POST-WAR DISASTER PREPAREDNESS

Mr. Silvano Langa, DPCCN National Director, Dept. of Prevention and Control of Calamities, Ministry of Foreign Affairs, Mozambique
"War Experiences and National Capacity in Natural and man-made Disasters Prevention and Control: the Case of Hurricane Nadia"

Mozambique has suffered from cyclic droughts, floods and cyclones. In order to manage better those recurrent natural disasters, the Government created in 1980 the Department for Prevention and Control of Natural Disasters (DPCCN). By the mid 80's the raging war had internally displaced about one million persons. The government had to organize Humanitarian Emergency Relief. The DPCCN became its operational arm. NGOs and the international community supported the DPCCN in distributing more than 200,000 annual tons of emergency items. By 1992, The DPCCN was serving approximately 3.7 million IDPs who fled the rural areas to the commercial corridors, pushed by hunger due to the combining effects of the war and the worst drought in the last 50 years in Southern Africa.

The Nadia cyclone occurred in March 1994, in Nampula province, right before the 1993-1994 harvest. The food security of the internal returnees was still quite poor at that time due to the late return of certain populations fearing a renewal of the war and due to the insufficiency of the seeds and tools distributed. An intersectorial coordination body was set up at central, provincial and district levels in order to plan for the cyclone. Local NGOs, UNOMOZ and UNOHAC collaborated and gave their support. Three groups worked together to secure: (1) housing and health, (2) sanitation, roads, drainage (3) energy, water and communication, (4) security. An assessment of the situation after the cyclone was planned. Fast distribution of relief to victims became possible thanks to the existence of relief stocks in the country and to a 24 hours alert communication system.

The cyclone hit 13 districts out of 21 in the Province and touched between 0.9 to 1.5 million persons. Forty-five deaths and 228 wounded were registered. Thirty buildings were damaged. The costs of the damages were evaluated at US$20 million, from which about US$2.3 million were urgently needed.

The direct health consequences of the cyclone were thus minimal. Nevertheless, the next six months about 300 persons were registered to have died from malnutrition in the Province. It is argued that those deaths resulted from the probable combined effect of the cyclone on food security, the inaccessibility of multiple areas to food aid and the looting by ex-military of food aid stocks in the pre-electoral period.

To conclude, it should be re-emphasized that population health and nutritional surveillance should not be limited to immediate disasters but should be permanent.

POST-WAR ECONOMIC MIGRATION

Dr. Maria Alice Mabota, President, League of Human Rights, Mozambique "Migratory Movements, Health and Human Rights"

South Africa's economy has always relied on migratory labour from neighbouring countries. Approximately 25,000 Mozambicans live in South Africa. Seasonal and illegal labour forces live in poor conditions and enjoy low salaries. Prostitution is common, access to health services and education is difficult. Large concentrations of migrants are focuses of diseases. Compulsive deportations without medical control allows trans-border epidemic transmission. Special disease surveillance and education of border population should be undertaken. The economic hegemony of a country in a region can impede the economic development of migrants countries of origin.

Dr. Jonathan Crush, Director Southern Africa Migration Project, RSA Queen's University, Kingston- Ontario, Canada "Southern African Migration Project: Prospects and Priorities"

Undocumented migration between Mozambique and South Africa is clearly one of the major long-term consequences of the destabilization and destruction of rural Mozambique in the 80's. The precise numbers of Mozambicans living in and migrating to South Africa are unknown but figures seem to indicate that the numbers are large and growing. In 1995, the Department of Home Affairs in South Africa has arrested and deported over 130,000 Mozambicans. The figure is almost double the 1994 figure of 74,000 and over 300 percent greater than the 1990 figure.

These remarks serve to introduce two concerns which are at the core of the South African Migration Project. First, within South Africa, at least, the official response to post-conflict cross-border migratory movements has been both diverse and inconsistent.

Second, to have any chance of success it is essential that policy be based on the best possible information and analysis: the types, patterns, causes, consequences and impacts of the various forms of migration are complex and variable and large knowledge gaps currently exist. The project is a research based project.

