Reproductive Health for Refugees Consortium
Assessment of Reproductive Health for IDPs
Angola
February 15-28, 2001

IDPs in Kuito, Bie waiting for health services, Februrary 2001

IDP youth in Luena, Moxico, February 2001

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Acronym List

AIDS	Acquired Immune Deficiency Syndrome
CCF	Christian Children's Fund
DRC	Democratic Republic of the Congo
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IMC	International Medical Corps
MINARS	Ministry for Social Assistance and Reinsertion
MINFAMU	Ministry of Family and the Promotion of Women
MOH	Ministry of Health
MPLA	Movement for the Popular Liberation of Angola
MSF	Medecins Sans Frontières (Doctors Without Borders)
MSI	Marie Stopes International
NGO	Non-Governmental Organization
OCHA	UN Office for the Coordination of Humanitarian Affairs
RH	Reproductive Health
SGBV	Sexual and Gender-Based Violence
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNITA	National Union for the Total Independence of Angola
WHO	World Health Organization

MAP OF ANGOLA

Reproductive Health for Refugees Consortium

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An assessment was conducted of reproductive health among internally displaced persons (IDPs) in Angola from February 15-28, 2001 by Columbia University, JSI Research and Training Institute and the Women's Commission for Refugee Women and Children on behalf of the Reproductive Health for Refugees Consortium (RHRC).[1]

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The assessment team visited IDP camps in Bie, Malanje, Moxico, and Huambo provinces as well as Viana IDP camp on the outskirts of Luanda.

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Background

"Life is difficult. We are in our own country, but in the territory of others and dependent of the charity of outsiders." – UNFPA video *Nkulimbwa - The Forgotten*

[1] Reproductive Health for Refugees Consortium members: American Refugee Committee, CARE International, Columbia University's Heilbrunn Center for Population and Family Health, International Rescue Committee, JSI Research and Training Institute, Marie Stopes International, and Women's Commission for Refugee Women and Children. Website: www.rhrc.org.

Angola is located in southwestern Africa; it borders Namibia, Zambia, Democratic Republic of Congo and Congo-Brazzaville. Angola gained its independence from Portugal in 1975, and has been embroiled in armed conflict ever since, resulting in the dislocation of a large proportion of the population. The U.S. Committee for Refugees estimated that approximately 340,000 Angolans were refugees in neighboring countries at the end of 1999.[2] Many more have become internally displaced within the country's borders. The number of IDPs is now estimated to be between 3.8 and 4 million, or approximately one third the total population of 12.6 million.[3]

Angola has a wealth of natural resources, including oil and diamonds. The United States imports approximately 8% of its oil from Angola – this is more than it imports from Kuwait.[4] Unfortunately, those resources are fueling the war rather than benefiting the Angolan population.

Currently, the two major parties involved in the conflict are the Angolan Government/Movement for the Popular Liberation of Angola (MPLA) Party and the National Union for the Total Independence of Angola (UNITA). Technically the government controls all of the provincial capitals and 80% of the municipalities. UNITA, however, is still very active throughout the country, particularly in areas that are not dominated by the government. In general, the ongoing conflict between the two factions causes constant and often volatile insecurity. This has added to the logistical challenges of humanitarian assistance.

Landmine survivor in IDP camp in Malanje province, Feb. 2001

One of the horrific consequences of the war is the huge number of landmines planted throughout Angola. Angola is estimated to have more landmines than any country in the world - every kind imaginable, including those placed above ground that are painted in bright colors to entice children to play with them. The devastating effect of landmines in Angola cannot be stressed strongly enough. It is estimated that one in 400 Angolans has suffered a landmine accident.[5] Landmines blanket the countryside making it impossible in many regions for people to cultivate food or raise livestock. This has created a dependency on the World Food Program (WFP) for food deliveries by air.

The Angolan Ministry for Social Assistance and Reinsertion (MINARS) is the government agency responsible for the IDPs in Angola. MINARS works closely with other government branches, as well as with the UN Office for the Coordination of Humanitarian Affairs (OCHA), other UN agencies and international NGOs. The UN agencies and international NGOs provide financial and

[2] United States Committee for Refugees, *World Refugee Survey 2000*, December 1999.
[3] 3.8 million is the estimate of the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), and 4 million is the estimate of the Angolan government.
[4] *New Yorker*, August 14, 2000.
[5] UNDP, http://www.undp.org/erd/devinitiatives/mineaction/angola/report.htm.

technical support to many of the government services. During our visit, many spoke of an increasing donor fatigue in Angola and a real concern about who would fill in the gaps if these agencies leave.

General Health Services/Conditions

UNICEF considers Angola to be "the worst place in the world to be a child," based on the extremely high rates of morbidity and mortality among children under the age of five.[6]

The Angolan government spends less than 2% of its national budget on healthcare, and after years of neglect, the health system is in shambles. The government has committed to increasing its health budget from 2% to 5.5% but the increase has yet to take effect and while a sign of progress, does not come close to meeting the country's actual need for health services. The system includes basic levels of care and services. A health post offers primary care services, a health center has more advanced care, and hospitals are where people are referred for specialized care and surgery. During our visit, healthcare facilities at all levels were inadequately staffed and lacked basic equipment and supplies.

