Map of Mozambique

PROVINCE	REFUGEES	*IDPs	**DS	TOTAL
CADO D.	261	16017	13280	**29558**
GAZA	19360	13577	7993	**40930**
INHAMBANE	3917	8290	12864	**25071**
MANICA	4091	1586	12751	**18428**
MAPUTO	16185	6716	12721	**35622**
NAMPULA	2	6770	24504	**31276**
NIASSA	11374	17940	16791	**46105**
SOFALA	20596	10682	21300	**52578**
TETE	58126	38537	9213	**105876**
ZAMBEZIA	2835	15117	29119	**47071**

*Internally Displaced Persons
**Demobillized Soldiers

TOTAL DISTRIBUTION OF PERSONS TRANSPORTED BY IOM BY PROVINCE

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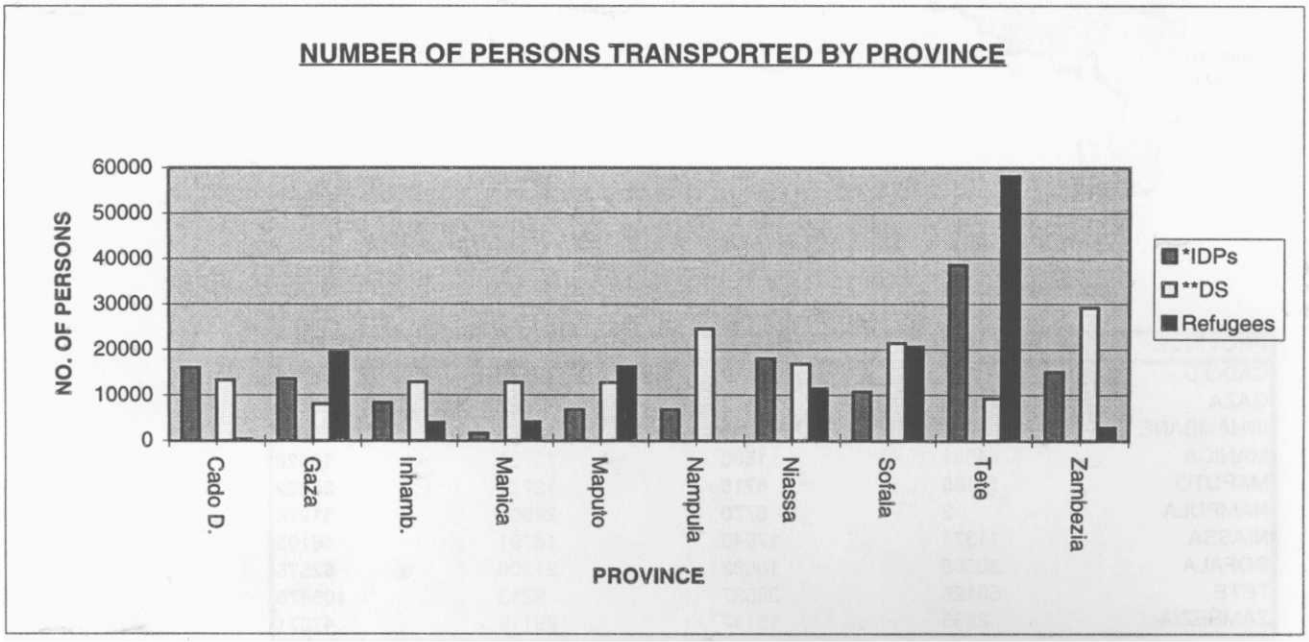

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EDITORIAL NOTE

The Maputo workshop was organized on a very tight budget with the objective of addressing issues relevant to the work which so many agencies and individuals had undertaken in the successful implementation of the peace process in Mozambique.

Mozambique is seen as the first in a number of similar peace initiatives within the Continent, and throughout the world, and it was thought that the experiences and expertise resulting from the diverse activities of those involved should be documented.

Attendance at the workshop was very impressive. Many papers were presented, each contributing to the rich pool of experience which was displayed and shared. An attempt to summarize such an exchange is very difficult, and this report is, in many ways, a most inadequate testament of that exchange. It is hoped, however, that the report may encourage ongoing dialogue in such a critical arena, and that from such exchange we may improve our capacity to implement the demanding and exciting disciplines involved in the activity of peace implementation.

The editor apologizes for any misrepresentation which has inadvertently been made, such error is entirely his and not the responsibility of the organizers or supporters.

Finally, although this workshop did represent the efforts of a large number of individuals, those that really moved the mountains were Dr Davide Mosca and Ms Loretta Iuri.

Vincent Keane

PREFACE

The International *Workshop on the Health Impact of Large Post-Conflict Migratory Movements – the Mozambique Experience* which was held in Maputo in March 1996, brought together a diverse group of individuals and agencies involved in the peace process in Mozambique. This workshop was jointly organized by the International Organization for Migration (IOM) and the Mozambique Ministry of Health, with financial and logistic support from a wide range of agencies and individuals.

