Community 2. Community 1 reflects more evenly the combined mean and the RR breakdown, revealing its predominantly RR proportion.

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[17] In this order
[18] As role definition described in Chapter Two
[19] Traditional Birth Attendant

The other listed optional health services came in with a very low result as reflected in the combined total results of TBAs (1.1 per cent), witch doctors (0), and community activists[20] (0). Responses under the choice of *other* received only one from each IDP and RR group.

variable	*com 1*	*com 2*	*com 3*	*combined*	*idp*	*rr*
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*	*n/40 (%)*	*n/141 (%)*
health clinic	46 (41.4)	5 (33.3)	37 (67.3)	88 (48.6)	26 (65)	62 (44)
hospital	47 (42.3)	7 (46.7)	10 (18.2)	64 (35.4)	10 (25)	54 (38.3)
mobile clinic	14 (12.6)	3 (20)	3 (5.5)	20 (11)	1 (2.5)	19 (13.5)
traditional	1 (.9)	0	4 (7.3)	5 (2.8)	2 (5)	3 (2.1)

Table 6.13: Most important health service (HHS)

Epidemiology reports collected from the main health centre reveal that on average 1008 patients were seen in the clinic every month. The top five diagnoses over the year period from May 2004 to April 2005 were: malaria; diarrhoea (all types); intestinal parasites; headache; and skin infections. These results were collected by the government nurses in the referral health centre in the town of Lumbala Nguimbo. The clinic health staff compiled the data and trends were observed. Levels of accuracy of the data are questionable, not necessarily due to the compiling process but throughout observation of the examination procedures it was revealed that diagnoses were limited. The availability of equipment and tests for accurate diagnosis was very low in the area and treatments were often given using skills of observation and a level of guess work.

The Lumbala Health Director felt that those coming from Zambia had more diseases including: TB; STDs; leprosy etc, but that those from the bush had less complicated diagnoses. The village health worker in Community 3 also made comments to support this thinking. The NGO health coordinator commented that more serious cases were being dealt with at the health centre, as the population increased.

General questioning in the household survey regarding current health revealed that 77.3 per cent of the respondents stated that they had been sick within the last month, with 92 per cent of IDPs and 73 per cent RRs. Of the total 181 households, 34 pregnant women were identified, equalling 7.5 per cent of the IDP and 22 per cent of the RR household

[20] NGO trained Community educators who train village committees and peer educators

population. Table 6.14 reveals the total number of deaths occurring within the sample group in the month prior to the survey period. The breakdown of deaths within the variables were unremarkable except for the six 15-45 year olds in Community 3, for which no other data is available in order to examine further. The under five year old death rate is higher than the other age brackets but is revealed at six per cent of the total within that age range. National figures reveal the under five year old mortality rate at 260 per 1,000 live births (UNICEF 2003).

variable	***com 1***	***com 2***	***com 3***	***combined***	***idp***	***rr***
	n/623 (%)	*n/81 (%)*	*n/250 (%)*	*n/954 (%)*	*n/203 (%)*	*n/751 (%)*
total deaths	7 (1.1)	3 (3.7)	19 (7.6)	29 (3)	12 (5.9)	17 (2.3)
< 6 months	*0*	*2*	*1*	*3*	*3*	*0*
6m-5 years	*4*	*1*	*7*	*12*	*7*	*5*
5-15 years	*2*	*0*	*3*	*5*	*2*	*3*
15-45 years	*0*	*0*	*6*	*6*	*0*	*6*
>45 years	*1*	*0*	*2*	*3*	*0*	*3*

Table 6.14: Total deaths over month period in study areas (HHS)

The general feeling from the international community represented in the area was that the health care services were inadequate for the needs of the population. The implementing NGO health coordinator stated that the *"population is increasing much faster than the health care is increasing"* and that more advanced health care was required.

The UNHCR representative described the situation as being *"dynamic"*, in that the implementation and investment of money into a situation had to be justified by a real need which was often represented in population numbers. He said, *"we are going to work in order to get those conditions, for that we need people"* and "*no one's going to put a health centre in a place with 20 people, you've got to be practical"* (UNHCR, Interview).

The community also had a strong view on the subject and, as one woman put it when discussing the current health services, *"there is nothing. In our opinion we are saying they are not adequate"* (female, FGD, Community 2) and another who said, *"we are still suffering like the way we were in the bush. We are depending on roots again like in the war time"* (female, IDP, FGD, Community 3).

With the need for health services easily identified and justified, it is interesting to consider the wants and expectations of the population.

Wants

> *"We are suffering, we are used to where we were having many things"* (female, RR, HHS, Community 1).

The desire or want for something may go beyond actual need but in most cases is a representation of a real need. The *wants* was defined to participants during data collection as, *what they would like to see*. Expectation from the population of the provision and services of health care appeared to be quite high prior to investigation. This desire for the attainment of something, (the want), is linked to the expectation of it. Many comments were made by people who felt that they deserved or it was their *right* to have access to a certain level of health care. It was of interest to consider where the motivation for the desire of these levels or services came from. Expectation of something generally comes from knowing what you think you know about a situation or from actually being informed. It was found to be difficult to measure.

Group discussions revolved around what was expected for health care in the different areas. One woman explained the situation for her as an IDP during the war when there was no hospital medicine. When a person got sick they had to dig roots to treat themselves. From here she stated,

> *"...this is why our expectations are the same because of war, starvation, not having clinics and clothing together with seeds, all these are still our expectations"* (female, IDP, Community 2).

She was explaining that nothing had changed since the time of war, that there were these things which she expected and needed and still didn't have.

An IDP woman from Community 2 shared that she felt the expectations were the same between the two groups of IDPs and RRs. Her thoughts were that since both parties were unsettled and had to leave their homes, all people were now returning back with the same expectations for the newly settled area. My impression from listening to the IDPs talk within a mixed group of IDPs and RRs was that they perceived that if they didn't follow with the RRs they could possibly miss out on improvements, just as they had experienced with the food and non-food distributions.

The general theme from RRs seemed to be that, 'we were told this, and so we expected that', and it is revealed in the three quotes below.

> *"When we came from Zambia, we had expectations that we were going to find hospitals but when we reached here there is nothing"* (female, RR, Community 2).

> *"Our desire was to come back to our deserted home and that the government would bring to us all our needs like clinics, schools for children and good water wells."* (female, RR, Community 2).

> *"We had expectations that when we go back to our home, we will find everything. But when we have come here, all that we expected to find is not there"* (female, RR, Community 1).

The same tone and issue is reiterated throughout each community, the fact that the returnees had expectations that everything was going to be established in their area of return, their home country. Only two responses out of the discussions surrounding expectations revealed the reality of the current situation, with one male stating why he had chosen to settle in an area proximate to the main town (35kms):

> *"They told us that no one was going to bring us food and health services if we went to settle in our areas of origin. This is why we have decided to settle here so that we can have access to these needs"* (male, FGD, Community 3).

From this it appears that he has chosen not too settle in his true home area due to the lack of services available there.

The *Sobas* of the communities had differing opinions. One *Soba* (Community 1) expected everything to be available including established clinics, but was disappointed in the reality of the situation. In contrast another *Soba* stated,

> *"I know that I will find nothing just because of war. I just decided to come to my country so that I cultivate to earn a better living"* (*Soba*, Interview, Community 3).

The health centre director from the main town realised prior to his transfer to the area that there would be nothing functioning well and that everything would need to be established due to three decades of problems in the country. He also tried to explain the confusion in the community regarding the issue of health services by saying,

> *"Many people were living in the bush, some in Zambia while others in various towns within the nation. All of these people don't know the rules of government, so they complain of the services"* (health director, Interview).

The health coordinator from the implementing NGO outlined the reality of the situation in this explanation and example:

> *"I think they have heard about how the health care is working here, but I don't think they understand it. I think they expect it to be a bit like Zambia where they have got quite good, (it sounds like it is quite good anyway) basic health care, and if you need to go to a hospital for an x-ray or a laboratory test you can do it. The thing is that we don't have anything like that here. An example, a guy came with his wife who had had a lot of tests and x-rays and examinations in Zambia, and when coming here expected us to continue that treatment and also try to find out what is wrong with her. I tried to explain that we really don't have anything here that we can help his wife with, that he would have to go to Luena[21]. And I know even in Luena, they probably can't do what they had had done in Zambia. So that is the problem, because people here, the people coming from Zambia expect a lot actually. And its not strange, it's not wrong or anything, it's just that we don't have it"* (health, Interview, NGO).

Within the household survey the participants were asked if they had been informed of the health services in the area prior to moving there. Table 6.15 shows a positive response came from 52.5 per cent of IDPs and 71.1 per cent of RRs. This reflects the knowledge that refugees who were staying in organised settlements in other countries were informed of the situation of their area of return. As mentioned previously, 59.6 per cent of the 141 RRs identified that they stayed in an organised settlement for the greatest period of their time in the host country. This number does not indicate that they returned from these organised areas recently, thus receiving current up-to-date information for their area of return. The 59.6 per cent does not include people who may have only been in the organised settlements for a short time very recently to make use of the organised repatriation phase.

variable	*com 1*	*com 2*	*com 3*	*total*	*idp*	*rr*
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*	*n/40 (%)*	*n/141 (%)*
yes	78 (70.3)	9 (60)	35 (63.6)	122 (67.4)	21 (52.5)	101 (71.6)
no	31 (27.9)	6 (40)	20 (36.4)	57 (31.5)	19 (47.5)	38 (27)
n/a	2 (1.8)	-	-	-	-	2 (1.4)

Table 6.15: Informed of health services prior to arriving in settlement area (HHS)

One man stated his expectations for his return to the area,

> *"The UN told us that we were going to find hospitals and schools already built by our government. They went on to say the NGOs and the government were going to give us something to start with"* (male, RR, Community 2).

[21] closest town with a hospital (approx. 350km away, only accessible by air due to the condition of road and landmines) (or possibly bicycle and foot).

Another returnee identified a problem with being self sufficient and said,

> *"This time we feel neglected by the UN because where we were, we used to trouble them a lot seeing that it was a country of refuge. Now that we are in our country, we should look after ourselves and this is our problem now"* (male, RR, Community 1).

Expectations on the work of the UN were reflected in this statement,

> *"How can the UN in Zambia operate differently from the one here when it is one organisation?"* (male, RR, Community 1).

The UNHCR officer-in-charge responded to these issues of expectation in his comments regarding the process of repatriation. He said that there is a commitment to provide all returnees with the truth of what is happening in their areas of final destination. The information comes from the area of return to the UNHCR and government offices in the host countries and the information is passed on. People are told that there are many difficulties and there are issues in getting jobs and treatment, but that the challenge is to come back and work for the development of the country. He stated in an interview that *"there are many rumours all the time and there is a lot of corruption"*. It is noted that the host countries are keen to send people back as part of the repatriation agreements between countries. His experience in the Namibian repatriation resulted in UNHCR intervening in the talks that the host governments were giving to the refugees, as they were painting a very rosy scenario and saying that the country was all fine with plenty of opportunities, when the reality was often very different than that. All of the repatriates in the area of study came from the host country of Zambia.

Further expectations of the services of the UN are reflected here. Most of the voices which consider the role of the UN come from Community 1 which is predominantly made up of RRs.

> *"We are looking forward to and want the UN to assist us like they did in places where we ran to during the war"* (male, RR, Community 1).

> *"We expected to find many (health services) because this is what they used to tell us. They told us that everything was being prepared just like the way we were being taken care of in the countries we went to"* (male, RR, Community 3).

> *"The UN where we were, used to tell us that the same assistance we were receiving there, would be the same here"* (male, RR, Community 1).

On a more positive note for the system of communication, one woman returnee stated:

> *"The UN used to tell us that even when we were to come back home, we were* ***not*** *going to find bridges, good roads, health clinics, that is why most of the people with infections have remained in Zambia so that they treat them. As for us, we thought of coming back so that we come and rebuild our country"* (female, RR, Community 3).

The UNHCR representative commented on these issues by saying,

> *"We know that the conditions are not yet in place, but since the people want and are eager to come back, what we were doing is letting them come and making sure that they are at least assisted with some help and that they are not arrested by the authority, and to provide them with very basic rights"* (UNHCR, Interview).

He also said that they were working on advocating for the rights of RRs as normal citizens and ensuring that they were not harassed by authorities or the local population. There were seen to be some situations of unrest towards returnees from the local population regarding resources and jobs, as well as difficulties from some government departments towards the processing and assistance of returnees.

When asked if he had observed any difference between IDPs and RRs and their levels of expectations for the development in their communities the UNHCR representative stated,

> *"No, I don't see many differences. Very little. The only difference is that the IDP did not cross the border of some country" (acting officer-in-charge, Interview, UNHCR).*

The municipal government health representative summed it all up by saying:

> "*They may complain, but home is home whether they lived in Zambia or they were in the bush. There are a lot of things people are expecting to see, but all of us need to work hard together and unite to rebuild the nation which has been destructed because of war"* (government health representative, Interview).

The Experienced Reality

Present Reality

The reality of a situation is often different to the need or the want. Present provisions of health care services to the study areas were available in various forms which were the result of differing factors. In the case of health services, the issues of access, settlement time, funding, education, population size, etc., all appeared to have varying degrees of influence. Providers of health services included private community members, government, church, military, police and an NGO. Services from the church, military and police provided

very limited access for the general public and the study areas, hence the focus on the publicly available services for this study. None of the three study areas had an onsite functioning health clinic.

Health Clinics

The main health service available in the municipality was a government run health centre that had three to eight variously trained nurses who fluctuated in their availability and attendance to the clinic. This centre was the referral clinic for the area and was rehabilitated and heavily supported by an international NGO. It was based in the main town of Lumbala Nguimbo and was a minimum of 35km from any of the villages directly involved in the research.

Initial perceptions of the clinic were that the nurses were unmotivated and unwilling to invest in the clinic work, but time and observation showed that the work and living situation for the nurses was very difficult. These nurses were posted to the area, mainly from the provincial town of Luena, 45 minutes flight away. The nurses were brought from an established town to the area where there was no electricity, running water, or entertainment and just a small open market with limited and seemingly randomly selected stock. Housing at first was not provided until the international NGO built a very basic eight room accommodation building from blocks, with iron roofing. Three of these rooms were predominantly used as an overflow for the clinic, as there were not enough rooms available for patients at various times within the main clinic building.

The Health Centre provided daily basic treatment services with government standard medication and in-patient facilities of six beds. Diagnostic tools did not include blood or urine tests, or x-ray, and diagnoses relied on observation and experience. Rapid malaria test kits were introduced through a WHO initiative and ongoing support to this scheme was given by the NGO to carry over until government policy is able to incorporate it into the basic health care package. Ante-natal and delivery services were available and an immunisation programme was being implemented, but was not functional at the time of research. All services provided by the clinic were free of charge.