In the interest of social stability, regional integration, balanced development, and sound policy making, the project will promote greater understanding of the dynamics of contemporary cross-border migration in Southern Africa, examine the costs and benefits to both host and sources societies of the present and possible alternative migration regimes, and promote new policy initiatives for the consideration of governments in the region. The project is results-oriented and is designed to facilitate and support new South African and regional policies through international cooperation.

Research programme:

- Migration data base (trend, gender...)
- Country migration overviews (historical review of past patterns, statistical analysis and interpretation of actual patterns, economic causes and impact...)

- Immigration legislation and policy
- Public opinion survey (improve understanding of xenophobic anti immigrants' sentiment, and of the motives and perceptions of immigrants)
- Immigrants in the economy
- Skills distribution analysis
- Operation of borders analysis (ethnographic examination of local processes of border operation and cross-border interaction between communities)
- Comparative migration models.

The project will have the capacity to offer policy and legal advice in the immigration area on request. The outputs to government end-users and the public include: public information series, migration monitor, country surveys, radio programmes.

Future project development include Migration and Human Rights issues, National Migration Surveys Migrant Health profile, Health Impact for source regions.

Migration and Human rights: the treatment and reception of migrants will be a major focus.

National Migration Surveys: brain drain migration, household economics of national and international migration within the region.

Migrant Health profile: patterns of usage, access to and consumption of health care facilities, health consequences for undocumented migrants having to live undercover and on the margins of South African society.

Health impact for source region: do migrants bring diseases? Occupational diseases and disabilities in regulated and unregulated industries.

POST-WAR VULNERABLE GROUPS

Dr. Anselmo Zimba, Ministry of Social Affairs, Mozambique
"Repatriation of Refugees: The Role of the Ministry of Social Affairs in Relation to Vulnerable Groups"

From 1975 to 1990, the Department of Social Affairs belonged to the Ministry of Health, in order to consider the social dimension of health. Yet, due to the magnitude of the social problems caused by the war and the various natural disasters the country suffered, the Department was upgraded to a Secretary of Social Affairs in 1990 and to a Ministry of Coordination of Social Affairs in 1994 (MICAS), hoping to improve the efficiency of the government in this area.

Social Action is the organized and integrated intervention supporting individuals and communities to meet solutions to their problems, in order to allow them to participate in the development of society, in full possession of their individual rights and freedom.

Poverty has been defined as the incapacity to participate in the decision-making process in the civil, social and cultural life. Therefore, the Ministry of Social Affairs advocates positive discrimination in favour of the vulnerable groups such as children, the disabled, the elderly, and women head of household. The Ministry of Social Affairs works at different levels with different partners, national and international such as the Mozambican Red Cross, Help Age, SCF, Caritas, Redd Barna, etc.

In collaboration with the Ministry of Health and the local Administrations, MICAS:

- identifies the poverty level of the population.
- participates in the localization and reunification of families
- conducts household visits (especially when contagious diseases are transmitted through some cultural practices)
- promotes sanitation
- supports immunization campaigns
- supports mines prevention programmes

MICAS also works with the Education or the Agriculture sectors and any others where its intervention might be necessary. MICAS is present in the communities. Their volunteers bring some psycho-social support to returnees. Some volunteers lend their cattle to returnees to help re-open their abandoned fields. Local support strategies have even developed in some places into micro-projects to facilitate the economic reinsertion of vulnerable groups.

MICAS volunteers and staff also intervene at the family level to protect disabled children and the elderly from rejection and negligence for cultural or economic reasons. In addition, they support women head of household. MICAS privileges community and family interventions, where a participative approach is used to reach mutually agreed solutions. MICAS tries to fight against the structural and conjectural poverty of the vulnerable groups.

C. Simmons, E. Muñoz, IOM Mozambique presented by Dr. Enrique Munõz, Provincial Fund Manager "Reintegration of Disabled ex- Soldiers"

The Mozambican law recognizes the disabled soldiers' rights to an invalidity pension, for rehabilitation and for accommodation. During the war, on the government's side, the exact number of disabled soldiers was not known. The state tried to set up some resettlement and reintegration programmes for them. The programmes failed due to the rejection of the disabled by families and communities. Pensions and medical treatment were irregular or incomplete. Disabled soldiers were concentrated in overcrowded Transit Centres where they supposedly received treatment, rehabilitation and health benefits before going home. On the Renamo side, no information was available. Disabled soldiers had no access to the rehabilitation services. During the peace process disabled soldiers were not contemplated, but soon under pressure groups their problems became obvious and politicized. A special programme was created to handle this technically difficult group to demobilize.