The realities of the social and political changes taking place on the African continent made a gathering of persons with such experience highly relevant, given similar circumstances in Angola and, hopefully in the near future, in Liberia, Somalia and Rwanda.

The success of the implementation of the peace process in Mozambique was the result of a multitude of factors, not the least being the successful return and reintegration of the millions of persons displaced during decades of war, into a viable and evolving socio-economic structure. Addressing the health concerns of this huge population during the return process and onward into reintegration and national reconstruction is a vital ingredient which must not be ignored.

IOM is proud to have been associated with this workshop, and is greatly appreciative of the long-term collaboration and support offered by the Government of Mozambique in general, and the Ministry of Health in particular.

James N. Purcell, Jr.
Director General
International Organization for Migration

BACKGROUND

While large-scale conflict continues in many parts of the world, it remains true that a number of them, of long-duration, have ceased, or are at some stage of peace-brokering. The transition from war to peace is a tenuous one, and one which may not necessarily result in a favourable outcome. Indeed, the majority of peace initiatives and ceasefires that have been negotiated in the many areas of conflict throughout the world have broken down with a concomitant return to hostilities.

Africa has long harboured multiple, simultaneously-running civil wars with resultant untold suffering for the populations affected. In many situations there seems little hope for peace in the short or medium-term as the process of self-sustaining hatred and conflict is encouraged by those who stand to gain at the expense of the numberless victims of war.

In situations where a peace is negotiated, there exists a window of opportunity to reinforce what is invariably a tenuous and unstable lull in the fighting. If the peace is to be sustained an active process to enhance and nurture it is required. This process is complex, difficult, expensive, and requires among other inputs:

- *development of modalities to enhance the transition to peace*
- *assembly and demobilization of combatants*
- *assessment and support of minimal infrastructure needs to allow survival of those returning to their origins following conflict-related flight*
- *developmental support at all levels*
- *medium and long-term assistance aimed at ensuring economic viability*

The concept of a "peace process" is now well established, with a comprehensive and coordinated approach being adopted in locations as diverse as Cambodia and Mozambique. The global approach to the peace initiatives, with the objective of providing functional, democratic government able to govern a viable community, requires a diverse input of expertise and resources.

Of vital importance to the success of this process is the capacity of the international community to assist in the return of displaced populations to their homes following the conflict-driven disruption of family, community and nation. The experiences which the governmental, intergovernmental and non-governmental agencies acquired during the successful peace initiatives in Mozambique should not be seen as a series of isolated, not-to-be repeated exercises but rather as part of an evolving discipline, a pool of expertise, a methodology, needing documentation, modification and summary and then deployment in any of the other diverse situations in order that peace may be given a chance to spring from the gloom of so much war and misery.

With this in mind, the International Organization for Migration (IOM), in collaboration with the Mozambique Ministry of Health, organized a workshop in Maputo on *The Health Impact of Large Post-Conflict Migratory Movements*, from 20 to 22 March 1996.

THE WAR

Large scale migration has become an increasingly dominant feature of demographic and social transition in many parts of the world, particularly Africa. The latter half of the 20th century, and especially the last two decades, have seen the traditional mass movement of peoples, triggered by social and economic needs, particularly of pastoralists in search of grazing for animals, overshadowed by the flight of individuals and populations as a result of unbearable circumstances: internal strife, civil unrest, and natural disasters.

This trend has global dimensions and has affected diverse populations including; Afghanistan, Angola, Cambodia, Somalia, Mozambique, Rwanda, Burundi, Sierra-Leone, Bosnia and Liberia. There are Eritrean refugees in Sudan, Sudanese refugees in Ethiopia and Somali refugees in Kenya. Nations of Africa are disproportionately represented in such listings.

At present there are over 20 million displaced persons in Africa. Even in situations where peace is possible, the national devastation invariably thwarts initiatives directed at lasting peace, repatriation and reconstruction.

It is impossible to summarize the impact of war and displacement on the populations involved. Each situation has its own unique horrors. However, there are many constants in all theatres of war: death, destruction, and displaced populations. The numbers are different but to those affected there is a wearysome consistency in the price they must pay.

In Liberia, for example, only 20% of the health infrastructure which was present prior to hostilities remains (1). In Mozambique, food production fell by 51% from 1974-1988. This generated a severe nutritional crisis. More than 40% of health infrastructure were destroyed between 1982 and 1986. Neonatal and maternal mortality increased dramatically (4).

Basic needs such as the availability of potable water and environmental health services are lost early in situations of war. A survey of water supplies in Mozambique in 1990 indicated that 80% of urban water systems reviewed did not purify water, while rural water supplies are assumed to be worse off. Indeed, at the time of the survey only the capital (Maputo) was able to provide treated water to the population. Public health surveillance was rudimentary in the cities and non-existent in the rural areas (11).