The motivation to work in an isolated area was obviously very difficult when family and friend support was far away. Remuneration for services was often late due to the logistics

of getting pay into the area, and there was disillusionment from the limited resources and services available. The NGO put a lot of effort and emphasis on support and training for the staff, implementing a system of incentives that did not interfere with the government system of pay or create a level of dependence.

Building of a government hospital was commenced in the town of Lumbala Nguimbo during the time of research but was not anticipated to be functional for many months. No NGO support was given for this project. Three other government health posts were built and rehabilitated by the NGO beyond the town of Lumbala Nguimbo. These posts had one government nurse and basic treatment facilities. The three health posts were not easily accessible to the study communities and none of the communities had an established health clinic. Rehabilitation of other clinics was planned in various areas, but not completed.

Private

Military and police 'clinics' were available for people involved in these services. A very small, one roomed, mud walled Catholic mission clinic had been open for the public in Lumbala Nguimbo, but was closed prior to the time of research, due to lack of resources.

Community

General discussions revealed that traditional health services were available in all three areas of the study. From Table 6.16 it can be seen that more IDPs than RRs were aware of the existence of between one to four traditional healers and witch doctors in the area. The HHS showed (not indicated in table) that 27.5 per cent of IDPs thought there were none in their area and 15 per cent didn't know, compared with 24.1 per cent and 46.1 per cent of RRs respectively. The higher number of RRs not aware of traditional healers was because of their recent arrival in the area. It could also be said that IDPs would most likely have a higher number of traditional healers in their communities due to their past reliance on this treatment throughout the period of war. The low *traditional healer* response in Community 2 shows that the availability of traditional services in the area is sparse. A breakdown of the community variables reveals that the IDP responses are much higher than the RR group.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	n/15 (%)	n/55 (%)	n/181 (%)	n/40 (%)	n/141 (%)
traditional healer	15 (13.5)	1 (6.7)	49 (89.1)	65 (35.9)	23 (57.5)	42 (29.8)
witch doctor	6 (5.4)	2 (13.3)	39 (70.9)	47 (26)	21 (52.5)	26 (18.5)

Table 6.16: Respondents aware of the availability of traditional health services in their community (HHS)

Traditional healers provided services of treatment with herbs as well as more spiritual based techniques from witch doctors. The general feeling revealed through all forms of data collection, was that traditional medicine was not working as well as it used to. One village health worker[22] stated in an interview that *"nowadays even our traditional herbs are not working"*, and this was reflected throughout discussions and interviews and can be seen later in this chapter under the heading of Use of Health Services.

Consideration of how the role of traditional health services fits into current systems had the NGO health coordinator stating that she saw the *"need to take the good things from the old system, to see if you could learn things from them, to integrate and work together"*, but that some parts of it were hard to accept. The government health representative saw that the traditional healer had a definite role in society. He said, *"(in other towns) you will find herbal roots are being sold in streets or in some shelter. This medicine helps people from various types of diseases and they also develop health"*.

The ongoing development of the knowledge of traditional medicine within the community appeared limited. One *Soba* answered when asked if there was a traditional healer in the area, *"no, there's only some few individuals who have some knowledge on traditional medicines that help themselves. As for those who don't know any traditional medicine, they stay like that. People are used to being treated from a clinic"* (*Soba*, Interview, Community 1).

Mobile clinics

A mobile medical clinic was put into action by the NGO to cater for the increasing health needs outside of the health centre's main catchment area. It was assessed that people were walking for many hours or days to access clinical health care and that this problem would be exacerbated with the increase of people returning to the area throughout the

[22] Non-formal village health representative, often not formally trained. In this case, he had been an assistant in the Portuguese hospital in Lumbala Nguimbo prior to Independence (1975).

repatriation phase. This mobile team was staffed with two imported Angolan nurses and local health assistants. At the time of research the clinic was accessing eleven areas on a rotational basis, visiting each location approximately every four weeks. The team was providing basic clinical treatment, health education, child vaccinations and ante-natal services[23]. Complicated and complex cases were referred to the Lumbala Nguimbo Health Centre and transport provided if possible.

Health education programmes

The NGO employed 10 community health workers who were trained to teach village educators in topics of health and sanitation. They were also involved in the national community based programme involving the training of village committees which were started in areas where water rehabilitation occurred. The communities were then involved in hygiene education sessions.

Reception centre

Within the town of Lumbala Nguimbo was the Reception Centre for returning refugees. This centre had a health clinic that was accessible for use only by those staying in the centre. It completed health screens on all returnees and gave basic treatment as required.

In reflection of the available services one *Soba* said,

> *"if there is nowhere we can get food then who can give us medicines? People treat themselves with roots and leaves of trees"* (*Soba*, Interview, Community 2).

Past Reality

The past experiences of the availability of health services reveal some meaning towards current expectations. In Table 6.17, respondents were asked to list all the services available to them in the area where they spent the longest time during the period of unrest in the country. The experiences of health services for the two groups of IDPs and RRs are quite different, with 17.5 per cent of IDPs having no access to health care compared to only 2.8 per cent of RRs. Identifying traditional medicine as an accessible health service was much more prominent for IDPs at 15 per cent, compared to zero for RRs where they may have used the service but not considered it part of the essential list. Access to

[23] Not to all areas

hospitals was greater for RRs but also fairly high for IDPs, which would reflect time spent in the main towns during refuge.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*	*n/40 (%)*	*n/141 (%)*
health clinic	97 (87.4)	10 (66.7)	30 (54.5)	137 (75.7)	19 (47.5)	118 (83.7)
hospital	21 (18.9)	2 (13.3)	15 (27.3)	38 (21)	7 (17.5)	31 (22)
none	2 (1.8)	3 (20)	6 (10.9)	11 (6.1)	7 (17.5)	4 (2.8)
traditional medicine	0	0	6 (10.9)	6 (3.3)	6 (15)	0
military clinic	2 (1.8)	0	1 (1.8)	3 (1.7)	1 (2.5)	2 (1.4)

Table 6.17: Past availability of health services (HHS)

The providers of the health services in Table 6.17 (above) are listed below in Table 6.18. NGOs were identified as the RRs prominent health service provider at 58.9 per cent, compared to 12.1 per cent for IDPs. Experiences of government, mission[24] and military services are much higher for IDPs. Community 1 reflects the higher proportion of RRs but Community 2 has higher government experience. The availability of traditional medicine reflects very low in Table 6.. In a direct question (not reflected in the below table) relating to the number of traditional healers and witch doctors available in the past, the response was more positive. Fifty-five per cent of IDPs and 60.3 per cent of RRs stated that there were one to 21 traditional healers accessible in their area, compared with 52.5 per cent of both groups with access to a number of witch doctors.

variable	com 1	com 2	com 3	combined	idp	rr
	n/120 (%)	*n/12 (%)*	*n/52 (%)*	*n/184 (%)*	*n/33 (%)*	*n/151 (%)*
ngo[25]	68 (56.7)	4 (33.3)	19 (36.5)	91 (49.5)	2 (12.1)	89 (58.9)
government	42 (35)	8 (66.7)	20 (38.5)	70 (38)	16 (48.5)	54 (35.8)
mission	6 (5)	0	1 (1.9)	7 (3.8)	4 (12.1)	3 (2)
military	2 (1.7)	0	4 (7.7)	6 (3.3)	4 (12.1)	2 (1.3)
traditional healer	0	0	3 (5.8)	3 (1.6)	3 (9.1)	0
don't know	2 (1.7)	0	1 (1.9)	3 (1.6)	0	3 (2)

Table 6.18: Service providers of past health services (HHS) (N=total responses in Table 6.17)

Throughout the group discussions on this topic of past health services, RRs painted a very good picture of what was available, or how they perceived those services. It was clear that in organised settlements in Zambia, clinics were available at all times, with staff and

[24] Services provided by a religious organisation
[25] Includes national and international NGOs

medical stock, and that people were able to be referred to larger hospitals or institutions for more appropriate care if required.

One woman returnee stated,

> *"For us who went to Zambia, we were nicely welcomed and received a lot of assistance like food, health clinics with a lot of medicine, in short everything was provided and we lacked nothing"* (female, RR, Community 3).

Compared to a women IDP in the same group who interjected with,

> *"We used to live in the bush. The only medicine which was available was traditional roots. This is what we used to use whenever a person fell sick"* (female, IDP, Community 3).

An IDP male also stated,

> *"For those who lived in the bush, there was nothing. We only depended on roots but it was a big problem because you would find a situation when the attacks started where by the traditional healer runs his way and the patient runs his own way and that is the end of the treatment"* (male, IDP, Community 3).

In comparison to a returnee male who said,

> *"The UN welcomed us in a good way... they gave us all the necessities of life"* (male, RR, Community 2).

Participants from the interviews had different past experiences of available services. One returnee *Soba* shared his experience of health care in the main town of Lumbala Nguimbo (Angola) during the early period of the war,

> *"We had a big hospital with white men, the medicine it was the governments' responsibility. Many people used to get help"* (Soba, Interview, Community 1).

In comparison, he also discussed his experience in Zambia in one of the organised settlements and said,

> *"UNHCR were powerful, they built clinics and they were much concerned to see how the lives of people are"* (Soba, Interview, Community 1).

The government health representative indicated that during the war, when UNITA's (National Union for the Total Independence of Angola) armed forces controlled the area, the people didn't live well.

Use of Health Services

Present use

With the reality of the health situation revealed, consideration of the use of these services can be made. Respondents of the household survey were asked where they liked to go first for help if someone in their household got sick. The responses as seen in Table 6.19 below, show that the majority of people liked to attend the health centre in the town of Lumbala Nguimbo, even though it was 35–80 kilometres away. The mobile clinic was fairly popular, possibly due to its locality in the area once a month.

For Community 1, accessibility to the *health centre* (Table 6.19) was probably the easiest out of all the communities. Community 2 shows its inaccessibility through a higher use of the *mobile clinic* and treatment of *self*. Community 3 reveals itself as the only *traditional medicine* user. The IDP results show a higher number making use of the *mobile clinic*, *traditional* services and treating of *self* than the RR group.

variable	*com 1*	*com 2*	*com 3*	*combined*	*idp*	*rr*
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*	*n/40 (%)*	*n/141 (%)*
health centre[26]	82 (73.9)	8 (53.3)	29 (52.7)	119 (65.7)	23 (57.4)	96 (68.1)
mobile clinic	13 (11.7)	4 (26.7)	8 (14.5)	25 (13.8)	7 (17.5)	18 (12.8)
self	5 (4.5)	3 (20)	8 (14.5)	16 (8.8)	6 (15)	10 (7.1)
no where	9 (8.1)	0	2 (3.6)	11 (6.1)	1 (2.5)	10 (7.1)
traditional	0	0	6 (10.9)	6 (3.3)	3 (7.5)	3 (2.1)

Table 6.19: First place of preference for treatment when sick (HHS)

Combined overall satisfaction of the respondents chosen health services (Table 6.19) show that the services were considered *fairly good* (35.9 per cent), with 30 per cent IDPs and 30.5 per cent RRs saying the services were *not good*. A further breakdown of these responses as shown in Figure 6.1 reveals that none of services were considered *excellent*. Traditional services obtained the highest percentage of *good* feedback, with satisfaction in self treatment being quite low.

[26] There was only one health centre in the municipality and it was based in the town of Lumbala Nguimbo.

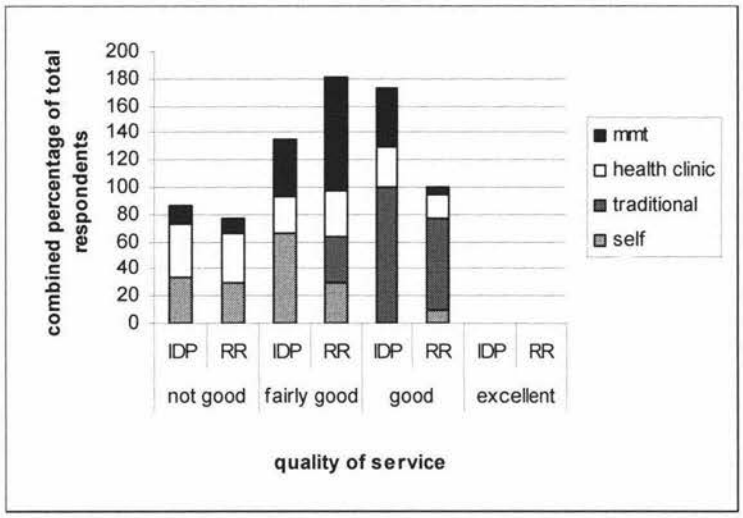

Figure 6.1: Total responses to the quality of services as identified in Table 6.19.

As shown in Table 6.20, 84 per cent of the total household survey respondents stated that either they, or someone in their household, had been sick in the last month. For IDPs, this equated to 95 per cent and for RRs 80.9 per cent of their total numbers. With the total numbers of respondents who were sick in the last month revealed, it is noted that IDPs at 92.5 per cent are relatively higher than that of RRs at 73 per cent. In order to track the health service use and satisfaction of users more effectively, it was decided for the purpose of the study that, if a household survey respondent had not been sick in the last month, then they were asked to identify if someone in their household had been sick, which revealed a greater percentage to work with.

variable	***com 1***	***com 2***	***com 3***	***combined***	***idp***	***rr***
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*	*n/40 (%)*	*n/141 (%)*
self	80 (72.1)	13 (86.7)	47 (85.5)	140 (77.3)	37 (92.5)	103 (73)
self or hh[27] member	89 (80.2)	13 (86.7)	50 (90.9)	152 (84)	38 (95)	114 (80.9)

Table 6.20: Identified as sick within last month period (HHS)

Of this total of 152 people, as seen in Table 6.20 above, only 50 per cent of IDPs and 50.9 per cent of RRs stated having received treatment for their sickness. Their choice of treatment in this process of illness was as follows in Table 6.21. The percentages reflect the results divided by the total number of people who stated that they accessed treatment.

[27] Household

The access of the RRs to a hospital is reflective of their recent arrival in the area and would have occurred prior to moving to the area, either on route or at their recent host settlement. It is noted that no one chose to treat themselves. A comparison of Table 6.19, indicating where respondents would like to attend for treatment, with Table 6.21 revealing where treatment was actually received, shows that actual access to the health centre is in reality limited. The mobile clinic took on much more of the demand of services than previously identified.

variable	*com 1*	*com 2*	*com 3*	*combined*	*idp*	*rr*
	n/38 (%)	*n/9 (%)*	*n/30 (%)*	*n/77 (%)*	*n/19 (%)*	*n/58 (%)*
health clinic	22 (57.9)	4 (44.4)	13 (43.3)	39 (50.6)	6 (31.6)	33 (56.9)
mobile clinic	13 (34.2)	3 (33.3)	16 (53.3)	32 (41.6)	12 (63.2)	20 (34.5)
hospital	3 (7.9)	0	0	3 (3.9)	0	3 (5.2)
traditional	0	1 (11.1)	1 (3.3)	2 (2.6)	1 (5.3)	1 (1.7)

Table 6.21: First service accessed for sickness identified in Table 6. (HHS) (N=total sick who accessed treatment)

The area health director identified different practices towards accessing health services between IDPs and RRs. The past experiences of health are shown to affect current action. He also noted that traditional medicine was an important service for IDPs which could reflect their access or lack of access to the services.