Once a law that recognized their rights was passed, the census and identification process started with the help from UNOMOZ, The Mozambican Disabled Soldiers Association, Handicap International and others (MINDEF-MINFIN-COSV-ISCOS). The process has been slow and

incomplete, leaving disabled soldiers waiting in poor conditions in the Transit Centres and others non-registered. Most International NGOs were reluctant to help ex-soldiers. Their policy does not contemplate this group.

Reintegration and resettlement strategies as a "Life Project":

- identification of the disabled ex soldiers and his family
- resolutions of legal conflicts linked to their rights
- access to physical rehabilitation to secure their socio-economic reintegration
- family reunification
- community preparation for the reintegration and reinsertion
- resettlement with family (providing transport, supporting house building, access to land, small resettlement grant,...)
- social follow-up
- socio professional reinsertion programme (identification of skills, training and work opportunities or needs in their communities).

Recommendations:

- the success of the programmes will depend on the degree of integration and coordination of activities
- ex soldiers 100% disabled, needing a permanent helper, will require special programmes. In their case, Income Generating Activities and Professional Training should expand to family members
- invalidity card for disabled ex-soldiers
- closing of the transit centres which represent instability and marginalization centres
- learn from experience and expand to all disabled in the country.

J.Opoku, A. Mamade, J.Wright, Save the Children Federation/ USA presented by Dr. Justin Opoku, Field Office Director "Community Based Reunification and Reintegration of War-Affected Children"

In 1985, the Mozambican Government announced a policy for the provision of assistance to children affected by the war. The policy emphasized the community involvement and assigned priority to the reintegration of unaccompanied children in their families and communities.

Only in 1988 was a programme for Documentation, Tracing and Reunification (DTR) established by the former National Department of Social Affairs (now Ministry for the Coordination of Social Welfare), Ministry of Health, Education, international agencies and NGOs. DTR was one of the most important instruments for implementing the government policy providing assistance to children separated from their families by the war.

SCF USA through its Children and War Project (C&W), agreed to help with the expansion of DTR in seven provinces and in camps in Malawi and Zimbabwe. SCF contributed directly to the reintegration of over 12,000 unaccompanied children and helped make possible the spontaneous reunification of thousands of others between 1988 and 1995.

Francisco G. had always lived in Dzimbene, Bilene District, until the village was attacked in 1986. After his wife had been raped repeatedly she was killed that night along with two of his three sons. Francisco escaped but his youngest son was kidnapped. Francisco and other survivors from the village moved to an isolated area to hide from the dangers of the war. When the cease fire was announced in October 1992, the villagers returned to Dzimbene. However Francisco stayed away from the village until September 1994 when he learned from DTR volunteers that his had been located. He then returned to Dzimbene to rebuild his house and to cultivate his abandoned fields. Francisco explained that he had refused to return earlier because he had considered himself to be a "nguendza", which means in Xangana (the local language) a person who lives alone with no responsibilities and that he had though that it was not right for such a person to live in the village.

It is crucial that family values be respected to avoid conflicts which could cause people to become hostile towards the reintegration program, and more importantly, threaten the success of local initiatives. In carrying out its work, SCF has learned that adults are also greatly affected by the separation from their children. Despite the Mozambique Government's policy of non-institutionalization of children, orphanages and similar centres were forced into accommodating temporarily a large number of children until their family could be located. The centres faced the challenges of caring for children of very different ages. The background of the children varied also widely: some had been separated from their families for less than a month, others for more than 10 years; some had been kidnapped while others became lost during attacks; some had been tortured and others had been forced to kill people, including in some cases their own parents or brothers or sisters.