Reproductive health suffered uniformly among displaced populations. The incidence of stillbirths and complications of pregnancy and delivery are high in such populations. The incidence and prevalence of STDs, including HIV/AIDS can also be expected to be high. In the case of Mozambique it is not clear to what extent this was associated with the high incidence of rape, but there is probably an association. In 1995, the infant mortality rate in Mozambique was 139/1000 live births, making it one of the highest in the world. Under five mortality was even more striking, and at 270/1000 live births, was considerably higher than it had been before the war began over 20 years ago. Malaria, measles, acute respiratory infections, and diarrhoeal diseases account for most of the deaths among under five's (12).

The impact of continued civil and military strife on the African continent is apparent. Populations that may establish a precarious socio-economic balance under optimal circumstances, are thrust back into the direst of poverty by being forced to flee their homes under the threat of violence. Refugee and internally displaced populations (IDPs) invariably place a burden on the recipient population as well as on the humanitarian agencies who tend them. The Mozambique refugees who fled to Zimbabwe during the civil war created hardships for the Zimbabwe nationals, as well as for themselves. Their stay in Zimbabwe coincided with the severe drought of 1992 when resources within the country were stretched and incapable of handling the overcrowded camps which were housing five times more than planned. Dysentery and cholera epidemics affected the host population, firewood became scarce, rodent and fly populations were at plague levels (9). Despite the strain posed on neighbouring host-countries by large influxes of refugees, attempts were made to absorb them into the national primary health care programmes extended to cover refugee needs, and training programmes were developed to allow refugees to manage their own PHC activities (21).

On the whole, however, it was the IDPs throughout Mozambique who suffered the most because national resources were even more scarce than in the refugee camps where there had been a concentration of international efforts under the umbrella of the United Nations High Commissioner for Refugees (UNHCR). The communities and regional administrations where the majority of IDPs relocated rarely had the capacity to handle them alone, and responsibility for the care and support of IDPs necessarily fell to a combination of the national government and international bodies, such as the UN agencies and NGOs.

The popular and evolving trend of exploiting non-combatants to facilitate military objectives has become widespread in Africa. Civilian populations are used as a commodity in furthering strategic requirements: refugee populations can assist in transport and in shielding combatants, with large populations accompanying military movements against their will. The implication for carriage and transmission of a variety of chronic diseases between refugee and host populations is enhanced because of the disruption of established medical interventions and loss to follow-up (2).

Coincident with the increased exploitation of civilians in conflict situations has been the disproportionate number of women and children affected. It is estimated that fully three quarters of refugee populations consist of women and children. Women are sexually exploited and reproductive health is essentially ignored (3). Reports of the situation in Liberia, for example, where some 120,000 refugees from Sierra Leone have fled, indicate that 80% of this population are women and children (5). In 1985, in Mozambique only 45% of women had a prenatal consultation, and in 1988 only 25% of women gave birth in an institution (12).

Among IDPs and refugees, infant mortality rates suggest that children were most seriously affected by the war. While all IDPs experienced high rates of acute malnutrition, much of the child mortality increase was a direct result of this, together with the added burden of frequent diarrhoea, acute respiratory infections, and vaccine preventable diseases.

Malaria transmission has actually increased in Maputo since the cessation of hostilities. Country-wide, 50% of outpatient consultations are due to malaria, 30-70% of hospital admissions are for malaria. The causes of this increase are multifactorial: overcrowding,

insufficient drainage systems, inadequate refuse disposal, migration from endemic areas, poor education and lack of vector control (35).

Populations move to urban areas in times of civil strife to avoid conflict and seek employement. Overcrowding results in unemployement and degradation of family support and values. The consequence of prostitution, poverty, destitution and lack of hope have lead to an increase in STD/HIV infections In Tete province in Mozambique AIDS already represents one of the three commonest causes of death (36).

Data drawn from various parts of Mozambique indicate that it is the destruction or interruption of pre-war health services which most seriously affected the health of the population, and that the lack of basic health care may have been a greater cause of morbidity and mortality than war injuries. Throughout the country the war also seriously eroded the health care services infrastructure and severely limited the capacity of the regions to meet the needs of both the stable and displaced population. Not only were facilities destroyed, but throughout the war it was often impossible to reach some parts of the country with much needed medical supplies and equipment. Large numbers of health care workers were also lost to injuries and displacement. Cholera and dysentery outbreaks were common in most of the IDPs situations, especially in the context of the seasonal water shortages and persistently poor sanitation (37).

Surveys undertaken by the ICRC indicate that where it was possible to maintain the original health care services throughout the war, health indicators did not deteriorate to the same extent as elsewhere (8). Unfortunately, maintenance of such services during a conflict situation is rare.