> *"Those who were living in the bush they don't urgently bring the patients to the clinic. After they treat a patient with herbal roots and there's no change, that's when they bring such a person to the clinic. Those who come from neighbouring countries, immediately they fall sick they rush to the clinic because they are used* (to the services)" (Health Director, Interview).

Use of traditional health services in Table 6.22 and 6.23 was varied, with IDPs showing a higher acceptance of traditional services. Community 2 reflected strongly against use but this could also represent the actual availability of traditional services in the area. Not included in these tables is the response that 15 per cent of IDPs and 2.8 per cent of RRs indicated that they always use a traditional healer when sick, and zero and point seven (0.7) per cent respectively indicated that they used a witch doctor.

variable	*com 1*	*com 2*	*com 3*	*combined*	*idp*	*rr*
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*	*n/40 (%)*	*n/141 (%)*
traditional healer	100 (90.1)	15 (100)	34 (61.8)	149 (82.3)	28 (70)	121 (85.8)
witch doctor	108 (97.3)	14 (93.3)	41 (74.5)	163 (90.1)	33 (82.5)	130 (92.2)

Table 6.22: Never use traditional services (HHS)

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	n/15 (%)	n/55 (%)	n/181 (%)	n/40 (%)	n/141 (%)
traditional healer	9 (8.1)	0 (0)	17 (30.9)	26 (14.4)	11 (27.5)	15 (10.6)
witch doctor	1 (.9)	0 (0)	12 (21.8)	13 (7.2)	6 (15)	7 (5)

Table 6.23: Sometimes use traditional services (HHS)

Group discussions revealed that traditional medicine impacted the community in different ways. The village health worker from Community 1 and the women's focus group in Community 2 felt that the traditional medicine was not working effectively anymore. The men's focus group in Community 1 explained that its traditional medicine did not work anymore due to the strong medicines that babies received when they were still in their mothers' womb. The women's focus group in Community 3 also noted that traditional healers can demand to be paid a lot of money, which can restrict the use of their services. Two people commented that they had no interest in traditional healers because of their Christian faith.

One man revealed a different motivation to use traditional services when he said,

> *"The idea to look for traditional medicine comes from the clinic. If you go to the clinic and they tell you that your illness cannot be cured here, that is when you now go and look for traditional healers. Sometimes there are diseases caused by witchcraft magic so you have to look for someone who can treat you and be healed"* (male, FGD, Community 2).

The *Soba* from Community 3 identified himself as a traditional healer and said that he provided herbal medicine for people in his community.

> *"Even if I go to Lumbala* (health centre)*, medicines are not good, so its good just to dig herbal roots to help us. It's good if you go to the clinic you are given an injection medicine to the clean blood (purify). If the clinic medicines have failed, then you have to look for a traditional healer to help you"* (Soba, Interview, Community 3).

The village health worker who was not actively working in the area of health stated,

> *"If there is not clinic and no medicine then how can we live? Even if you drink traditional herbs you cannot recover"* (village health worker, Interview, Community 1).

A female participant in the focus group discussion commented,

> *"As for a traditional healer, we the community do not want him because those things were there a long time ago. Nowadays if someone is lacking blood, they say take him to the hospital. In the past, we used to use traditional medicine but as for*

now, we are in a modern world. If a person falls sick, we have to go to the hospital (female, FGD, Community 1).

Past Use

Table 6.24 shows that in the past the majority of people did not have to pay for the health services (as identified in Table 6.17). Of those that were required to pay for services, the rate for payment is revealed as slightly higher for the IDP group.

variable	*com 1*	*com 2*	*com 3*	*combined*	*idp*	*rr*
	n/120 (%)	*n/12 (%)*	*n/52 (%)*	*n/184 (%)*	*n/33 (%)*	*n/151 (%)*
yes	21 (17.5)	2 (16.7)	10 (19.2)	33 (17.9)	7 (21.2)	26 (17.2)
no	97 (80.8)	10 (83.3)	39 (75)	146 (79.3)	23 (69.7)	123 (81.5)

Table 6.24: Payment requirements for past health services (HHS)

The satisfaction of past health services (as identified by provider in Table 6.18) is seen below in Table 6.25. It reveals that the satisfaction of services was fairly evenly represented as *good* across the groups. *Excellent* service was identified higher by RR groups than IDPs for past services.

variable	*com 1*	*com 2*	*com 3*	*combined*	*idp*	*rr*
	n/120 (%)	*n/12 (%)*	*n/52 (%)*	*n/184 (%)*	*n/33 (%)*	*n/151 (%)*
good	51 (42.5)	7 (58.3)	21 (40.4)	79 (42.9)	14 (42.4)	65 (43)
excellent	54 (45)	2 (16.7)	20 (38.5)	76 (41.3)	7 (21.2)	69 (45.7)
fair	8 (6.7)	2 (16.7)	6 (11.5)	16 (8.7)	7 (21.2)	9 (6)
not good	7 (5.8)	1 (8.3)	2 (3.8)	10 (5.4)	3 (9.1)	7 (4.6)

Table 6.25: Satisfaction of past health services (HHS)

The household survey indicates the use of traditional services in the past. It shows that 57.5 per cent IDPs and 80.1 per cent RRs indicated *never* accessing the services of a traditional healer and this response was higher concerning access to witch doctors. 25 per cent IDPs and 15.6 per cent RRs responded with *sometimes,* and 17.5 IDPs and 4.3 RRs with *always.*

As one male indicated, the use of a traditional healer in the past may not have been the automatic first choice, but may have been due to having no other choice. He said,

"We used traditional healers because some disease cannot be cured at the clinic or hospital" (male, FGD, Community 3).

Summary

This chapter has considered the health situation within three communities in rural Angola. Through highlighting the identity and personal attributes of respondents, it is possible to grasp a reality of the population makeup and identity. Tribe, education, language, and gender are all influencing factors on the outcomes for health through the influence on decision making and practice. The identification of needs in the community from the community themselves reveals the current reality of these people. Different methods of questioning revealed different types of need within the community. Health was identified as a strong priority. The want or desire for health services was dependent on past experiences of health. Respondents were clear on what they had received in the past. The reality of health care and what was actually available, was quite limited within the three communities. For RRs, this was especially limited when compared to their past experience of health care. The use of health care showed that respondents accessed and used services in the present according to availability rather than choice. Further comparison and a discussion of these topics and variables will occur in Chapter Seven. The following chapter considers the responsibility of recipients and actors in the development of health within the community.

Chapter 7: A Focus on Responsibility and Health

This chapter continues the analysis of the data collected within Angola. It is more specifically focused on the responsibility of health, and the implications for the community regarding involvement in its development. This chapter considers both present and past perceptions of responsibility and the role allocation of actors within the process. The ability of this chapter to stand alone, distinct from the results in Chapter Six, reveals its strength in drawing together the needs, wants, reality and use of health and its services, and considers the bigger implications for implementation.

Ownership and Accountability

Present responsibility

Each entity has a part to play in improving the situation of a community. From an NGO perspective, responsibility of development lies with everyone. The mission statement of the implementing international NGO in the area is: *"to respond to human suffering in emergency and disaster situations by implementing multisectorial relief and rehabilitation projects, in a compassionate and serving attitude inspired by its Christian ethos"* (Medair 2003). This statement carries with it a responsibility to assist in areas of identified need.

The phases of development have an effect on the implementation strategy of humanitarian assistance. Time frames, funding cycles, and international and donor agendas all affect how a project is implemented. Classification of the study area into a specific phase of relief, rehabilitation or development was difficult. The phase of development for the study area was considered by the NGO representatives as a mixture of all concepts, in that principles from all strategies were trying to be implemented through the use of a short time frame but with a focus on sustainability, participation and ownership. Time was seen as the biggest constraint and it was commented that community involvement, without the proper time, to prepare was very difficult. One coordinator stated *"we try to do development in a relief jacket…within the time frame it's impossible"* (NGO, Interview). The UNHCR representative saw that the area was still in the first phase of relief or emergency and was moving into the second phase of rehabilitation.

Throughout the programme of rehabilitating and constructing health programmes, there were different facets involved, from physical construction, obtaining and supporting health staff and medical materials, implementing education programmes, and the implementation of the interrelated departments of water and sanitation.

The NGO construction coordinator discussed the process of implementing the construction part of the health programme. This, he explained, started with the government identifying the needs in the area and then the government and NGO planning together what could be done to improve the situation. From there, the community was involved in deciding more of the details of the project and also their involvement in the actual construction process.

The health coordinator saw that support from NGOs in a country like Angola is needed but that the main responsibility of the department was to give knowledge. It was obvious that training was seen as a priority and it was observed that weekly education sessions were planned with the nurses at the health centre. The nurses were also encouraged to give training sessions themselves and hold workshops on topics in which they were confident. Beyond the main town, the focus was on providing clinical health services to areas prioritised by population size. The biggest constraint for the programmes was the availability of government nurses.

The UNHCR representative said that the government should take the lead on these issues. He also recognised that the international community had their share of responsibility due to the outcomes of some of the international actions and interest in the country during the war process.

An open question in the household survey asked who was responsible in the community for the health services. The response in Table 7.1 revealed slightly ambiguous thinking, with many stating that they didn't know.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	n/15 (%)	n/55 (%)	n/181 (%)	n/40 (%)	n/141 (%)
health worker[1]	31 (27.9)	1 (6.7)	26 (47.3)	58 (32)	15 (37.5)	43 (30.5)
don't know	33 (29.7)	2 (13.3)	18 (32.7)	53 (29.3)	8 (20)	45 (31.9)
no one	29 (26.1)	5 (33.3)	10 (18.2)	44 (24.3)	12 (30)	32 (22.7)
ngos	6 (5.4)	1 (6.7)	1 (1.8)	8 (4.4)	0	8 (5.7)
government	2 (1.8)	3 (20)	1 (1.8)	6 (3.3)	2 (5)	4 (2.8)

Table 7.1: Entity identified as responsible for health services in community (HHS)

From group discussions, the overall theme seemed to be that the responsibility for health services was to be shared across all entities, but firstly from the government, then the NGOs and then from the community. Generally, people felt that everyone should unite and work together to improve things.

Four various responses from the communities regarding this topic were,

> *"The Administrator[2] says everything is in the hands of the NGO but when the NGO comes they say some of the things should be solved by the government. This situation is confusing us now"* (male, RR, FGD, Community 1).

> *"We put everything in the hands of NGOs. The government is the one which receives NGOs from their respective countries to come and help in different aspects... in short we say it is the responsibility of both the government and NGOs"* (male, FGD, Community 3).

> *"There is nothing we can manage to do unless the government leads us"* (female, FGD, Community 2).

> *"Since it is now a country, the government cannot fail to build us a clinic nearby with a lot of medicine and an ambulance"* (female, FGD, Community 3).

Interviews with key informants revealed a process for the responsibility of health services which incorporated the government, NGO and community working together to certain degrees. There were also a variety of other responses. The government vice-assistant in Community 2 felt the responsibility was with the government. The *Soba* in Community 3 felt it was primarily the community's responsibility. The local government health representative stated,

> *"It is the duty of government. Our friends the NGOs should kindly help us because the government has got many programmes to be done. Let them help us like the*

[1] A Community health worker with no or limited professional training, often refers to a promoter / educator.
[2] Head of the local government administration

> *way they are currently doing at the clinic (in Lumbala). The community can do work if we tell them what to do. A lot of things are needed to be done in the community. There are things that the community can do and the government, while with other things we still need to be helped. Health is the major important thing/aspect to enable people to do various activities"* (government health representative, Interview).

With varying roles of responsibility for health services identified, it is interesting to consider the responses to the question of who should be involved in the improvements to health services. As seen in Table 7.2, RRs responded higher than IDPs that as a community they should be involved, and they also laid more emphasis on the role of the NGO than did the IDPs. The variable of *self* is a result of the respondent identifying that they were personally to be involved. More than one answer could be made for this question. Other responses noted included: others; don't know; and no one.

variable	***com 1***	***com 2***	***com 3***	***combined***	***idp***	***rr***
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*	*n/40 (%)*	*n/141 (%)*
community	64 (57.7)	9 (60)	32 (58.2)	108 (59.7)	18 (45)	87 (61.7)
government	32 (28.8)	3 (20)	20 (36.4)	55 (30.4)	13 (32.5)	42 (29.8)
ngo	27 (24.3)	1 (6.7)	7 (12.7)	35 (19.3)	3 (7.5)	32 (22.7)
self	17 (15.3)	6 (40)	8 (14.5)	31 (17.1)	6 (15)	25 (17.7)

Table 7.2: Entities identified as who should be involved in improvements to health services (HHS)

As one female participant commented,

> *"It is not only us on our own who can develop the health services but the government and NGOs should also assist us in forming committees that can be looking on health and teaching people on how they should be living. We, the community cannot do anything on our own unless the government and NGOs lead us so that we can have the right to work together in order to develop our country"* (female, FGD, RR, Community 3).

With the health services previously identified in Table 6.13 the respondents were asked if they were doing anything specifically to assist in the improvement of these health services (Table 7.3). The variable responses are relatively close to the combined average, with IDPs only identifying a slightly greater involvement. Of the positive responses given, the type of main work identified included (combined variable totals): communication 23.5 percent; general labour 19.6 per cent; toilet construction 13.7 per cent; and a range of other combined activities at 29.4 per cent.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	n/15 (%)	n/55 (%)	n/181 (%)	n/40 (%)	n/141 (%)
yes	57 (51.4)	8 (53.3)	37 (67.3)	102 (56.4)	26 (65)	76 (53.9)
no	51 (45.9)	7 (46.7)	18 (32.7)	76 (42)	14 (35)	62 (44)

Table 7.3: Involvement in the improvement of health services (HHS)

These following comments reveal a variety of responses. Issues are raised including, the need for resources, lack of options, hunger, and past experiences. Only the last quote from a female in Community 2 shows a fully positive response towards involvement in the development of health.