In many villages, local groups of DTR volunteers have had an important role in the creation of community schools as a response to the lack of access to formal education system. With the help of these groups, the population organized, itself, registered the children who did not attend school, recruited teachers and identified sites for the schools. To complement these efforts, the C&W Project provided school materials and tried to facilitate the formal recognition of these schools by government authorities so that the pupils could be allowed to take official exams and the schools could receive adequate pedagogical support. One of the most serious difficulties faced by SCF was gaining access to the areas of the country that had been most affected by the war. For years SCF had to use small aeroplanes and helicopters to travel to the sites where they registered unaccompanied children and located and reunited families. Although this process was difficult and costly it enabled thousands of children to be reunited with their families. Even after the war, road access remains difficult due to the mine danger.

The process of reuniting families consists of six stages:

- identification of the child separated from his/her family.
- registration of the child's biographical information and the taking of a Polaroid photo.
- searching for members of the child's family through dissemination of information by posters, radio and circulation of the children's information sheets to thousands of DTR collaborators
- once the family has been located, confirmation by the family and the child that they wish to be reunited
- family reunion
- follow-up through home visits and other activities aimed at facilitating the process of reintegration of the child into the family and the community.

SCF worked in close collaboration with over 10,000 community volunteers, who identified and registered unaccompanied children, placed them in substitute families, located the children's families and reunited them.

Nelita S. D. was kidnapped when she was 11. She escaped from captivity where she had been forced to serve as a soldier's wife for a year – between the ages of 13 and 14 – during which time she became pregnant. She was taken in by a family in Manjacaze, and later suffered the still-birth of her child SCF located her parents in Chongoene-XaiXai district. Nelita's family decided that she could only move in with them, after a house purification ceremony was held. This ceremony is normally only held when a family member passes away. During the ceremony, Nelita was visited on many occasions by her parents, and since the reunification both families (biological and substitute) have exchanged regular visits.

Family reunification constitutes an answer to the problems of social, cultural and family identity faced by the children, and it is the start of a complex process of reintegration in the family and the community. According to local practices, the children are submitted to traditional rituals and ceremonies in order to treat emotional problems. Through those ceremonies ancestors are thanked and praised for having protected and enabled the children to return home. The ancestors are also asked to purify and forgive the children for the wrongs committed during their absence, to calm their spirits and purify their families. At the same time, the children are introduced to the leaders of the village who welcome them and promise to help the family. In order to assist children who have been reunited with their families, volunteer groups implement a variety of activities, such as socialization and life skills programmes, which include singing, dancing, traditional games, sports, crafts, story-telling as well as income generating activities and vocational training. Many groups also hold meetings with the reunited families to discuss problems, seek possible solutions and mobilize assistance from the community. Volunteer groups recently support families by providing counselling and helping them to obtain identification documents, medical assistance and schooling. Assistance is also provided in carrying out traditional ceremonies and rituals for the children's reintegration.

C. Chico, B. Efraime, V. Castelo-Branco, AMOSAPU (Mozambican Association of Public Health), Mozambique
presented by Mr. Celestino Chico
"Psycho-Social Rehabilitation of Ex-Child Soldiers and Other War-Victims"

Children, during the war, by force and cohersion, became part of the Renamo Troops, or on the Government Side, were incorporated into militias. Other children were used as slaves or sexually abused. Some were physically assaulted or mutilated. They were also testimony of violence. They suffered the loss of their families.

The AMOSAPU is a Mozambican NGO offering since two years psychotherapy services to 500 children, youth and their families.

Symptoms experienced by war traumatized children:

- loss of confidence in themselves and in others
- poor capacity to project their future
- isolation
- depression
- resignation

- aggressivity
- loss of sensitivity
- regression
- introversion
- diverse and multiple phobias
- loss of adequate conflict and problem resolution mechanisms
- poor tolerance to frustrations
- diverse neurotic and psychotic symptoms
- poor intellectual flexibility
- poor memory capacity
- poor concentration capacity
- poor imagination capacity
- permanent tiredness
- headaches
- vertigo
- sleep disturbance
- gastric pain
- flashbacks
- perturbation of socialization mechanisms, especially in the acceptance of social norms and values
- a range of symptoms difficult to classify and interpret with the classical psychodiagnosis tools, reflecting the cultural psychic elaboration mechanisms developed from the trauma.

They develop preventive work as well as therapies.
They collaborate closely with traditional healers, religious leaders and community workers. The team is composed of a psychiatrist, 2 psychologists, 2 psychotherapists, 2 social assistants.