Violence and the destruction of infrastructure and health services are obviously not the only cause of the spiralling morbidity and mortality associated with protracted conflict. The absence of functional health services contributes more to this than do those from hostilities. Ongoing surveillance and control mechanisms are disrupted, and diseases which were controlled or limited in time of peace, reappear. Angola had seen reported trypanosomiasis cases fall from 2,500 in 1949 to 3 in 1974. With the almost complete destruction of the health system, it is now estimated that one of every three Angolans is at risk of human trypanosomiasis (7). Similar increases in incidence and prevalence of previously controlled conditions occur in many situations of displaced or compromised populations, or of those who remain within a poorly functioning health network. Relatively simple measures, such as water treatment facilities, soon fail in a hostile enviroment. A survey in 1992 in Mozambique, 69 of 143 water treatment systems demonstrated that 81% did not adequately disinfect water for human consumption. The resultant transmission of water-borne diseases, particularly in drought or in a compromised population, will have serious consequences (34).

Despite the dramatic downturn in most health services, and population parameters, it is apparent that well-managed and innovative programmes targeting accessible populations can improve health dynamics, even while the war continues. For example, an aggressive vaccination programme in a central Mozambican district resulted in a fall in vaccine preventable diseases at the time of continued hostilities (8).

The flight of refugees across borders, often to host populations that are not equipped to accommodate them, poses complex questions on issues of human rights. Exploitation of

refugees in labour and prostitution markets occur. Access to health and other social services, including education, is limited or non-existent. Compulsory deportation (often back to a hostile and dangerous environment) without medical controls facilitates the transmission of cross-border epidemics (10).

As the numbers of displaced spiral with time, so the capacity to offer the basic requirements of food, shelter, sanitation and protection becomes increasingly stressed. Funding is less readily available and the region and its people become more and more disadvantaged as the war drags on. Compromised individuals who have fled an intolerable situation frequently find themselves vulnerable, with none of the traditional means of coping with the rigours of survival. The reversal of their fortunes is much more complex than a simple return. Mozambique, at the end of the war, was a hostile environment with huge population displacements and very little national infrastructure. The task of facilitating a safe and viable return, as well as creating an environment in which populations can thrive and grow, is a daunting one. The capacity of the international community to assist national bodies in the return and reintegration process is a most vital and difficult aspect of the peace process.

THE END OF A WAR/THE PEACE PROCESS

At the end of hostilities in Mozambique there were approximately eight million displaced persons, two million refugees and six million IDPs. This represented half the population of the country. It is estimated that six hundred thousand were killed during the war as a result of conflict. A disproportionately high number of infants and children died, agricultural production fell by over 50%, 40% of health services infrastructure were destroyed. Rural populations became inaccessible and health services could not be provided, resulting in dramatic increases in mortality.

Following the return of the displaced populations and the return of government authority, the task of reconstruction is daunting (4). Of course Mozambique's experience is similar to other situations of protracted war. In Liberia, the civil war has thus far left 150,000 dead, sent 750,000 refugees to five neighbouring countries and produced one million IDPs. Malnutrition and cholera epidemics continue to have a very high mortality (6). Child soldiers (numbering some 20,000 in Liberia) represent a highly vulnerable population (a problem which has yet to be addressed). Sexually transmitted diseases remain unchecked and uninfluenced (5).

The emergency phase of any complex disaster is characterized by humanitarian organization action involving staff who often come from outside the country and are not familiar with its past or its future aspirations.

It is a phase that is all too often characterized by poor coordination and frequent overlapping and duplication of services. In some cases, it is marked by open competition for resources between agencies. Development efforts should on the other hand be based on a different logic, and require that efforts be directed to ensuring sustainable and equitable development. These objectives tend to be defined through a political process which depends on stability and predictability of government, but which is often a grey-zone in which policies are changing from decentralization to greater administrative coordination and, possibly, centralization.

The impact of post-conflict population movements on health must be seen against this overall background. It is equally important that the relationship between health and mass population return be understood in light of the fact that direct military damage may have been less important than the indirect effects of political, economic and social changes that underlie and result from armed conflict. In this sense, reconstruction needs go beyond mere physical rebuilding to the root causes of instability. In the case of Mozambique, the resolution of the conflict made possible a massive repatriation programme. While this was successfully completed, the reintegration of refugees constitutes a major challenge to Mozambique and the international community. To date, for example, relatively little is known about the range of needs, expectations and capacities of the people concerned, and even less is known about the capacity of different parts of the country to absorb them and provide the economic base on which they can plan any long-term development (15).