> *"We know that we are supposed to help ourselves but how can we help ourselves without resources?"* (male, FGD, Community 1).
>
> *"If some things are available, we can develop the health services"* (female, FGD, Community 3).
>
> *"We can volunteer to work, even if we are still new arrivals. We can even build a clinic of our own and then ask the government to bring us health workers and medicine. But only because we are left without an option"* (male, FGD, Community 1).
>
> *"It is not that we are not willing but it is because of hunger"* (male, FGD, Community 1).
>
> *"Where we were in Zambia, the UN built us clinics for free"* (male, RR, FGD, Community 1).
>
> *"We can work together so that our health services can develop by way of doing whatever work which is supposed to be done"* (female, FGD, Community 2).

The reasons for non-involvement in the improvements of health services give better understanding to the responses in Table 7.3. The use of an open question format allowed for a variety of answers from which these six responses were the strongest. With 55.1 per cent of RRs having returned to the area within the last 6 months, it is not overly surprising to see *just arrived* at the top of the list for reasons for non-involvement in the improvement of health services (Table 7.4). All of the percentiles are quite low, reflecting a very broad range of answers given, in addition to these answers not included in the table below of: don't know, don't want to and others.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	n/15 (%)	n/55 (%)	n/181 (%)	n/40 (%)	n/141 (%)
just arrived	23 (20.7)	1 (6.7)	8 (14.5)	32 (17.7)	2 (5)	30 (21.3)
no authority[3]	6 (5.4)	5 (33.3)	7 (12.7)	18 (9.9)	6 (15)	12 (8.5)
illness	8 (7.2)	1 (6.7)	4 (7.3)	13 (7.2)	4 (10)	9 (6.4)
no resources	4 (3.6)	0	2 (3.6)	6 (3.3)	3 (7.5)	3 (2.1)
too old	2 (1.8)	1 (6.7)	2 (3.6)	5 (2.8)	1 (2.5)	4 (2.8)
poverty	4 (3.6)	0	1 (1.8)	5 (2.8)	0	5 (3.5)

Table 7.4: Reasons for non-involvement in improvement to health services (HHS)

Many comments were made from the communities regarding the availability of food. From the way people spoke of the task of collecting wild fruits, it appeared that this was not a normal routine, if there were other easily accessible food items available. One male stated,

> *"...people don't have time to work because of going to collect wild fruits all the time"* (male, FGD, Community 3).

Community participation, or involvement in development, is a concept which came with different levels of understanding from those involved in the programmes. The three sector coordinators from the NGO, had differing meanings for the term *community participation,* which they stated as follows:

> *"...people helping out to construct a water point and being involved in teaching the community (about water) (voluntarily)"* (water, NGO).

> *"That the community feels they own the programme, have their input into the build up of the programme, freely participate without force. They would not be paid but they get paid out of the result of the programme"* (health, NGO).

> *"A lot of promises from the community and then them not keeping up (fulfilling them) when you're there"* (construction, NGO).

It was perceived through discussions, that participation from the community in the programmes of health in reality was lacking, and that there was a desire from the NGO coordinators for the community to take ownership and make more effort in the work that was being done.

The NGO workers commented that motivation for participation from the community varied from area to area. It was noted that in some places where the government was trying to

[3] Refers to a person who feels they do not have the authority to make initiatives within the community

force the people to work, the people were not motivated at all by such an approach. Community leadership was seen as a key factor in participation, and that in areas where the leader was not an organised person, the community reflected that disorganisation. It was identified that the levels of participation varied according to what was happening in the community. The water coordinator saw that many times other priorities rated higher than water, and so the people did not get involved as much. Planting and cultivation of food crops took up much of the people's time at various times of the year, although the construction supervisor felt that there was not a lot of demand on people's time, but that they didn't organise themselves properly. Another problem affecting involvement of the community was the mobile population, where people had just arrived in the area and were not completely settled, or where they were still travelling to their final destination. This transient culture, even though in a temporary phase, has a huge effect on community development. All coordinators agreed that participation increased ownership and resulted in the community taking responsibility for what was being accomplished.

The UNHCR representative stated,

> *"This sense of community participation, sharing resources and responsibility etc, we can have it here, it takes time and awareness, people need to be educated but also to give time for themselves. They have the ideas for development but not the time"* (UNHCR, interview).

He went on to say that in his experience, this process of initial settlement took up to one year and then things started to happen.

As seen in Table 7.5, the majority of the respondents' time was spent working in the fields, planting and cultivating crops for subsistence living. The identification of *majority* of time was left to the respondent to determine under five optional answers including, *other*. These activities reflect the seasonal work at the time of research, when it was high season for the planting and maintenance of fields. Most of the population were also newly settled in their area, requiring extra time and effort for initial preparation and cultivation of their fields. Community 1 shows the only *paid employment.* It was on a road that was more often travelled by government and NGO vehicles, thus improving access and opportunities. Community 2 and 3 had no paid employment which reflects their remoteness and therefore difficulties in accessibility. This must have an effect on the local economy or is possibly the result of the lack of it, as the existence of actual cash is very limited. This is not an issue that will be considered here.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	n/15 (%)	n/55 (%)	n/181 (%)	n/40 (%)	n/141 (%)
in the fields	90 (81.1)	15 (100)	53 (96.4)	158 (87.3)	35 (87.5)	123 (87.2)
paid employment	10 (9)	0	0	10 (5.5)	3 (7.5)	7 (5)
work at house	6 (5.4)	0	1 (1.8)	7 (3.9)	1 (2.5)	6 (4.3)

Table 7.5: Current daily activities (HHS)

With such high responses in Table 7.3 on who should be involved in the development of health services, a question of clarification was used in the household survey in order to identify who was willing to volunteer their time in general labour at the clinic. This resulted in a high positive outcome from all groups as seen in Table 7.6. The responses from this question do not appear to reflect accurately the general outcomes of the focus group discussions. They do not show the reality of the situation regarding voluntary community participation where in actual fact the workers required some form of payment and their participation was limited.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	n/15 (%)	n/55 (%)	n/181 (%)	n/40 (%)	n/141 (%)
yes	83 (74.8)	12 (80)	39 (70.9)	134 (74)	30 (75)	104 (73.8)
no	28 (25.2)	3 (20)	14 (25.5)	45 (24.9)	10 (25)	35 (24.8)

Table 7.6: Willingness to volunteer general labour at clinic (HHS)

Generally from the focus group discussions it was agreed that the community would willingly participate in community development but there was some stipulation that payment was necessary. One female participant discussed what she saw as the difference between war and peace, and that with peace there were expectations for services. She stated,

> *"Let there be some payments when there is work to be done because we the Community are in poverty. When the government and NGOs come, let them not just say we work without payment, how do they expect us to develop if we just keep on working for nothing, how can we find something to help ourselves with? We have been doing all these things for nothing during the war time. Now that there is peace, the government and NGOs should care for us so that we can have good health"* (female, Community 3).

A male from the discussion group considered that, with the development of peace, there was the need for permanency of structures. He discussed the ability to develop his community but also revealed that his ideals were set by observing the standards of others

from the outside. In order to complete this, outside assistance to the community would be required. He said,

> *"We can work because this will uplift our health standards. We built a school for our children to learn from, so we can even build a clinic provided it is small. If they say a big one, we cannot manage unless there is some cash. The old type of life has ended and this time everyone is trying to lead a new life. If they ask us to build a clinic of poles and grass, it cannot be as strong as expected. Let them assist us with iron sheets and cement. As for blocks, we can mould our own. Let the government or NGOs give us these things. A thatched one cannot take us anywhere. We are not saying we can't build a thatched one but we are looking at it in terms of strength. We build once and forever"* (male, Community 3).

The *Soba* from Community 2 considered the need for food in order to be able to work, and he stated,

> *"People can have the willingness to work but hunger can draw them back because where a person works it's where he can eat from. But if there is no food, a person to work without eating, it is impossible. If a person knocks off* (from his work) *around 1200hrs going to his house there is nothing* (to eat for lunch), *he comes back again for work then he knocks off around 1800hrs going to his house he gets nothing* (to eat for dinner). *Then the following day is he going to have strength to work?"* (*Soba*, interview, Community 2).

The health worker from Community 1 commented,

> *"If we are given work to do, we can work because it is part of developing the country. One who works, leaves all his works (at home), then something is needed to be given to him, so that he can sustain his life. Then if they say that we should construct a clinic we can build but they need to pay us"* (health worker, interview, Community 1).

The health director felt that from his experience, the people didn't have a *"mind to work on a voluntary basis"* but that they felt that they should be paid. The UNHCR representative felt that it was difficult to get people involved when they had empty stomachs.

The government health representative commented that he was surprised when people did not get involved quickly in the development work in their community when they were told to. He went on to explain that usually, when they told people to work, they did actually *"obey"*. He said that the role of motivating people to work had been given to the *Sobas*. The quoted word 'obey' was translated from local language and checked for accuracy of meaning. It possibly signifies the attitude of the government official towards the community and the level of superiority he portrayed.

All three *Sobas* indicated that people got involved in working in their communities, and that their role was to explain to the people what was required and then organise the people to do the work. The *Soba* from Community 3 said that there was work that people could do without being ordered to from the government, like making toilets and cleaning surroundings, but with bigger things they needed help from NGOs.

Prevention of the spread of disease within the community setting requires basic facilities like latrines and rubbish pits. Table 7.7 shows the proportion of respondents who acknowledged that they had a latrine or rubbish pit in comparison to the actual existence of the latrine or pit, as observed by the research data collectors. Prior to the commencement of the household survey, it was noted that many people say that they have a facility but in actual fact there was nothing constructed. The identification of the facility was included to clarify actual existence. The difference between positive responses to the actual existence is quite high. RRs had a higher rate of actual latrine existence compared to IDPs, but IDPs showed a much higher existence of actual rubbish pits. Community 3 response was low on the construction of these facilities.

variable	***com 1***	***com 2***	***com 3***	***combined***	***idp***	***rr***
	n/111 (%)	*n/15 (%)*	*n/55 (%)*	*n/181 (%)*	*n/40 (%)*	*n/141 (%)*
have latrine	75 (67.6)	10 (66.7)	20 (36.4)	105 (58)	24 (60)	81 (57.4)
latrine identified	60 (54.1)	6 (40)	12 (21.8)	78 (43.1)	16 (40)	62 (44)
have rubbish pit	61 (55)	8 (53.3)	24 (43.6)	93 (51.4)	22 (55)	71 (50.4)
pit identified	39 (35.1)	4 (26.7)	18 (32.7)	61 (33.7)	19 (47.5)	42 (29.8)

Table 7.7: Existence of latrines and rubbish pits (HHS)

A key component identified by the NGO coordinators in the development of health services was communication. The water coordinator chose to first talk to the *Soba* of the community that was identified as requiring water assistance, then to walk through the community and involve as many people as he could, women, children and men, and to observe, and then to discuss the findings with the government administration.

It was felt by the coordinators that the NGO could improve communication, and it was suggested that they should meet more often with the *Sobas* in order to understand each other better, and to be able to explain how each other's leadership styles worked. The health coordinator saw communication as a key factor with the communities and that village health committees would be of benefit to this process, but that it was difficult to

implement that programme due to time factors, as well as the fact that it wasn't part of the current government health policy.

From the general community it was identified that issues of health matters are passed onto the government and the NGO. It was noted that the *Sobas,* as the village leaders, were disillusioned with the response that they had got from their meetings with both the government and the NGO. Generally it was felt that many things had been promised but nothing had been delivered. The government representative responded that they did not sit around idly waiting to receive reports from the community, but that they were active in hearing and seeing for themselves what was needed and happening in the communities. He then went on to say that they met with the NGOs to discuss what could be done. While completing the field research, government people and vehicles were seen in each of the areas visited at various times, but the purpose of their visits was unknown.

The communities discussed this issue and identified their processes of communication. The Community 1 male discussion group recognised that the process involved firstly the *Soba* and committee. The spokesman for the committee then took what was discussed to the government and the NGOs. The females from this community spoke in response to the question of how health issues were communicated,

> *"We have yet to choose him* (the person concerning health). *You have come to remind us about it and again you have taught us another effective way of communicating to the government and NGOs"* (female, FGD, Community 1).

Community 2 and 3 also commented that there was no one specifically chosen to deal with health issues and communicate these to the appropriate departments. The women in Community 3 identified the process clearly by saying,

> *"The first thing we do, if there is something we want to talk about, we talk to the secretary, the secretary talks to the committee then the committee chairman takes the issue to the government. If there is no need to take it to the government, then it is resolved by the committee and the Soba"* (female, FGD, Community 3).

The community was asked an open question regarding the route of communication in the community (responses in Table 7.8). The *Soba* was identified by all groups as the primary source of communication. RRs rated the government much stronger than the IDP group. Community 2 was very strong on identifying the *Soba,* compared to the other communities.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	n/15 (%)	n/55 (%)	n/181 (%)	n/40 (%)	n/141 (%)
soba	82 (73.9)	14 (93.3)	45 (81.8)	141 (77.9)	31 (77.5)	110 (78)
government	21 (18.9)	7 (46.7)	8 (14.5)	36 (19.9)	6 (15)	30 (21.3)
village committee[4]	8 (7.2)	0	10 (18.2)	18 (9.9)	6 (15)	12 (8.5)
health worker	11 (9.9)	1 (6.7)	0	12 (6.6)	0	12 (8.5)

Table 7.8: Entity identified for communication of health issues (HHS)

The local research team observed from their experiences that the *Sobas* were the most influential figures in each of the communities. Two of the communities came under the direct government authority of the town of Lumbala Nguimbo[5] and daily issues were dealt with at community level with the *Soba* as the present authority in the area. The other community was a *communa*[6] and had a resident government administrator and vice administrator. It was perceived that there was a power struggle between the government appointed leaders and the traditional leader of this community. The *Soba* had been the recognised leader for many years, even during displacement. The newly appointed government representative was from another town and this created some conflict. The *Soba* said about the authorities, *"they only want to satisfy their own life, not for their community"* (Community 2). A feeling of disregard was manifested strongly in Community 2 concerning the issues presented by the *Soba* to the government leaders.

The *Soba* from Community 3 identified his role in saying,

> *"A Soba is a guard, watching the people to see how they are feeding their talking and making sure there's no confusion and that they are peacefully settled"* (*Soba*, interview, Community 3).

My personal experience with the *Sobas* was very positive. All three were older gentlemen who were genuinely concerned with their communities. All made me feel very humble to be in their presence and to have the opportunity to discuss community matters with them.

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[4] The committee of the Soba, all male in the areas studied
[5] The government representatives were based in the town 35 kms away
[6] Portuguese word, referring to an area with local government office, representative has government authority

The willingness of participants to pay for accessing health services is an indication of their commitment and responsibility for the services provided. The responses as seen in Table 7.9 reveal that the IDP group was slightly more willing to pay than the RR group.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	n/15 (%)	n/55 (%)	n/181 (%)	n/40 (%)	n/141 (%)
yes	36 (32.4)	3 (20)	21 (11.6)	60 (33.1)	14 (35)	46 (32.6)
no	75 (67.6)	12 (80)	34 (18.8)	121 (66.9)	26 (65)	95 (67.4)

Table 7.9: Willingness to pay for health services (HHS)

Finally, in consideration of all the areas discussed regarding involvement in health services, 92.5 per cent IDPs and 97.9 per cent RRs indicated (HHS) that they were willing to participate more in the development of services in their community. This was indicated positively across all three communities.