Their aim is to:

- rebuild children's trust in themselves, in others and in society
- rebuild significance their trauma
- rebuild self-confidence (existence of extreme arrogant or passive attitudes)
- re-establishing self control of their aggressivity (children were aggressed and obliged to perpetuate violence to survive)
- rebuild an identity. Children see themselves as "soldier unit"
- re-establish capacity to project themselves in the future
- rebuild the confidence of the secondary victims: families and communities.

Mabasse, for example, a child soldier, was considered a hero when he saved from death a woman from his village and ran away. Yet, he suffers from nightmares, remembering past atrocities: during his time as a soldier, he had gained admiration and affection from his superiors for his courage and his capacity to accomplish the worst atrocities, while he was only defending himself from his own death fears.

Armanda is 14 years old. Her mother and herself were taken as captives during the war. When Armanda's mother ran away from captivity without telling her daughter, Armanda felt betrayed and abandoned. She also suffered physical mutilation (her ears and fingers were cut off) as retaliation from her captors. She now hates her mother and lives away from the family. Her mother explained that she escaped alone fearing the possibility to be killed and not wanting to put her daughter through the same perils. Her father who was not taken hostage, has become an alcoholic due to his loss of self-esteem for having failed to protect his family during the assault.

THE EXPERIENCE OF LIBERIA

Dr. Nyaquoi Kargbo, Medical Emergency and Relief Cooperative International (MERCI), Liberia

"Medical Response to Mass Migration Movements. The Experience of Liberia"

For the last five years, Liberians have experienced the complete breakdown of their national infrastructures (socio, economic, political, health, etc.), lost their pride and social integrity. They have become helpless and demoralized, and this represents an even more serious long term medical problem than the acute physical illness that can be easily taken care of.

So far, the civil war has left 150,000 dead, created 750,000 refugees in five neighbouring countries, and over 1 million IDPs. But Liberia had also to cope with refugees from Sierra Leone (120,000). Eighty per cent of these are women and children.

The gathering of the populations in shelters poorly provided with water and sanitation, in towns(Monrovia, Buchanan) has seen the development of several epidemics of diarrhoeal diseases, cholera, Yellow Fever. Malnutrition plagues the rural areas without access to relief. Child and maternal mortality have been on the increase. The 20,000 child soldiers will represent a difficult societal problem to handle in the post-war period.

STD and HIV transmission are enhanced by several factors such as prostitution, the migratory movements of populations, the presence of a Multinational-Keeping Force and local sexual practices. It is to be noted that prostitution and child pregnancy were already on the rise before the war. Alcohol and substance abuse have become of concern, as well as the disrespect for humanitarian activities and staff.

At some point, all relief and UN agencies were forced out due to the poor security and when relief workers were present sometimes they were prevented from rescuing the wounded under the threats to be killed by army personnel. The war became so intense that all hospitals had to close down, leaving the population to its own faith.

Response to the emergency

The Liberian Health Committee, a national initiative of doctors, nurses and paramedics, to coordinate health related activities in the absence of the government, was set up in the capital and run many clinics offering curative and preventive services, with the support of relief agencies. When the MOH resumed its activities, all services run by the LHC were handed over. Free health services have also been replaced by a symbolic cost-sharing scheme with the long-term objective to establish a drug revolving fund. Private institutions have played an important role in providing health services especially behind the rebel lines.

Later, the coordination of the relief services came to be placed under the umbrella of the UN, with the collaboration of the MOH and social affairs.

The measles vaccination schedule has been changed from 9 months to 6 months + booster dose at 9 months in order to try to reduce the morbidity Mass vaccination against Yellow Fever has been carried out in the country to prevent the spread of the epidemic.

Special attention is given to the treatment of STD. Emphasis is put on support to women by the Association of Abused Women and Girls.

A programme to train child soldiers useful skills has been created. Psychiatric consultations and counselling are carried out to detraumatize the society.

Preparation for demobilization, repatriation, resettlement and reintegration is under way.