In Mozambique, over the course of the conflict, no part of the country was spared, although some areas were more affected than others. Provinces such as Inhambane (55% of the IDPs), Gaza, Tete, Manica, Niassa, and Zambezia were among the most seriously affected. This

influenced the pattern and flow of refugees and IDPs during the conflict and has equally influenced the pattern of repatriation. In so doing, it has produced serious implications for the emergence of new regional health needs, and the allocation of health resources The population loss as a result of the war has been a major deterrent to the socio-economic development of Mozambique.

The problem of rehabilitating and reintegrating more than 300,000 orphans and abandoned children, many of them traumatized by the war, is very complex (4).

Demobilization of combatants

The demobilization of combatants followed their gathering at defined quartering areas where their health was the responsibility of the World Health Organization, delegated to Non-Governmental Organizations (17). The combatants were returned to civilian life, with a small number entering a combined National force. Within this population the disabled soldiers represented the most complicated group to be demobilized, requiring ongoing medical attention, physical rehabilitation, assessment for pension eligibility, specialized transport assistance, reintegration assistance and long-term follow-up. Included in the "vulnerable" group of ex combatants should be child soldiers (38). The assessment of pension eligibility was delayed, perhaps because disabled soldiers were viewed as an element of instability. The census of RENAMO's disabled was carried out by IOM/UN, while the Health Department conducted the census for the government forces. Special commissions were set up to discuss benefits, level of disability and the value of health benefits and war pensions (13).

Return of refugees and IDPs

The demobilization process, concurrent with assisting the return of refugees and internally displaced was addressed. UNHCR was responsible for this overall programme and developed a three-pronged approach, embraced in the National Reintegration Strategy:

(i) assistance to refugees during their return, including transport,
(ii) facilitation of conditions at their end-point, making their return a durable one,
(iii) establishment of appropriate linkages between UNHCR funded projects and longer-term development efforts.

This has resulted in some 1,400 micro-projects targeting water, health, education and roads. In addition, enhancement of food security has been accomplished through the distribution of basic food rations, seeds and tools. Most of these activities have been carried out by selected NGO's with UNHCR-sourced funding (18).

IOM was the agency responsible for the identification, registration and transport and reintegration assistance to the IDPs. The organization transported a total of some 500,000 persons (representing 10% of the total displaced population). This consisted of 150,000 internally displaced (IDP's), 200,000 demobilized soldiers plus 150,000 refugees transported on behalf of UNHCR from four neighboring countries (14). The populations transported included 150,000 children and infants, 30,000 pregnant women and tens of thousands of elderly, war disabled and persons with chronic illness. During this process IOM staff were

confronted with over 300 violent incidents, including road blocks, hostage taking, looting of stocks and even death of staff members. Well over 75% of all displaced persons returned spontaneously and with little or no assistance. However, the rapidity of their return often placed unmanageable burdens on existing resources.

The effective and safe transport of returnees required: the establishment of close links with all agencies involved, from the pick-up to the drop-off point, the collection of statistically valid data on populations to be moved, and the appropriate dissemination of such data to involved agencies and individuals, the need for establishment of sound protocols for handling health problems during travel and immediately after return, and finally the need to evaluate end-point conditions of returnees, thereby linking, as much as possible, the needs with the available services (16).

The immediate need of returning populations is for adequate and acceptable food supplies. To address this most basic of human needs, different strategies must be developed relevant to each group and area. Decentralization and intersectorial coordination is necessary. Individual skills need to be identified and exploited, dependence on donor support should be avoided and high risk groups should be identified and assisted (21).

Mines

The huge number of land-mines scattered throughout Mozambique have exacted a frightful toll in death and morbidity, and continue to do so. Two years after the cessation of hostilities over 40% of amputations in the country are a consequence of mine injury. It has been calculated that for every amputee there are 1.2 persons killed by mines (22). The tragedy of mines cannot be ignored at the expense of more conventional development initiatives despite the incredibly complex task which confronts those who address it. Habitation and successful national reconstruction is dependent on addressing the mine issue in a comprehensive manner.

Health service infrastructure

The problem of the decimated health service infrastructure in the country, as a part of the immediate and medium-term needs was addressed on a multi-factorial level under the overall control of the Government of Mozambique.

To begin dealing with the national health service requires a pragmatic approach given the finite resources and huge need. This is a complex issue, and one which is yet far from completion. As stated, the war had decimated health services and infrastructure, particularly in the rural setting. In addition, it caused lack of equipment and supplies, decrease in public expenditure on health, urban bias in staff distribution and overall decrease in health care, surveillance and upkeep. Rehabilitation of the services requires not only restoration of infrastructure but an opportunity to reflect on priorities and to balance pre-war inequities. Such an approach requires long-term planning with post-war health sector rehabilitation through maximal use of available resources and better management capacity. This necessitates the following:

(i) rehabilitation of health network
(ii) human resource development
(iii) institutional development (including decentralization) with financing from government and international donors (19).