Past Responsibility

A comparison of the responses of IDPs and RRs reveals very similar results from within the past setting. Across the community variables the results are less even. Community 2 reveals a low response for assistance given. Further breakdown of the responses from this community are difficult due to the small numbers involved, but the response of *no* involves 54.5 per cent IDPs and 45.5 per cent RRs. Of these responses, 63.6 per cent had no education and 28.6 per cent had received education. Assistance given by participants to the development of past services is interesting in comparison to current activities. These findings (Table 7.10) show similar combined results, with 56.4 per cent currently identifying that they are involved compared to 55.8 per cent identifying that they were involved in the past.

variable	com 1	com 2	com 3	combined	idp	rr
	n/111 (%)	n/15 (%)	n/55 (%)	n/181 (%)	n/40 (%)	n/141 (%)
yes	67 (60.4)	3 (20)	31 (56.4)	101 (55.8)	23 (57.5)	78 (55.3)
no	44 (39.6)	11 (73.3)	23 (41.8)	78 (43.1)	16 (40)	62 (44)

Table 7.10: Regular assistance given to develop past health services (HHS)

An open question obtained the reasons for not being involved in the development of past health services. The variations in these responses are seen in Table 7.11. RRs responded at 35.5 per cent that all services were provided, thus not requiring involvement, compared

to 12.5 per cent of IDPs. Community 2 had no response under this variable, indicating a high percentage from the other two communities in order to gain such a high combined mean. IDPs had much less *time* to be involved. When questioned regarding daily activities in the past, 42.5 per cent of IDPs compared with 64.5 per cent of RRs revealed that they spent most of their time in the fields.

variable	***com 1***	***com 2***	***com 3***	***combined***	***idp***	***rr***
	n/44 (%)	*n/11(%)*	*n/23 (%)*	*n/78 (%)*	*n/16 (%)*	*n/62 (%)*
all services provided	16 (36.4)	0	8 (34.8)	24 (30.8)	2 (12.5)	22 (35.5)
no time (war/work/school)	6 (13.6)	3 (27.3)	6 (26.1)	15 (19.2)	8 (50)	7 (11.3)
we were visitors	8 (18.2)	0	2 (8.7)	10 (12.8)	2 (12.5)	8 (12.9)
not given direction	6 (13.6)	3 (27.3)	3 (13)	12 (15.4)	1 (6.3)	11 (17.7)
too young/old	4 (9.1)	1 (9.1)	0	5 (6.4)	1 (6.3)	4 (6.5)
poverty	0	3 (27.3)	0	3 (3.8)	1 (6.3)	2 (3.2)

Table 7.11: Reasons for assistance not given (N= total of variable 'no' in Table 7.10)

From the household survey, 44.5 per cent of IDPs and 23.4 per cent of RRs identified being actively involved in military service during the war. Of this total number, 52.9 per cent of them were IDPs who spent over 20 years in service. In comparison, 54.5 per cent of RRs spent less than five years involved.

Summary

The study communities portrayed, through their participation in the research, the impact that the transitional post conflict phase has on health and its development. This chapter considered the issues surrounding the responsibility for health in the study area. These results revealed various responses and levels of understanding toward the issues. Overall, responsibility for health is seen to lie with everybody involved, but the level of responsibility is variable. This variability is influenced clearly by past experiences of health services and therefore expectations for the present. RRs involvement in the past was limited due to the high provision of services. The community revealed strongly that they should be involved in improvements to health services. For the implementers of projects, time was seen as a factor in having the community involved. People were hindered due to their recent arrival in the area and lack of food and resources.

The phase of the implementation was seen to have a short time frame with long term objectives. The NGO identified that this was a difficult approach to balance. Challenges were also experienced in the process for the communication of health matters within the

community. These were not completely organised due to recent arrival and establishment. It was identified that better communication and understanding of the roles of all actors was needed for each group. *Sobas* were identified as highly motivational in their communities with power to influence change.

Comparisons between the past and present health situations give some explanation for expectations of current services. The effect that the responses and thoughts have on the development of health care services will be explored and discussed within the next chapter, and possible outcomes for the improvement of implementation outlined.

Photo 7: The legacy of war. The old Lumbala N'guimbo hospital.

Unfortunately it was deemed irreparable.

Photo 8: Distribution of monthly food rations.

Beyond Lumbala N'guimbo town

Photo 9: Typical village scene, Lumbala N'guimbo

Chapter 8: The Influences on Health Development

The influences on health development are vast and varied. Chapters Six and Seven identified the health situation for three communities and the sub-groups of IDPs and RRs. The responses revealed trends and influences towards knowledge, attitude and practice of health and its services, both individually and as a community. These influences were identified as, tribe and gender, and past experiences of refuge, settlement, education and work. This chapter proceeds to compare these influences and identify significant areas that impact on health development. The comparisons are not intended to identify direct cause and effect but allow for a discussion to reveal influences and awareness for practice.

Impact of Identity

Daily experiences shape the identity of people and influence the way they respond to a given situation. Past experiences of war, trauma, refuge, education, job opportunity, and health play a role in defining people's knowledge, attitude and practices in the present. Therefore the past has a major influence on the present.

IDPs and RRs had different experiences throughout the period of war. Those who sought refuge in other countries may still have spent considerable time within Angola. The areas of settlement during the period of war were different, often even within families. Those who stayed in the organised settlements had the potential to develop levels of dependency due to the provision of basic needs. The IDP population did not necessarily receive this assistance in their area of refuge. The literature identified the similarities between the two groups showing that both were displaced, but the differences were not so clearly documented. Within that, the past experiences of IDPs and RRs were not considered beyond the effects of trauma.

Differentiations of people groups within the study area were made using the classification of ex IDPs and RRs by international standards issued through UNHCR. This classification had potential for division but within the three communities studied it did not appear as a big issue. Outputs of jealousy and minor conflicts due to unequal resource allocation through the distribution of food and non-food items were said to occur, but chiefly within the main town where unification was more difficult because of a larger population. Limited

population and the desire to live in peace contributed to the unity of the study communities. The traditional leaders were influential in promoting peace and harmony.

The RR group showed a greater variety and strength of responses compared to the IDP group, appearing to have a greater understanding of who they were. Of the five open questions asked within the household survey, RRs on average, gave more responses than IDPs. Table 6.12 gives an example of this, showing that RR answers were more comprehensive and aware of current international trends, revealing wider exposure to ideas and experiences. The international influence was greater within Zambia, especially in the organised settlement camps, compared to the study area of Angola which was fraught with war and inaccessible for so long.

The impact of this knowledge and experience on culture depends on the life genre. Past experiences brought changes to culture through the acceptance of new practices, introduction of new language and differences in standards of living. For the returnees, the basic culture in Zambia was very similar to Eastern Angola, although the trade language was different. The experiences though, led to a greater source of knowledge and understanding on which to draw for decision making, input into society and improved options for the community. From a negative perspective also created expectations and frustrations with the limited resources in the area. This gave potential for further conflict and unsettlement.

Tribal affiliation

Table 6.4 showed the four main tribal affiliations within the groups of IDPs, RRs and the three study communities. The graph below (Figure 8.1) considers the top four tribal groups and their longest area of settlement during the period of war. It reveals that the tribes were fairly evenly distributed within the areas of settlement identified by the respondents. The reason for settlement according to tribe cannot be surmised here.

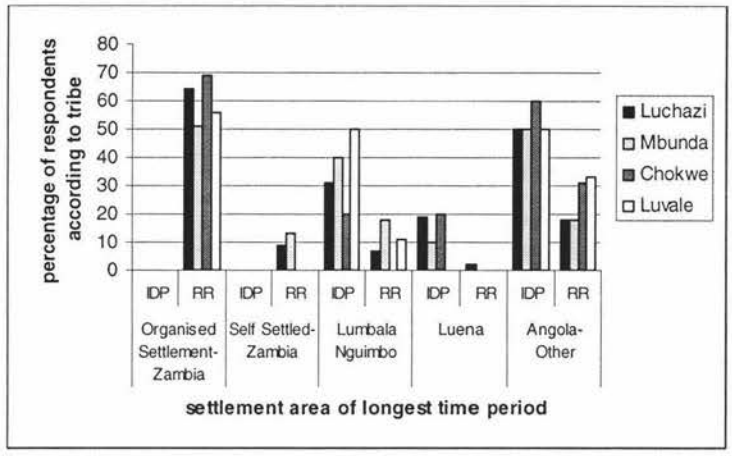

Figure 8.1: Area settled for the longest time period within the last 30 years according to tribal affiliation and IDP / RR identity

Education

The literature clearly identified the destruction of infrastructure and specifically educational facilities during conflict. This damage leaves a community with varied levels of education, depending on their settlement area during the period of war. Figure 8.2 shows the percentages of those with education (from Table 6.5) according to their tribal group. The Luvale tribe revealed 100 per cent education levels for the IDP group but it is also important to note that this is the smallest population group represented[54]. The RR group has a more even representation whereas the IDP shows a low percentage, especially with the Luchazi tribe which has the highest number of IDPs represented out of all of the tribal groups. Settlement areas as outlined above (Figure 8.1) do not give any clear indications on reasons for variances in education levels. According to this chart (Figure 8.2) it appears that tribe affiliation could influence opportunities for education, but that the reasoning is undetermined.

[54] Two people

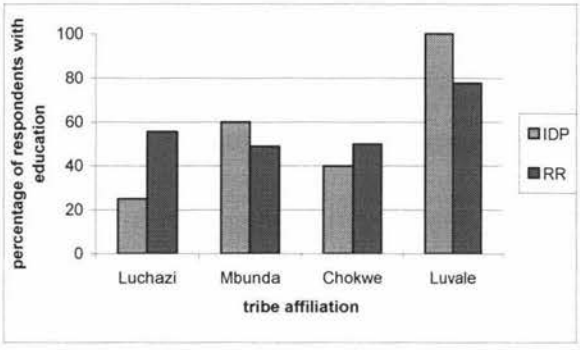

Figure 8.2: Tribal affiliation and respondents with education (grades 1-12) according to IDP and RR identities

The effect of these outcomes on health development is difficult to surmise. If communities were settled according to tribal group then this would affect the overall level of education within the community. Table 6.4 showed the tribal make up of the three study communities and was mixture of the groups. The direct effect of education on health development is difficult to determine due to the expansiveness of what health development actually is. As seen in Chapter Three a health programme can range from a community based educational initiative to a professional medical practice requiring qualified staff and resources.

Both bottom up and top down approaches to implementation as considered in the literature are limited in the development of community based and supported health programmes when there is a low literacy and education rate within the community. Availability of qualified staff within the area can be difficult to find, resulting in the need to bring people from other main towns and areas. Community initiated programmes with non professional staff is appropriate for certain outcomes but is not expansive enough for complete medical care. These programmes are also known to take much time and effort to implement. Within the post conflict phase this can be a challenge, with immediate health needs often taking precedence over preventative and educational programmes.

At the root of education is language and literacy. As noted, the official language of Angola is Portuguese. Language is required for effective communication and within the area of health this is critical. The communities taking part in the study spoke predominantly in the local language. Training programmes that took place outside of these areas, within the main town, involved the use of two languages to ensure full comprehension from everyone

involved. This brought a challenge to the centralised training programmes and gave emphasis to the promotion of community based training. It created the added pressure of ensuring that written handouts and signs were translated into the appropriate languages. The referral health centre also experienced the challenge of having out-of-town staff who were unable to communicate in the local language, and with patients who were unable to understand either English or Portuguese, a translator was required. The extra burden of this was even heavier when compounded with the other difficulties of inadequate resources and staff.

Gender

The full effect of gender on the responses and actions of the participants is difficult to determine without looking deeper into the traditional roles within society, of which this study has not covered. Due to the limitations of the statistical data it is only possible to consider the trends and the stories of the participants.

Chapter Six revealed the differences between females and males in the area of education, literacy and language skills. Notably the male group has a much higher achievement rate in all three of these areas (Table 6.6; 6.8; 6.10). This can be surmised to have an effect of a number of cultural norms. These include the general promotion of education for males, childbirth responsibilities that may limit opportunities for females in education, business ventures encompassing primarily a male role due to female domestic role, which broaden opportunities for travel and increases the need for further languages, and also military roles that promote language skills.

The effect of greater education, improved literacy and more language skills leads to greater opportunities and choices for employment, travel and decision making. When one particular group is lacking in all three of these areas (as in the female IDPs) then the opportunities for them to participate in resolution reforms are potentially limited.

The responses for priority of needs (Table 6.12) were differentiated by gender. These trends in Figure 8.3 reveal that there are differences in the identification of needs within the community, according to gender, and within the IDP and RR groups. The transitional period of the post conflict phase created enormous resource limitations. It was seen in the literature that effective assessments of communities were crucial to the identification and

prioritisation of genuine need. Combining this with the desire to empower and build capacity within the community leads to a conflicting scenario where the NGO and donors' priorities may be different from the community requirements. Accurate identification of need, community empowerment, building of capacity, and donor and NGO priorities, can be conflicting and result in action that does not reflect the community requirements.

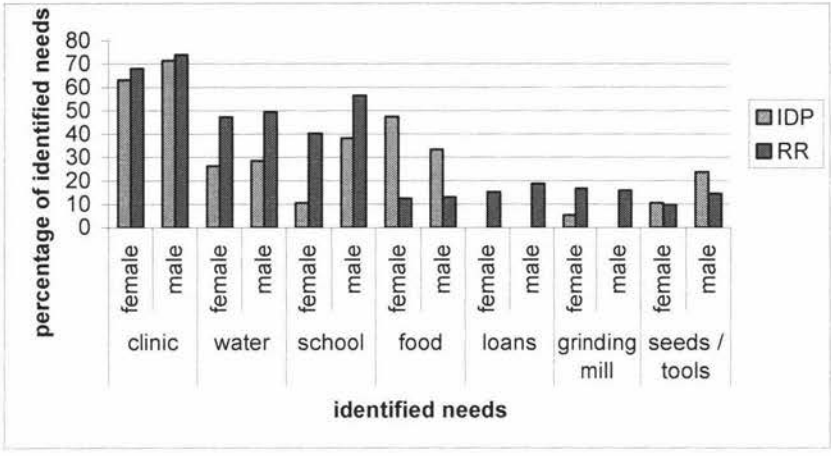

Figure 8.3: Identified needs according to gender and IDP / RR identity

The impact of tribe, education and gender on health and its development within the community cannot be fully identified through these brief comparisons. These comparisons though, have been used to show that consideration of these influences is necessary. How they effect health is not determined directly here, but further comparisons with other influences reveal the impact that they may have.