Dr. Nyanquoi Kargbo, Medical Emergency Relief and Cooperative Incorporated – MERCI/Liberia
"Emergency Medical Response to Cholera Outbreak in Monrovia"

Monrovia and its environs has been occupied by a large number of internally displaced persons and refugees. Water and sanitation problems have been major since the inception of the Liberian civil war. Cholera is endemic in Liberia. Over the last 3 years epidemic have occurred every year between June and August. The 1994 outbreak presented a high fatality rate (4,7%) due to unpreparedness. However, it was contained after a well-coordinated effort on the part of the relief community and the Ministry of Health. In 1995, the case fatality was reduced due to conscious preparation for the outbreak. In 1996, the pattern of the epidemic seems different, with early cases. No deaths have been reported so far, due to better case management at the hospital and intervention at the community level.

Response to the emergency:

- definition of referral hospitals and laboratory
- case management training, community health and sanitation team training
- oral rehydratation centres
- community clinics
- stocks preparedness
- transport system
- weekly information meetings
- house-to-house awareness and detection programme
- disinfection and protection materials and activities
- water chlorinating
- public awareness campaign
- shelter hygiene programme
- longer-term proposal to improve the sewage system.

Mrs. Roselind J. Wesley, Health Education Officer, WHO-Liberia
"Community Mobilization and Empowerment for Health: A Liberian Experience"

The intervention which aimed at controlling a diarrhoeal outbreak, had place among a 25,000 refugees and IDPs gathered around a border town. Deaths due to diarrhoea occurred due to the poor sanitation and poverty of the refugee and IDP community, which reduced their access to the "fee for service" health care.

After a preliminary assessment mission by a joint Ministry of Health and Social Welfare and WHO, Community Leaders Mobilization and Training of Health and Sanitation Community Teams were started. Traditional Birth Attendants participated in the training which encouraged the trainees to conduct an assessment of the sanitation conditions. A series of problem-posing visual aids were used to facilitate discussion and the sharing of information on prevention, control and management of diarrhoea. Following this, participants identified their plan of action and recommendations. Toilets in local material, garbage sites and covered toilets holes were built by the Health and Sanitation Teams (H.S.T.). Field visits were conducted to verify if plans were undertaken.

Diarrhoea Surveillance Forms were introduced to the teams and they were taught to analyse the data collected. The exercise enabled H.S.T. to determine the health status of their community and also gave them a direction to pursue. The session was attended by the officer in charge of the town clinic, strengthening the link between the community and the health facility. As a means of promoting sustainability, a soap making income generating activity was supported by the WHO. In addition, a request for funds to begin wood-milling business was approved. The same teams contributed to clearing villages to enable resettlement of IDPs, and assisted victims of floods to resettle

The only constraints were the lack of collaboration among agencies working in the communities

THE EXPERIENCE OF ANGOLA

Mr. Igor Mantsurov, Assessment and Planning Officer for Population
IOM/Angola
"Post-War Populations Movements in Angola"

The difficulty in obtaining reliable and accurate information has plagued humanitarian assistance programming in Angola In such a large country ravaged by war and poverty and lacking sufficient communications or open roads, it has often been impossible to obtain basic data and has made survey impossible. The onset of peace has begun to make information gathering in Angola a little easier but it is still a daunting task. More information that is currently needed cannot yet be obtained due to poor infrastructure throughout the country and the lack of centralized information systems. The difficulty of determining the numbers even for those based right where migrants are, for example, has discouraged quantitative analysis in preference for micro-studies and sociological work.

The United Nations Department for Humanitarian Affairs (DHA), known in Angola by its Portuguese acronym UCHA, is involved in the assessment and planning of population movements. Two reports have already been produced with the help of IOM, in collaboration with the Ministry of Social Affairs, the National Institute of Statistics, UNITA, UNICEF, UNHCR, and other UN agencies and NGOs.