It was obvious that in order to ensure a viable peace, the populations would require very significant input to reinforce infrastructure and re-establish economically viable communities. This is probably the most daunting of all tasks associated with the peace process, the one with the highest price tag and that requiring the most long-term commitment.

PEACE, STABILITY AND RECONSTRUCTION

Rehabilitation of infrastructure is dependent on funding, access, safety, personnel, support services, and a clearly articulated agenda. It is a complex and demanding task which requires targeting of the specific populations according to their needs. A good example are the SCF/US projects in Gaza Province. This is a very poor low density district where a number of projects targeting food security, water, sanitation, and infrastructure improvement were implemented. The initiatives were reliant on community support and engendered a sense of community empowerement in decision making, and were pragmatic and attainable (29). An alternative outcome is illustrated in the rehabilitation of health infrastructure in the Zambezia province, where diverse imbalances occurred when the priority for rehabilitation programmes reflected donor or local authority interests. In Zambezia, investments have been made in some areas, neglecting others, with little balance or assessment of the real needs. Financial and material support should be directed first to the planning of reconstruction, and then to capital and recurrent costs. Following the signing of the peace agreement it became urgent to rehabilitate the system in order to satisfy the health needs of the hundreds of thousands of returning refugees and IDPs. The pre-war health infrastructure had been found to be seriously lacking; however, the reconstruction process proceeded to restore it to its pre-war state with virtually no adjustments to the reality of what was required (33).

The need for forward planning and broad based assessment of the real needs must preceed all reconstructive initiatives. It is clear that the government should lead the coordination of all such initiatives with transparent and open discussion among all involved parties/donors and relevant experts.

Even given the serious shortfalls in funding, personnel and infrastructure, it remains true that very cost-effective interventions are available and should be implemented nation-wide and early in the reconstructive phase. ICRC has demonstrated the efficacy of implementing EPI for under fives, tetanus toxoid for pregnant women, vitamin A distribution, a deworming and health education campaign, with a very good response, even during hostilities (39).

Recovery of health service infrastructure

In 1993, most rural areas in Mozambique had only one medical officer for every 337,200 inhabitants; in urban areas it was one per 9,300 inhabitants. Nursing staff also remained in short supply, and in the case of MCH nurses, the ratio of nurses to population was 1:65,300 in rural areas and 1: 13,300 in urban areas.

Although to date anecdotal reports suggest that the return of populations to their communities of origin has been accomplished with remarkable success, it is clear that any prolonged deprivation of health care could result in drift of populations to overcrowded urban areas (12).

Despite the dreadful statistics as they relate to health service infrastructure, there is some reason for optimism: in Maputo Province at the end of the war there were only 51 of 109 health structures that were operational. Four years later 80% of the initial health infrastructure

has been rehabilitated, including provision of housing for staff. In Maputo Province at the same time the number of medical doctors at the primary health level has increased from 2 in 1990 to 16 in 1996 (20). Although this stride forward is not necessarily reflected nationally, it is an encouraging development.

The need to identify and exploit all available qualified human resources in the health sector has been highlighted in the training and reintegration of former combatants with health service experience and/or skills. With the formation of the new (smaller) army following demobilization it was apparent that former RENAMO and government forces medical personnel would soon become redundant. Individuals will be assessed by a Ministry of Health Working Group to evaluate training levels acquired and training requirements to reenter the health service. Although some problems exist in relation to recognition of training, this initiative should capture the most qualified among the demobilized soldiers and facilitate their contribution to the Ministry of Health (30).

The importance of local NGOs in carrying the national peace process from emergency to reconstruction cannot be overstated. It is important for non-national bodies to identify, work with and strengthen local institutions rather than evolve as separate entities. The Mozambican Red Cross Society (CMV), although founded less than ten years ago, has a national network of 70,000 members, works with 4,000 volunteers and is represented in every province. The CMV targets vulnerable groups and has recently launched a campaign called "Back Home", which supports the resettlement of refugees and IDPs in eight provinces. The programme articulates three areas of involvement: Primary Health Care, STD/AIDS, water and sanitation. The CMV policy is to promote preventive community health projects with development of the communities knowledge in order to solve basic health problems (32).

Health influences as deterrents to successful integration

In some situations, refugees and to a lesser extent IDPs, may have returned from a situation of relative stability, with access to acceptable health services, to find that the situation at their end-point was far less acceptable than that as a refugee/IDP. For example, the sophisticted HIV seroprevalence surveys, HIV awareness campaigns and condom distribution to which Rwandan refugees were exposed in the Benaco camp in Tanzania are unlikely to be available in Rwanda in the near future (40). Expectations of displaced persons, born of exposure to superior health services can result in dissilusinment and despondency when refugees or IDPs return. Again, the fact that refugees represent a captive audience, and are relatively easy to expose to educational material and mobilize and empower, can facilitate management of health emergencies in a way that would be difficult or impossible in a community setting. A model of training in prevention, control and management of diarrhoeal diseases among some 25,000 Liberian refugees and IDPs resulted in a successful intervention based on a multi-factorial approach, and with aggressive community participation (31). Such an intervention in a rural or urban based community would be difficult without grass-roots support from the community at large.