Combining Experiences

Needs

At the time of research, demand for food was notably higher on the IDP priority list compared to the RR group, and hence the requirement, for a period of time, on the cultivation of food products. It is noted that *seeds and tools,* though, are not a high priority in Figure 8.3 which may reflect the fact that RRs received these items on arriving at the Reception Centre and may have shared with the IDPs in the community, thus reducing the immediate demand. Comments from the community and the traditional leaders also revealed the need for food if there was to be adequate participation in the work that was

communal development work. The UNHCR representative identified in his interview that time was the issue stopping people from becoming fully involved in the development of their community. There was a period of settlement required prior to the people being available for other things outside of the establishment of their homes.

Time

This initial settlement period was also noted in the literature as critical for community empowerment. In less established communities the period for empowerment to effectively occur is thought to take two to seven years. It could be said that community empowerment is much bigger than the desired outcome of the establishment of an effective health programme but it is also an essential criteria for the success, especially within the transitional phase from relief to development. If this is truly the case then it is difficult to find the balance between time, post conflict issues and the objectives of effective health care.

The greatest time spent on an activity during the day (Table 6.30) showed similar results between the IDP and RR groups. Clearly, the majority of time was spent in the fields where the priority for the time of year was preparation and planting. A further breakdown of this data (Figure 8.4) in consideration of gender reveals again a fairly even response of time spent in the fields for both women and men. Paid employment was equal for both IDP and RR women and reflected the responses of the male groups, although interestingly the IDP males had a higher response for paid employment than the RR males. Further investigation shows that all of the males were from Community 1 which had the greatest access to the main town and transport route. The job descriptions are unknown. The low employment rate in general, reflects the remoteness of these communities. This does not reflect the views of the NGO coordinators who felt that IDPs lacked the necessary skills for the current work needs of development in the community.

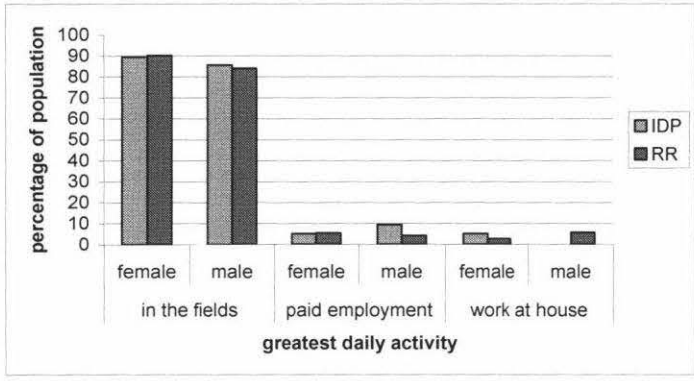

Figure 8.4: Activities representing the majority of daily time spent according to gender and IDP / RR identity

The amount of time spent in the establishment and maintenance of the fields, especially at the height of the planting season, must impact on the amount of time that the population is available to invest in other activities within their community. I recall from my time spent in the area that during the year there is a particular focus from the community on different jobs that need doing, and this mainly centred around the agricultural year. Being a predominantly subsistence farming culture, the year is broken up into planting, maintenance, and harvest cycles. Traditional holidays and festivals reflect this cycle. There appears a period of 'down time' at the end of the main harvest when people are free from focusing their energies on that particular field work. This period may allow greater time for other activities, including community development, and more specifically health, but this was not researched. Re-examination of the expectations of organisations, donors, government and the community on what should be established for health is therefore required in light of the consideration of time.

Expectation

Within the health setting, the experiences of the past can have an effect on expectations for the present by inadvertently raising the standard of health care, through adequate staffing, resources, knowledge and accessibility. This level of expectation from experience is also enhanced by information given to the refugees prior to returning to Angola. The responses from RRs, when considering their return to Angola, showed that most thought that everything was going to be ready and set up for their return. This expectation, when not met, created confusion and frustration. People appeared to feel let down by the government and the humanitarian aid system. The communication processes were either ineffective or the wrong message was given, as the UNHCR representative found in the

Namibian repatriation. The NGO coordinator noted that people came expecting certain services, depending on what they had experienced in the past.

Discussion and feedback from both groups regarding past services show that RRs had a fuller experience of health services than the majority of the IDP population. This experience was generally positive, especially for those within organised camps where international standards ensured that adequate care was available. These people were used to a certain service and level of care and, as Table 6.18 shows, over 50 per cent of RRs recognised an NGO as the main provider, therefore influencing expectations.

Figure 8.5 reveals a breakdown of the IDP feedback on the health service providers that were identified in Table 6.18. The satisfaction of the quality of *traditional* services is revealed as quite low compared to the other represented services. Government and mission services received a high percentage of *good* feedback, whereas NGOs achieved *excellent*. The *military* showed a strong line towards excellent.

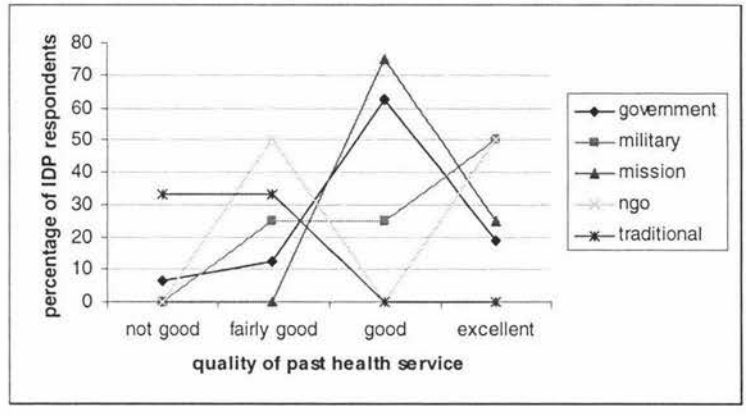

Figure 8.5: IDP responses to the quality of identified past health services

In comparison to the IDP responses, Figure 8.6 shows the RR past experiences of health providers. This graph shows the satisfaction levels of the service providers in Table 6.18. As can be seen, identification of government services as *good* is fairly high although the percentage of responses with *excellent* drops off. The result for military services is 100 per cent *good* out of two responses. The feedback concerning NGO health services reveals the most positive trend, with the highest responses of *excellent*.

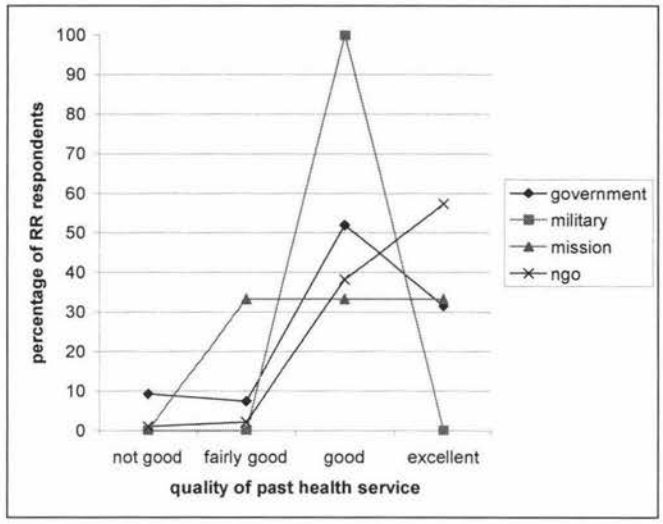

Figure 8.6: RR responses to the quality of identified past health services

Current trends on usage appear linked to accessibility rather than past experiences. This can be seen through the consideration of possible influencing variables which include IDP and RR identity, past settlement, current sickness, education, and tribe. Comparing these variables against the responses of health services accessed reveals no significant or distinctive trends, thus pointing back to the issue of access. People who don't have a choice use what is available.

A comparison between past health service availability (Table 6.17), current first choice for treatment (Table 6.19) and actual service accessed (Table 6.21) reveals past and present trends. This shows that 47.5 per cent of IDPs had access to a health clinic in the area in which they spent the longest time during the war. In comparison, 57.4 per cent of IDPs would currently like to use a health clinic, with a further 31.6 per cent actually using those facilities. Within the RR group, 83.7 per cent had health clinic access compared with current preference for use of 68.1 per cent, as opposed to actual use of 56.9 per cent. Due to the low past accessibility, and the difference between the past and present wants, IDPs actually reveal a higher desire for health clinic use, which potentially increases their expectations for health services. The RR responses in Figure 8.7 show the sliding trend indicating that past availability was much higher than current access and use. The potential frustration that this may create is noted from the group discussions and interviews which reinforce the desire for a clinic to be established nearby (Chapter Six).

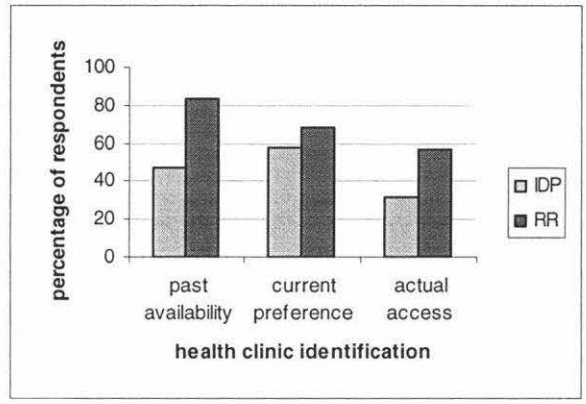

Figure 8.7: Trends of health clinic access, preference and use according to IDP / RR identity

The impact on use and access to health services relates to length of time settled in community, expectation of services, availability of health workers in community, access to traditional services, transport, and distance from established services.

Sickness

Further breakdown of the self identified sickness levels from Table 6.20, demonstrates the effect of gender and education on this response. As identified in Chapter Five, the overall IDP group had a higher level of self identified sickness within the last month compared to the RR group. It was also revealed that combined female and male responses showed a slightly higher sickness rate for those with education (between grades 1-12) compared to those with no education (52.9 / 47.1). Non educated females in total identified a higher sickness level than males (66.7 / 33.3). The IDP / RR breakdown revealed similar responses from both groups. Educated males in total identified a higher sickness level than females (60.8 / 39.2). The IDP / RR breakdown was not reflected evenly across the groups.

Figure 8.8 shows the effects of gender and education on the responses of self identified sickness. Of those with no education, IDPs had a slightly higher sickness rate than RRs; females were higher than males. The results from the identities of IDP, RR and community are unexplainable. For example, female IDPs without education and male IDPs with education revealed a very similar result. The impact of this on health is undetermined. The identification of sickness cannot be directly linked here to the number of years of education.

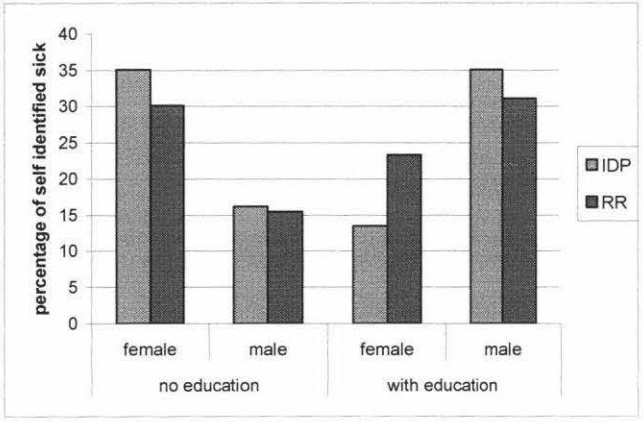

Figure 8.8: Self identified sickness within previous one month period according to gender and levels of education (no education and grades 1-12) and IDP / RR identity

The actual health needs of the communities studied are comparable to the rest of rural Angola according to the literature documentation. The types of diseases that presented in the health clinics were expected from the population groups represented, corresponding with specific IDP and RR health needs. What was of concern to the implementers, both government and NGO, was the availability and access to these services for the growing and moving population. In most instances, newly established areas were distant from the established health services. This was the case for the communities studied. These communities were unable to have health clinics established straight away, mainly due to the lack of qualified staff available to run the clinics. The NGO had the means to assist in the construction of a clinic building, supervise staff and the provision of initial resources, but without qualified staff the programme at that level of health care was ineffective. As noted earlier, qualified staff were required from outside of the area. These workers didn't get to choose where they worked, and to end up in a remote area with limited infrastructure proved frustrating for them.

The literature reveals that prioritisation of needs, when involving funding and international assistance, is often based on numbers, and these communities, especially Community 2, had limited numbers of people which created difficulty for approving implementation of services in that area. The prioritisation of health services for the community appears linked to past experiences of health care and the positive or negative satisfaction of those services.

Responsibility

Communication was identified as playing a critical role in the successful development of health services. Effective communication was required between communities and their members, and the wider circle of the communities, government, and aid workers. The identity of leaders and communication processes were still being formulated, resulting in a teething stage of development within the community. Communication with the community was predominantly instigated through the traditional leaders. The influence of effective leadership in the communities involved was revealed throughout the results. The *Sobas* identified themselves as peace keepers within the community and key motivators for addressing issues. The NGO coordinators understood the need to develop this relationship with the traditional leaders in order to improve communication and understanding.

Leadership within the area of health beyond the traditional roles of the *Soba* or committee members was not clearly identified within the communities. Most participants in the survey were unaware of who was responsible for health and its development. This can be attributed to the ongoing movement of population and the initial period of settlement where the population priorities may not reflect the actual needs.

It was found that the people who were identified as having no education, did not know who was responsible for the health services in their community, compared with those with some level of education (62.3 / 37.7 per cent). Those with no education and thought that no one was responsible stood at 47.7 per cent and those with some education, at 52.3 per cent. Recognition of a health worker as being responsible for health in the community was much stronger from those with an education compared to those without (69 / 31 per cent). The responses here in Figure 8.9 reflect this impact of education. Recognising that the male group has a higher level of education, their responses are more positive for actual identification. The female group show a higher response of *don't know* and *no one*. RRs, both female and male, show the only identification for NGO responsibility.