Survey results

The sex ratio of the migrants is 105 (number of men corresponding to 100 women). Fifty per cent of the total number of refugees outside Angola and internally displaced persons are under the age of 14 years. The national average age is 22 years. This information is useful to define future requirements of infrastructures such as schools, teaching personnel, as well as school supplies. About 30% of possible new comers to the areas of origin are above 20 years old. This represents 400,000 person as potential labour force. This must be taken into consideration when planning for economic and social development in the areas of resettlement. Most respondents are identified as belonging to the occupational group of farmers. The second most numerous group is that of workers . This group includes carpenters, mechanics, metalworkers, plumbers, etc.. Most people who qualify for transport assistance are in good health. When discussing the influence of migration on population distribution, it is necessary to consider three different factors: (1) returned refugees, (2) intra-interprovincial movements of resettlement of internally displaced persons, and (3) future movements of demobilized soldiers

Obviously, intra and interprovincial movement does not influence the national migration balance, but it can play a significant role at provincial level. For example, in Bengo, Kwanza Norte and Moxico the percentage of IDPs in relation to the total estimated provincial population is 26.5, 20.1; 17.4, respectively. Similarly, the majority of external refugees will return to the specific areas of origin in Moxico, Luanda Sul, Uige, and Zaire provinces. As a result, the influence of incoming returnees will contribute about 80% of total provincial population evolution, while the natural growth will contribute the remainder.

Conclusions

Despite its limitations the reports provide population data and an analytical framework that will help to define parameters for relief and initial rehabilitation requirements in a transitional approach during 1996. To that effect, the Inter-Agency Appeal 1995 is being revised and will be extended to and updated for 1996. Three programmes will be presented to donors all under the general theme of a "Complex Transition" to peace and development. The low level of confidence between the Government and UNITA, an anaemic economy, the reduced circulation of goods and people because of mines and limitations imposed by the two parties , the serious devaluation of the local currency and the serious disruption of the civilian society contribute to the complexity of the transition to reconstruction and development.

All three programmes are shaped to deal with empowerment of communities to resume production with a view to reach self-sufficiency and to establish the conditions of access to basic services. Schemes of projects are developed to target the IDPs, refugees, war-affected, demobilized soldiers (with priority attention to disabled and underage soldiers) and their respective families. An effort is made to mobilize organizations on the principles of co-operation and complementarity with an emphasis on the capacity-building of government institutions.

Prof. Josenando Theófilo, National Director, Programme of Trypanosomiasis Control, Ministry of Health, Angola
"War-Related Trypanosomiasis Recrudescence in Angola"

Through good coverage and appropriate control measures Angola had succeeded to reduce the number of cases of human trypanosomiasis from 2,500 in 1949 to 3 cases in 1974. The complete destructation of the nation and the health system due to the war has had as consequences the recrudescence of human trypanosomiasis. Refugees and military migration movements have spread the disease through the country. It is estimated that one third of the Angolan population is at risk for human trypanosomiasis. Private institutions are allowed to treat patients with the sleeping disease under the Ministry of Health coordination.

OTHER EXPERIENCES: RWANDA, BRAZIL

Dr. Godfrey Sikipa, Regional Director for Africa, AIDSCAP/Family Health International – Nairobi
"Health Interventions Among Refugee or Displaced Populations: The Experience of Family Health International"

FHI is a non-profit , private, voluntary organization founded in 1971. FHI's commitment is to assist people throughout the world to have safe acceptable and affordable family planning methods to help them achieve their desired number and spacing of children; to prevent the spread of HIV and other STD and to help improve the health of women and children. FHI tries to link the intervention to the basic needs of the refugees and make the refugees the possessor of the intervention.

FHI has projects with migrants throughout Africa, from truck drivers in Senegal, to miners in Southern Africa, and Military in Ethiopia and many others. FHI has worked with UNFPA, UNHCR, and many other partners in the drafting of the Reproductive Health Manual in Refugee Situations.

The Benaco Rwandan refugees camp in Tanzania resulted from the rapid and massive migration of populations fleeing the violent events triggered by the shooting down of the plane carrying the Presidents of Rwanda and Burundi. Before the disaster in Rwanda, Aids was a major health problem as sentinel site surveillance at prenatal clinics in 1992 showed a HIV seroprevalence of between 0.51 and 4.1% in eight rural communities and 19-35.7% in four urban sites. In the refugee camps, it soon became apparent that HIV infection and Aids remained a major threat to the population and that actions needed to be taken to limit and control the spread. No Aids prevention project had ever been carried out at a very early stage of the settlement of refugees. The Benaco started four months after the arrival of the refugees. First, an assessment was carried out to determine the direction of the project. Consultations were held with community leaders on the desirability of the project, their possible role in it and the general organization of the camp. Focus group discussions were held with various groups in the camps, community leaders, women, men in different groups to explore issues of sexuality and Aids prevention.