Already there is a significant population movement from Mozambique to Nsanje in Malawi in search of health care. Although most of these people have been coming from Sete, Sofale and Zambesia, the trend now appears to be gradually involving people from other parts of the country (28).

Planning and monitoring the health of populations, particularly those people moving for health or economic reasons is important. In addition, the sharing of health records between provinces and across borders is necessary. This is especially so where communicable diseases are concerned.

Communicable disease patterns

Migrating populations can have a profoundly negative impact on disease patterns, particularly when the migration is rapid and poorly planned. The Mozambique experience demonstrated many situations in which such an impact has disseminated diseases. Identification of outbreaks requires an adequate reporting system. The Mozambique sentinel surveillance system, includes hepatitis, diphtheria, trachoma, typhoid fever and tuberculosis. The epidemiology of meningoccal meningitis epidemics since 1993 indicate an increased incidence in some rural areas (particularly Gaza province), but also from urban areas (Maputo, Nampula and Lichinga), presumably a result of increased movement of asymptotic carriers, overcrowding, poor sanitation and ventilation and poor reporting and control at the provincial and district level (25).

HIV prevalence can be expected to increase in times of stress, rapid unplanned migration, loss of traditional family support and destruction of health service infrastructure. The association of HIV and tuberculosis has been well established and was confirmed in a cross-sectional survey of seroprevalence of 1437 tuberculosis patients. The mean seroprevalence rates of new tuberculosis patients was 13.6%, 22.3% and 33.1% for smear positive, smear negative and extra-pulmonary cases respectively. The seroprevalence rates of females was higher than men in all categories of tuberculous disease. The female group aged 15-24 had the highest seroprevalence. Geographically, the highest seroprevalence rates were associated with important trading routes. The high prevalence of HIV and tuberculosis in neighboring countries influences directly the prevalence in relevant border areas. The high prevalence in women is assumed to result from the fragmentation of traditional family structures, the lack of education and employment and the increased drift to prostitution (27).

Chronic illness

The problem of maintaining follow-up on chronic illness during a period of rapid population movements is highlighted by the studies of leprosy cases in Mozambique immediately after the cessation of hostilities. In the first year of peace the defaulter rate for paucibacillary leprosy peaked at 39%, and thereafter declined (along with a predicted increase in cure rate). It is probable that the high defaulter rate in the first year of peace was associated with the accelerated migrational movements within the country, a period during which the health service was unable to maintain contact with defaulters. The phenomenon of defaulters was highlighted and compounded by the lack of sufficient education being given to patients, the fear of punishment by patients, unplanned and rapid travel schedules, and arrival at end-points where no health facilities existed. Clearly such problems can be addressed by planning, education, accurate records, and persistent follow-up of defaulters (26).

Food security

Food security means access by all people at all times to the food needed for a healthy life. In the post emergency (return) phase food security is critical to the success of the peace process. The objective, however, should be to not only assist populations in overcoming the immediate needs associated with return and reintegration but also to improve their overall living conditions so that they become less vulnerable to future threats. The main constraint to improving food security in the post emergency situation is the ability to collect accurate and relevant multi-sectorial data relevant to food (agriculture, nutrition, health, markets, etc.), and to use it for planning and policy-making. In a population that has lived for a prolonged period in a refugee camp, or dependent on distribution of food rations, knowledge and traditional food acquisition and handling habits can disappear. Locally adapted nutritional education should be developed for such populations. Special attention should be given to vulnerable groups, infants, the aged and infirm.

Restoring agricultural production requires access to land, distribution of seeds and tools, restocking of traditional livestock, stimulation of markets and transport and increasing the employment opportunities and income. Food aid should continue through to at least the first successful harvest (24).

Improving national capacity for disaster response

The potential for Mozambique to improve its national capacity to address disasters, including rapid migrational movements, has been demonstrated by the initiatives of the Department for the Prevention and Control of Natural Disasters (DPCCN), created by the Government in 1980. As the war resulted in more and more displaced IDPs, the DPCCN became the operational arm of the government's humanitarian relief programme. With the support of the NGOs and international community, the DPCCN was eventually serving approximately 3.7 million persons with food distribution. Again, with the arrival of cyclone Nadia in March 1994 the DPCCN, in collaboration with local NGOs, UNOMOZ and UNOHAC gave support to the population, and specifically in: (i) housing and health, (ii) sanitation, roads and drainage, (iii) energy, water and communication, and (iv) security.(23). The lessons from these initiatives are important and heighten the need for donors and foreign implementing agencies to be mindful of the fact that the primary initiatives for intervention and preparedness should come from existing national structures. They have the potential to collaborate with other (local and foreign) partners but the support of local infrastructure, such as DPCCN is clearly much more beneficial in medium and long-term than the establishment of new, and externally managed, bodies.