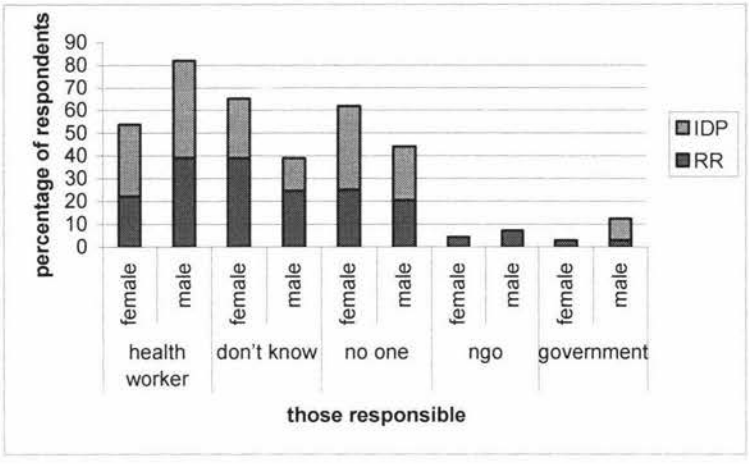

Figure 8.9: Responsibility for health services within community according to gender and IDP / RR identity

Responses from the IDP group to the question of who should be involved in the improvements to health services (Table 7.2) has been further broken down in Figure 8.10 to reveal the responses according to the influencing variables of gender, education and longest settlement area. The male group shows a higher response to *government* involvement compared to the female group who identifies the *community.* The *females* reflect the *no education* response, whereas the *males* reflect the *education* response, indicating the reality that in general, the female groups are less educated than the males. This influences the responses of who should be involved in the improvements of health services. The responses from the settlement area reveal the total percentages from the gender and education variables, revealing overall a strong identification of community and NGO involvement.

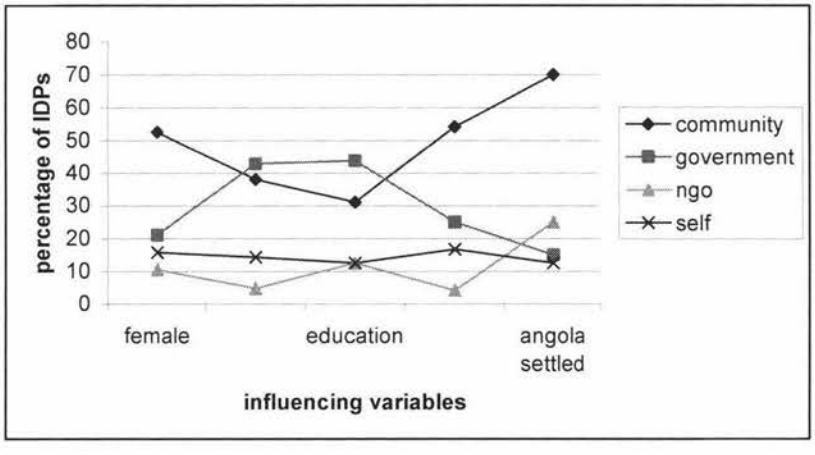

Figure 8.10: Top four responses from IDPs indicating who should be involved in the improvements to health services in consideration

of influencing variables of gender, education and settlement area

The same considerations can been made with the RR responses. These show (Figure 8.11) that overall the community identified themselves (Figure 8.11 key: *community*) as those who should be most involved in the improvements except in the case of those self-settled in Zambia where the government was the highest response. The female participants showed a stronger response to the *government* and the male group to the *community*. Education or the lack of it appeared to influence the response of self involvement. Those who were self settled in Zambia revealed a higher response for *government* involvement and a lower response for *self*. Those who identified settling in Angola for the greatest period did not identify strongly with *government* involvement.

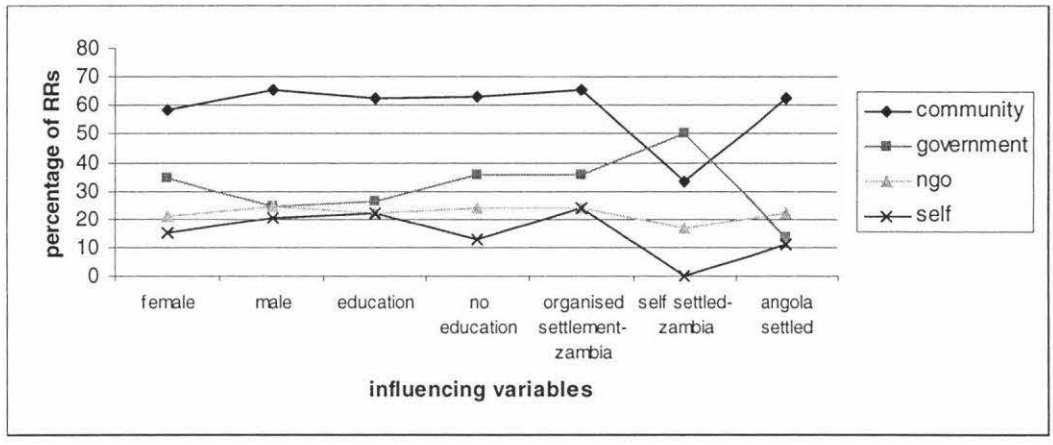

Figure 8.11: Top four responses from RRs indicating who should be involved in the improvements to health services in consideration of influencing variables of gender, education and settlement area

Comparison of Figures 8.10 (IDPs) and 8.11 (RRs) shows that *NGO* is ranked higher by RRs. Those who settled in Angola, from both IDPs and RRs, show remarkably similar response trends which reveals that settlement area is influential in this outcome.

Participation

Figure 8.12 reveals that IDPs identify themselves as having a higher level of participation. Comparing past health service experiences with the present ones, and knowing that RRs have generally had a much greater involvement and exposure to health benefits, the expectation would be for higher motivation for the improvement of current services from the RR group. This was not initially apparent. Settlement period, as considered below, has

an effect on this motivation. Possibly RR incentive is affected by recent arrival, lack of resources, tiredness, etc. The level of dependency experienced in the area of refuge may also have an effect. For RRs to have come from an organised settlement where everything was provided, to an area with nothing, could be considered a difficult transitional period. IDPs may also experience this to a certain level, if they have come from a township where there were health services available. It is acknowledged though, that the health services of the main areas of Angola were considerably lacking compared to those provided in the settlement camps of Zambia.

The construction of latrines and rubbish pits by the community themselves, reveals the motivation for self help and the willingness to establish and invest in the area. Ongoing unrest occurred at different levels of intensity over nearly 30 years. There had been periods of peace and glimmers of hope within that time but none of those periods lasted, even though there were opportunities for resettlement and development. In the end the investment didn't last and war broke out again. With this picture of past history it must be difficult to take hold of the present and believe in the peace process in order to be able to invest in the community, not knowing if it is to be a positive venture.

Participation in the development of health services, both past and present, is compared below in Figure 8.12. This uses the data from Tables 7.10 and 7.3 and reveals that IDPs self identified a greater overall level of participation. In comparison, the lesser RR identified participation rating in the past could relate to the greater provision of services available, and in the present, to their recent arrival and adjustment to the area. The overall percentages of self identified participation are fairly low. In consideration of the literature, participation comes in a variety of forms and can be an individual or a community response.

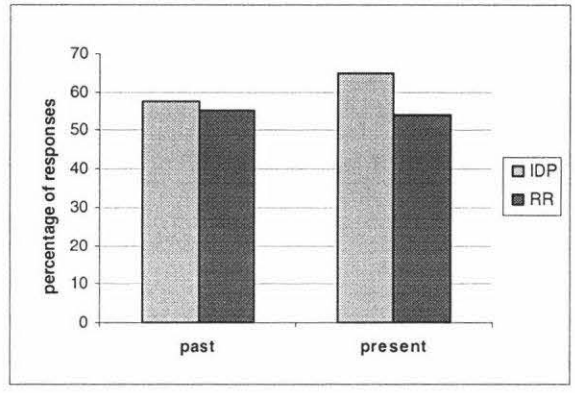

Figure 8.12: Comparisons of past and present self identified participation in the development of health services according to IDP / RR identity

Examination of the responses from RRs regarding who should be involved in the improvements of health services, reveals that education did not have a big effect overall, as those with education responded at 54.8 per cent and those without at 45.2 per cent. This issue did appear to influence the response of *self* with 68 per cent of those with education responding, compared to only 32 per cent without. Gender was equally represented in the total responses and was fairly even throughout the variables. Settlement had a bigger effect on those who identified staying in an organised community for the majority of their time in Zambia, and showed overall, a greater influence on the number of responses and ideas relating to who should be involved.

The length of time spent in the newly settled area appears to affect the input into development (Figure 8.13). New arrivals of less than six months (<6m) appeared to identify with having a greater involvement than those in the six month to one year bracket (6m-1yr). This may be attributed to initial enthusiasm for return although reasons given by RRs for non-involvement (Table 7.4) lists *just arrived* as the largest factor. The one to five year (1-5yr) bracket shows a higher level of identified involvement which reflects the period of settlement identified as required for empowerment and capacity building to occur within the community. The five to ten year bracket is acknowledged as having only a small number of participants identifying with this length of settlement, but they all responded as not involved.

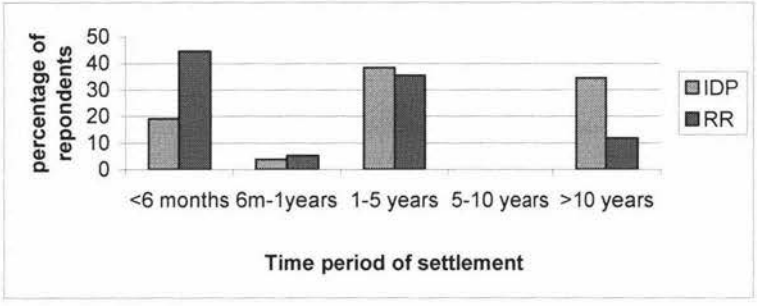

Figure 8.13: Self identified involvement in health development influenced by length of settlement time in area of return according to IDP / RR identity

Reflection of the responses for self identified involvement and participation in health services reveals a general willingness of the population to be involved in community development. Further discussion with the community as noted in Chapter Six revealed a strong emphasis on the need for payment of some kind for services and time given. This need, considered within the relatively short new settlement period, may reflect the balancing of establishing a new home and providing basic needs like food for family, with helping out and getting involved in bigger projects within the community. This conclusion is not reflected by the population of RRs who have been settled for under six months, as seen in Figure 8.13. The need for food and a stable environment is required for the process of development to be achieved.

Coordination

The perceptions of the community, government and NGO concerning their position and attitude towards health development are noted here. This identifies more clearly the reality of the situation according to the data processed within this research.

The community revealed that they had many needs that required attention. There was a mixed result in who appeared responsible for this process of development, this outcome being attributed to past experiences. Basic health needs were being met but not in a sustainable manner. Appropriate access to a community health clinic was identified as a basic need from all three communities. Expectations from the community on the roles of government and NGOs were different, according to past experiences.

The government acknowledged the limitations of the health system and the need for assistance in its development (from NGOs). They endorsed the concept of the community

being involved in working to develop their own area, including health initiatives. Limitations on the strength of the national health system created difficulties in determining appropriate systems to implement.

The NGO was working to find the balance between the immediate response to health needs and the establishment of long term sustainable health programmes. There was a concern over the development of dependency and false hope in a national system if too many vertical and quick impact projects were implemented. Difficulties were experienced in communication and the lack of health policy initiation at national level. Coordination was noted lacking between some agencies and government departments, and the health policy limitations were a frustration.

Summary

The influences on the development of health are vast and varied. A clear outcome of the cause and effect of these influences was not the aim of this discussion, but the interaction of them reveals issues to be considered for practice. Tribe, gender and education have not been shown to influence health directly, but their impact can be seen through respondents' identification of need, expectation, sickness, responsibility, participation and coordination.

Needs identified by the community were different for both women and men, and IDPs and RRs. This was attributed to gender roles[55], educational opportunities and past work experiences. Expectation of health services was raised through past experiences of health care. Both IDPs and RRs showed a generally *good* satisfaction of past available services. They also identified that current access to health care was less that past availability. Identification of sickness was different for both women and men, educated and non-educated. Within this, females with no education responded similarly to males with education. Males identified actual entities for the responsibility for health services much more than the female group. RRs identified NGO roles whereas IDPs did not. Participation and involvement were also shown to be influenced by gender, education and settlement area. Within the IDP group, males and those educated identified government involvement as most important whereas females and those without education strongly identified the community. IDPs combined identified the community as responsible for improvements. The RR group also identified the community as responsible strongly across all variables,

[55] Acknowledged as not discussed within this study

although those self-settled in Zambia identified the government. Settlement time in respondents' current area was shown to impact on self identified involvement in health development. The period between one to five years had the highest combined involvement identified.

This chapter has correlated the key variables that influence the outcomes for the objectives of this study. As discussed, these include past and present identity (tribe, gender, IDP / RR), past experiences (language, education, health, settlement), and current influences (access, time, community makeup). It has been established that all of these influences are interrelated and cannot be considered alone. To discuss further the connection and relationship of all of the variables mentioned within this chapter would create a never-ending circle of cause and effects that go beyond the focus of this study.

It is identified that this transitional phase requires flexibility and understanding from the implementing NGO / agency, patience throughout the establishment of leadership styles and community coherence, understanding and perception of time, the consideration of resources and effective processes of communication. Examination of these results narrows the outcomes of the study and draws a conclusion within the next chapter.

Chapter 9: Conclusions and Recommendations

This research examined important issues for practice in the implementation of post conflict health services. Its aims to develop greater understanding of the current issues for all actors involved within the transitional post conflict phase. This thesis does not give all the answers for health and system development post conflict but it does present the experiences of a region in Angola, in order to learn from them.

The post conflict phase is unique as it comes with a real hope for the future. The response to it is different than that of the complex emergency, which is in the midst of conflict and ongoing devastation of society. This phase though, has immediate needs coupled with opportunity and potential for true development, through a hopeful and responsive population, a developing government, and a willing international community.

The experiences of Angola post conflict, in regard to the development of health, have been discussed from an historical viewpoint through literature, and currently through research. The outline of the historical events of this country gave reason to the current situation and the responses of many of the actors within it. The legacy of mistrust resulting from the slave trade, colonialism and continuous tribal conflict, continues to impact on society in Angola today.

The literature focused mainly on the systems and actors in health development. It also revealed international thought on disasters, both natural and conflict related, and the humanitarian responses to them. The impact of this on health revealed complex scenarios that require much thought and intervention. The ongoing discussion regarding the best practice for health development post conflict revealed the overwhelming influences of variables which are conflict or country specific. These create great difficulty in defining exactly the best implementation strategy with a solid evidence base.

The experiences of the three communities who took part in the study were very real, allowing a glimpse of the reality of life and health in rural Angola. These areas were individually unique in their varied proportions of previously identified, internally and externally displaced people. The opinions, voiced experiences and observations of these

people can be learned from to influence improved practice from government, NGOs and the community.

The combination of the literature on systems and actors, together with the reality of the research from community and implementers, was culminated within Chapter Eight. The linking of these concepts allowed for a discussion that reveals again the complexity of health development post conflict. It found itself in the midst of mass population movement, limited infrastructure and resources, and potentially unhealthy population groups. In order to be successful and effective, it involved aspects of relief, rehabilitation and reconstruction, while aiming for developmental initiatives.

Reflection on the Objectives

Reflection on the eight initial research objectives that were discussed in the introduction chapter summarises the outcomes of the research.