The following observations were made during the consultations:

- Attitudes related to sexual practices were largely determined by feelings of shame.
- Sexual activity had increased dramatically among the youth.
- Teenage pregnancies were expected to increase due to the increase in sexual activities and lack of contraceptives, despite the fact that teen pregnancy was regarded as a big shame.
- Married women and men living in the camps claimed that their sexual activity had decreased due to the hardship and struggle for existence. Men with more financial resources were suspected to have become more sexually active.
- People had conflicting sentiments on reproductive intentions. Some argued that the population had to make up for the lost lives, while others said that camp conditions were extremely difficult and dangerous for child-bearing women. Men and women said that family planning services should be established soon.

- Marriages occurred frequently in the camps and some people said that some of those unions were forced because of the need for procreation or the need for security and protection.
- Commercial sex was not common in the camp but could easily be seen outside the camp in the neighbouring village.

STD/HIV/AIDS Control Intervention at Benaco camp

The objective of the condom distribution efforts was to improve access to condoms. At baseline the accessibility was 52% and 43% respectively for men and women. One year later 95% of sexual active men and 85% of sexually active women reported having access to condoms. To increase knowledge of Aids prevention and achieve lasting behavioural change, special learning materials were used, women and men peer educators and outreach workers were trained. Individual education and intense counselling were performed in the camps

There were no significant changes in AIDS/STD prevention knowledge this probably due to the already high base line knowledge levels. Statistically significant effects could be discerned on the knowledge of sources of condoms and there were a substantial reductions in the number of respondents who had scientifically incorrect knowledge on HIV transmission. No significant changes were observed in "ever use " of condoms, which remained low at 37% for men and 17% for women.

Women reported condom use at a significantly high rate however from 5% to 17% after one year of intervention. Women were also more sexually active (87%) and had more often multiple partners during the previous two months(70%) as compared to baseline. Men were also more sexually active in the previous two months (70%) as compared to baseline and the proportion of men who had multiple partners over the most recent two months doubled from 12% to 23%.

There might be multiple ways to interpret the results in the area of sexual behaviour. First, the refugee environment changed rapidly over the first year of intervention. New patterns of dependency and distribution of wealth occurred especially during period in which food distribution was insufficient for some groups. This may have lead to changed sexual behaviour. Secondly, sexual behaviours may have been reduced in frequency during the early part of the intervention which was shortly after the population suffered traumatic experiences before and while fleeing Rwanda and during the initial phases of settling into the refugee camps.

Conclusions

Sexual activity and attendant results continue in migrant population in varying degrees given the high density of the population, lack of employment, boredom, and material needs of the population.

The spread of STD/HIV in migrant population may be a major problem especially among women given the need for security and social stability in the context of settlement. Intervention to limit the spread of STD/HIV should be done through consultation as this will enhance the participation of the target population. Intervention to control and spread of STD/HIV is acceptable to migrants or refugees population even if it is implemented soon after the population arrive at their new settlement

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"HIV Infection and AIDS in Brazil"

Objective: to determine the relationship between migration HIV infection among commercial sex workers and their clients in 3 large urban areas in Sao Paulo state, Brazil.

Methodology: from October 1990 until June 1991, the State Department of Health in Sao Paulo in conjunction with the University of California, San Francisco, conducted an epidemiological study of HIV1 among 600 commercial sex workers in 3 large urban areas, Campinas, São Paulo, and Santos. A standard questionnaire was applied and blood samples were collected after consent.

Results

A total of 65% CSWs were from other region of the country and referred that frequently visit their families and maintain their activities even away from their working site. Fifty-nine per cent of CSW referred having clients from other states in the last month. Fifty-two per cent referred having sex with foreign clients in the last five years (Philippines, Japan, USA, Germany). Sex workers with a higher socio-economic status were more likely to have had a foreign client in the previous five years.

The overall prevalence of HIV1 infection among CSWs was 11% and 45% for Syphilis and 39% for Hepatitis B.

Conclusion

Migration should be addressed in HIV/STD studies and interventions.