Approach reconstruction with a national perspective

The importance of approaching national reconstruction in a coordinated and global manner, through the relevant government institutions, cannot be overemphasised. The increased availibility of health services and resources is obviously not the only determinant of health status. The inputs of the reconstruction efforts to other sectors, such as provision of safe water supplies, sanitation, food security, etc. will have a profound effect on the health status. The restoration of general services to the rural community, water, roads, demining, etc. will

facilitate economic viability and, in turn, the health status of populations. Attention should be paid to the long-term recurrent cost implications of rehabilitation/reconstruction. Projects directed to technical assistance should be prioritized for funding. Financial information is particularly important for the Ministry of Health and donors. A critical assessement of the cost and performance of projects will improve cost effectiveness.

Health service restoration must not be addressed in isolation, rather as one facet of the multifactorial process of national reconstruction.

WORKSHOP RECOMMENDATIONS

Following the completion of the formal workshop agenda an open session to discuss recommendations was held. What follows is an attempt to summarise those points that the meeting considered vital to ensuring the health of large post-conflict migratory populations.

In order to secure the health of populations in the phase of post-conflict rehabilitation, taking into account the often large migration influx of returnees, it is recommended that:

1. Planning for return should start early

It should be remembered that return normally starts before peace is secured, at the first indication of peace. When return is safe the mass movement must be managed appropriately, on the basis of forward planning.

2. Assisted return should always include a health component

Return of populations is dangerous because of the transportation difficulties and can be disrupted by disease and disability. In order to ensure safe transport the following must be done:

(i) pre-transport registration of returnees should include a rapid health assessment;
(ii) clear protocols must be in place to address medical needs (both foreseen and emergency);
(iii) safe water and food must be available;
(iv) appropriate hand-over of those with illness at the end point.

Particular attention must be paid to vulnerable and disabled groups.

Medical records should accompany the returnees.

3. Reliable information should be made available to the returning population

Mass return is a difficult process to manage. Dissemination of plans and strategy will facilitate control and encourage cooperation. Force may lead to anger, apathy, violence and/or dependence.

4. Provision of basic services should be given priority

As in refugee camps, and in collection centres, it is important that shelter, water, food, sanitation, vaccination and primary health care is available and accessible to the returnees before there is significant investment in secondary and tertiary health care structures.

5. *Reproductive health concerns should be included in all phases of the emergency, return and reconstruction*

War causes morbidity and mortality, but only a small percentage of war-related deaths are caused by violence. The provision of adequate reproductive health services will play a key role in future development.

6. *Health manpower should be qualified for relevant services*

There may be a need to re-orient medical personnel to address the priority areas in the early reconstruction phase. Often there are professionals with relevant skills among the returnees, who can contribute to the establishment of community based services that are accessible, adequate, affordable, and appropriate. This resource should be identified and exploited. Furthermore, there is a need to re-unite health personnel from both warring sides.

7. *There should be a timely phase in-out of external assistance*

In the health sector, premature withdrawal will leave the vulnerable in a precarious situation; on the other hand, prolonged assistance may enforce dependency on the donor/providers. A strategy to address the two extremes must be debated early in the involvement.

8. *There must be a total, world-wide ban on the production and use of land mines*

Mine awareness campaigns and early de-mining exercises are of great importance to reduce associated trauma and expand areas for domicile and productivity. However, the goal should be a total global ban on the production and use of land mines.

9. *Food security and nutritional status should be closely monitored*

It is of concern that caloric intake will be insufficient and that diet may become deficient in nutrients or will include noxious substances.

10. *Evaluation and monitoring should be an integrated part of any programme of assistance*

Planned and obligatory evaluation not only provides information leading to more efficient and productive programmes later, but also improves the quality and relevance of programmes during their implementation.

11. *Any evidence of violation of human rights should be recorded*

Although it might be impossible to stop acts of abuse and violence, however, thorough, reliable records can serve to witness and possibly prevent abuse in the future.

12. High capital investment which is not sustainable should be avoided

The danger of high investment in non-sustainable health infrastructure, particularly by outside agencies, will have a negative impact on health services in the medium and long-term.

13. Disease surveillance across borders should be practiced

Evaluation of epidemic risk factors and management when they appear demand close cross-border collaboration.

14. Plan health facilities to address urbanization and rural-urban population movement

Populations will continue to move for a variety of reasons, not the least being the difficulty of attaining economic viability in rural settings. Health facility planning need take such movement into account.