Objective 1: ***Identify priority of needs in the community and role responsibility (of actors)***

The participants (combined results) identified their top priority needs as seeds/tools and health clinics, through two different methods of data collection. The need for health care was identified strongly throughout all forms of research and from both IDP and RR groups. The government, NGO and UN agency acknowledged the vast and diverse needs of the population and saw health as a priority sector.

The roles and responsibilities of the humanitarian actors were identified through a mix of responses. The community acknowledged that the joint efforts of the community, the government and the NGOs stimulated the development of community growth, with all exhibiting different strengths. Identification with NGOs was stronger from the RR community, and IDPs placed more emphasis on the government systems and their own initiatives. Government acknowledged their role in development of the communities but also sought the assistance of the NGO and UN agency, and demanded involvement from the community. The NGO and UN agency realised the international responsibility for the delivery of assistance to the area, and acknowledged the partnership that was required with the government and the community.

Objective 2: ***Identify current health services / activities in the community***

Identifying the current health services in the community was easily achieved due to the limited available services for the three communities. There were no permanent clinical facilities available in the study areas. Traditional services were utilised according to the availability of healers and there were strong mixed opinions on the effectiveness and appropriateness of the traditional medicine. The NGO mobile medical team provided the majority of curative care, with the distant government health centre as the next referral clinic. All areas received health and sanitation education through the NGO community activist programme. The government and NGO plans for the establishment of clinics were hampered by the lack of available health staff for the remote areas and the transient population. The development of preventative and educational health programmes for the mobile population was a challenge within this post conflict and transient phase of rehabilitation. Both IDP and RR groups identified a health centre as the most important health service for their area.

Objective 3: ***Identify past experiences of health services in the last 30 years***

Identification from the communities of the availability and use of health services in the past revealed a variety of experiences. A high response from IDPs showed that many had no access to health services and others primarily used traditional medicine. The government was the highest provider of services and hospital access was low.

RRs showed a strong experience of accessible and effective health care within Zambia, and more specifically from those who were settled in organised refugee areas. NGOs were the highest providers of care and health clinics were the most available service. Referral services were available for those within settlement areas. Dissatisfaction for past health services was higher for IDPs than RRs. Satisfaction rates, in general, were higher for services implemented by an NGO.

Objective 4: ***Investigate knowledge, attitudes and practice towards current health services in the community***

The knowledge of current health services was based on the limited accessibility. Past experiences of health influenced respondents' thinking on current services and their perceived knowledge of what they thought should exist. In general, most respondents

were aware of what was available within their area, but were unaware of who was responsible for it or what the plan was for initial or further development.

The general understanding or situation revealed by respondents was that the communities were dissatisfied with the services that were available. This dissatisfaction was linked with expectations which are discussed under Objective Five. Returnees (RRs) appeared stronger in their dissatisfaction regarding provision of services, especially toward the international community. Attitudes towards traditional services varied between groups, and would be interesting to reinvestigate this response when traditional services are more available.

Use of health services was based on accessibility and availability rather than choice. It was identified that people were not receiving adequate treatment due to access difficulties. The NGO acknowledged the lack of services and sought to provide immediate medical care and implement sustainable programmes within one year time frames. Use of traditional services was limited due to the number of traditional healers available in some areas, although there was a strong response, especially from the RR group, that the traditional services were no longer effective.

Objective 5: ***Identify the levels of expectations for health services in the community***

The levels of expectation were difficult to measure directly but were identified broadly. Participants were very clear in their discussions on what they thought should be available in their areas. Expectation for the provision of basic health care was noted from all communities and identities. A health clinic was the most important service identified by both IDP and RR groups. RRs within discussion groups, showed a much stronger expectation for established health services. This was linked to the greater experience of past health care. RRs also based their expectations on what they had been told prior to leaving organised settlement camps, which was in general very positive about the services available. The satisfaction of past and present services was linked to current expectations.

Objective 6: ***Explore the levels of participation by the community in the development of health services***

The levels of participation were explored using observation and qualitative questioning rather than a study of actual participation. Therefore participation was not measured directly but identified through attitudes and responses. The communities gave the impression that they were very willing to be involved in the development of health services in their community but that this was only possible with certain inputs. These inputs included; assistance in resources for development like construction material and tools; knowledge for themselves and the community; personal assistance of food and basic equipment for settlement; and cash payments.

The period of settlement was influential in the amount of involvement that the respondents felt they gave or could give towards health development. Although, the IDP and RR groups self identified similar levels of participation in current services. The government and NGO expected participation from the community in the form of volunteer work on projects. This gave a sense of participation but could be viewed as cheap labour and token ownership. This level of self identified participation from the survey responses appeared different to perception of participation from the NGO coordinators who felt that it could be increased.

Objective 7: ***Identify considerations for improved programme implementation processes for health services (community, government, NGO, agencies)***

The responses from the community, government, NGO and UN agency, pointed to issues requiring attention to improve the health services for the area. These are identified as improvement of access, standards, variety, and appropriateness of services.

Improvement of accessibility to health services would be achieved through expansion of the PHC programme with the establishment of more health clinics. Introduction of village health worker programmes would allow for areas with smaller populations to have basic services. Limitations identified post conflict are the challenges for participation, empowerment and unity in the transitional phase that a community based PHC programme requires. The input required to train village workers is long, with intense periods. Time is also a factor with donor restrictions on more short term projects.

Accessibility would improve to existing services with the repair of roads and transportation services.

Improvement to the standards of health care would occur through the ongoing training and supervision of staff. Introduction of international standards of care (Sphere Project 2004) would ensure minimum standards are achieved. Hygiene and sickness prevention programmes would be expanded to educate greater population of responsibility for own health. Access to government health policies would ensure national standards of services to improve sustainability.

A greater variety of services would be achieved with the availability of more trained staff and adequate supply of medical resources. The implementation of health policies and packages from government initiatives would give boundaries for the focus of health programmes.

Appropriateness of services would occur through ensuring community participation in all stages of the programme assessment, planning and implementation. Promotion and development of appropriate traditional services would allow for variety and greater access.

All of these improvements are beyond the initial immediate response to health needs of the population. These issues are reflected in Waters et al. (2004) framework for health in the restoring of essential health services and health systems rehabilitation. These processes require adequate planning, coordination, and resources in order to be effective. Further considerations for practice are made in the recommendations section of this chapter.

Objective 8: ***Identify methods for improved communication processes between community, government and international agency services***

The community identified the *Soba* as the key person responsible for communication of general issues. None of the communities identified someone specifically responsible for communicating health issues. Results from the data collected revealed clearly the difficulty in communication due to limitations on infrastructure, transportation, communication devices. The NGO and UN agency identified communication as important for success of

implementation. The implications for communication are further discussed within the next section.

Implications for Practice

Through the experiences of Angola and in consideration of the current literature, four main points have been identified as influential in the improvement of the health development process post conflict. The practical implementation is influenced most dramatically by community, time, and communication. These three very broad headings have been reflected throughout this thesis and will now be summarised.

1. Community – the influences

It was identified that gender and tribal affiliation, and past experiences of education, refuge, settlement and work, influenced people's attitude knowledge and practice towards health services, in varying degrees. It was difficult to establish the direct impact of tribe, gender and education but the combination of variables and differentiation of the two groups of IDPs and RRs showed their impact on health development.

Education levels, which allowed for greater opportunities for work and involvement in some programmes, were higher for men and for RRs than women and IDPs. Males and those educated, identified more strongly health responsibility roles. Theoretically, the success of the PHC programme is that it used workers with all levels of education (Sanders 1985) but the complexity of the health system showed that it also required educated staff to function effectively (Banatvala and Zwi 2000; Sondorp et al. 2001). The impact of the overall level of education within a community may be seen on health development through effective workers, accurate identification of health needs, appropriate decision making and community coordination. With limitations on education, these may be impacted.

The strategies of the PHC framework were thought of as appropriate by Sondorp et al. (2001) for the post conflict setting. The PHC framework though, was also shown to be ineffective through damage from private health infrastructure (Kloos 1988), alternative resource allocation (immediate needs), and initiatives lost through transient population (Toole and Waldman 1997; Zwi and Ugalde 1989). These initiatives included the foundational concepts of community participation and empowerment. The post conflict phase in Angola did not cater well for full participatory programmes due to the mobile and

transient population and the expectations for services. The acceptance of responsibility from the community was limited due to the unsettled nature of the areas.

Rogge (1994) identified that refugees who stayed in organised camps gained levels of dependency due to the provision of resources. It was recognised and that processes put into place to create self sufficient populations within these settlements would be effective in reducing this dependency (Rogge 1994; Simmonds et al. 1983). The RR data showed that even with the promotion of self sufficiency, the refugees still had strong expectations for provision of services and resources from outside sources. Dependency still existed. IDPs were identified to have had more limited experiences of health in the past. It was acknowledged that more attention is required internationally for IDPs and their plight (Global IDP Project 2002; IRIN 2005; Ludlam-Taylor 1998).

Regardless of the past experiences of health and the expectations, within the study area, the opportunity for choice of health care was largely determined by donors, policy makers, and implementers. This left the community choosing much of their requirements for health from options ordained from the outside. The rural community chose health services through their feet, using the most accessible option. Their desire to develop the health choices within their community was largely reliant of and influenced by pre-planned activities from donors and agencies that required certain levels of participation to be successful.

2. Time – a critical factor

Time was identified as having significant impact on the transitional phase post conflict. This period was flanked by relief efforts and development initiatives. Time was influential among other things, through the community settlement period, NGO planning, donor deadlines, and rapidness of government policy implementation.

Post conflict resettlement brought many challenges for the communities involved. People were settled together with many different experiences of the past and were coming together under new or reappointed tribal and government leaders. Adjusting to this leadership and the development of cohesion within the community took time. The *Soba* was identified as the motivating factor in all three communities.

The period of time required by the community in order to be established was surmised at one to two years. Laverack and Labonte (2000) noted that the period would be even longer. Full ownership and empowerment initiatives were seen to struggle prior to this. Angolan experiences reflected this, as the country is now three years beyond the establishment of peace and these initiatives are not fully established. This is due to the ongoing changes in the communities through the repatriation process and the limited capacity of government systems.

Planning ahead for the development of services with government and NGO input was seen as crucial for the success of the system, as reflected in the post conflict health framework (Waters et al. 2004). The NGO reflected Waters framework with the focus on immediate health needs, the restoration of essential health services, and health systems rehabilitation to certain degrees at the same time. Expectations from the community were time bound, expecting services straight away which can be related back to the dependence issue previously mentioned.

Pressure on time for the NGO was related to financial demands and constraints. The rehabilitation process involved high input projects with rapid justifiable results, as well as long term strategies for sustainability. This created pressure for the implementer in attempting to attain goals that may not have been entirely appropriate within the timeframe allocated. Giacaman et al. (2003) and Fagen (2003) noted the powerful impact of donors on implementation in the transitional phase. The donor timeframe limited the effectiveness of implementing community initiated and participatory programmes.

Governments were identified as generally weak post conflict and policy implementation slow (Banatvala and Zwi 2000). Government guidelines and health policies from ministry of health level were required to ensure sustainability and ongoing implementation regardless of the turnover of staff or assisting NGOs agencies. This was the situation in Angola, where the policies and programmes were limited. A policy and health package to cater for the needs of the population was required early in the post conflict phase.

This post conflict phase was identified as unstable and unpredictable. In order to be effective it required time for the community to develop their unified identity and understanding from all actors involved. In reflection, disease does not wait for participation,

communication and ownership; it occurs continuously, and the challenge is to find the balance between immediate response and development initiatives.

3. Communication – the link

Total success of a sustainable workable health system did not rest solely with the community, the government or the NGO. It was seen possible, through a combination of coordinated efforts and effective communication. Reflection on the journey from end of conflict through to development can be seen as linked together with effective communication. Communication is considered the key to this successful post conflict transition (Toole 1999).

The breakdown and limitations of effective communication is a reality post conflict (Zwi and Ugalde 1989). This was seen in Angola through the language differences and the need for translators, cultural differences within both formal and informal processes, and infrastructure limitations such as roads and communication devices.

The *Soba* was identified as the main figure for general communication. No one was identified as responsible to recognise and communicate specific health issues. The communities all commented that the role was considered important. The community was still new and developing cohesiveness, therefore communication was limited. Smithies and Webster (1997) identified the use of community groups to create cohesiveness and power. Health committees were considered for implementation in the area, but this concept had limitations in the transitional phase due to the still transient population. It was also affected by the limitations of the NGO time frame which would have been involved in the initiation of the programme.

The understanding of the communication techniques and processes used by each entity was identified as limited with each group. The NGO representatives noted the need for greater understanding of the community and their leaders.

Effective communication of repatriation issues to the refugees leaving the organised settlements within Zambia were identified as problematic. This information was influential to the expectations of the returning population and when given incorrectly had a large

impact. Many of the participants focused on what they had heard at that stage of repatriation.

As already noted, infrastructure impacted on effective communication, but beyond the physical problems were issues such as established and implemented policy, unity between actors, and understanding. Communication could be improved through understanding, tolerance and time.

Recommendations for Practice

- Recognition of the importance of identity and past experiences of the communities involved. Ensure that international staff have an understanding of the past influences and experiences of the population. Require that staff gain a reality of the situation through an initial period of introduction and a real push towards absorption of culture. Assist the community to identify their different experiences and to understand how these effect their expectations and decision making processes.

- Identify early in the humanitarian response, the stage of relief, rehabilitation or development. Reflect this stage of development in the programmes implemented. Ensure effective coordination between the community, government, agencies and donors. Cater for immediate needs while implementing strategies with medium to long-term strategies.

- Identify the individual communication processes used by each entity. Reflect these processes in coordination meetings. Allow adequate time for this process of communication, incorporating it into timeframe plans and project objectives. Ensure the use of effective translators.

- Identify the impact of time on all areas of aid. The identification of the stage of development denotes the time frame. Encourage and assist the promotion of health policy early in the post conflict phase. Identify an adequate initial settlement period for the returning population and cater for the side effects of a newly established community.

Recommendations for Research

Further consideration through research would be beneficial regarding the impact of individuals past experiences on the development process. This would allow for greater

understanding of the responses and actions of participants in the implementation of programmes. Another area for examination is the influence of health workers as promoters of peace and as contributors to the success of the post conflict phase. This is interesting to the overall process of health development but also considers the bigger picture of post conflict development. Recognising that health is foundational to development determines the role of health professionals as advocates for community development.

Final Thoughts

The post conflict phase, that remains largely undefined and without boundaries, creates a constantly challenging environment for health development. The requirements for international standards of health, coupled with the influencing variables within the community, create scenarios that require individual attention and focus for success. Beyond the policies and theories that are developed is the requirement to stop and consider the needs of the individual, in order to see beyond the often overwhelming situation.

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