Malanje hospital maternity, February 2001

Due to the war, many people have not been able to complete their education, and trained medical health personnel are in short supply. Many doctors have left the country, and others have relocated to the capital Luanda in order to make more money in private practice. As a result, provincial hospitals have a very difficult time hiring and retaining doctors. In one hospital we visited, an Angolan doctor had just been hired, but before his arrival, there had been no doctor in the entire province. In another hospital, the only doctors were expatriate doctors employed by an NGO. There are also shortages of trained midwives and other health personnel. During our visit, many NGOs cited the lack of trained and qualified health staff as a barrier to implementation of quality services.

The shortage of medical equipment and supplies is also a severe problem. Health care workers at every healthcare facility we visited complained of drug stock-outs and lack of equipment. The facilities that had any medicines or equipment were being sponsored or supported by NGOs and were not relying on the government health system for procurement.

[6] *The Economist*, **January 11, 2001. Web-link**: http://www.msf.org/projects/africa/angola/reports/2001/01/economist/index.htm

In theory, health care should be accessible and affordable for all Angolans, but the reality is quite different. Because government staff are so underpaid, many government health workers do not come to work or try to charge fees for their services. NGOs are only able to work in stable and secure areas, so there are large parts of the country where people are dependent on the government or UNITA for services that may or may not be available. Almost all health facilities in the four provincial capitals that we visited are supported or run exclusively by international NGOs. A major concern of the NGOs and some of the health providers is what will happen if these NGOs pull out of Angola.

Reproductive Health

Angola falls under the category of a chronic emergency, yet even the most basic minimum standards for reproductive health (RH) services are not being met. Even the many NGOs and UN agencies that signed on to the Inter-Agency Field Manual for Reproductive Health in Emergency Situations[7] are not coming close to meeting the minimum standards they committed to by signing on to this document. This is due not so much to a lack of interest or concern, but a lack of resources. And in some cases this is due to the pervading attitude of international health agencies that reproductive health services fall outside of emergency life saving interventions.

Although comprehensive reproductive health services are virtually non-existent, there are efforts to increase services in some locations. UNFPA is supporting the national reproductive health program in four provinces, and NGOs augment the government services in certain provinces. The government is also launching a national AIDS campaign. However, a representative from the Ministry of Health with whom we met is aware that many Angolans, including IDPs, do not have access to the most basic of reproductive health services, including antenatal care and contraceptives. Many provinces do not even have adequate emergency obstetric services, or people live too far away from the only existing services. In many areas, there is a great distance between communities and health facilities.

Although the needs are great in both the IDP and local communities, we were told that IDPs did have special needs and considerations. In the four provinces that we visited, health workers said that awareness of reproductive health issues is lower among IDPs than in the local communities. We were also told that IDPs often wait too long to access services. The reasons for this are unclear. We did hear complaints that IDPs were not treated well at certain health facilities, and that they lack faith in the health system. We also heard that some health workers demand payment from patients as a way to supplement meager salaries, and that IDPs are less likely to be able to pay for the services. At some hospital maternities we visited, the IDPs were sleeping on the floor because they did not have sheets to put on the mattresses.

[7] WHO, UNFPA, UNHCR. *Reproductive Health in Refugee Situations – An Inter-Agency Field Manual*, 1999.

Refugees International (RI) conducted an assessment of UNHCR's response to IDPs in Angola in April 2001. Although RI found that UNHCR had made great progress in service provision to the IDPs, one key recommendation to UNHCR was specifically "… to establish reproductive health, family planning and HIV/AIDS prevention programs…" for IDPs in Angola.[8]

Specific findings from each of the provinces we visited will be discussed in more detail below, but the following are some general findings and observations that were applicable to each setting. Please note that this assessment was limited to Luanda and four provincial capitals and only 30% of the country is accessible. Health conditions in the more rural and inaccessible areas of Angola are believed to be much worse.

Safe Motherhood

Angola has one of the highest maternal mortality ratios in the world, estimated at 1,500 per 100,000 compared to bordering Namibia at 370 per 100,000 and Canada at 5 per 100,000.[9] This should not be surprising, since fertility rates are high, use of family planning is low, ante-natal care is not widely available, and many women do not have access to emergency obstetric services. UNFPA-Angola produced a report in June 1999 titled *The Demographic Profile and the Reproductive Health of the IDPs.* The findings of this report are based on interviews with 1,422 IDPs in Huila, Benguela, Malanje and Zaire provinces.[10] This study reports that the average number of children per woman interviewed was 8.6. The infant mortality rate is 125 per 1,000 in Angola, whereas in Canada, for instance, it is 5.5 per 1,000.[11]

IDP woman in Luena maternity, Moxico Province, February 2001

Ante-natal care is offered in some health posts and health centers, but we were told that many women do not go for pre-natal care. This could be due to a lack of awareness of its importance, or because it was not widely available or accessible to many women. The majority of women deliver at home, and some NGOs are training traditional birth attendants (TBAs) to identify potential risks and refer women to the maternity center or hospital. However, many women in Angola do not have access to emergency obstetric services and this certainly contributes to the

[8] Refugees International, Angola: UNHCR Succeeds in Helping Internally Displaced, April 2001. Web-link: http://www.refintl.org/bulletins/ag_042501_01.htm

[9] WHO and UNICEF. *Revised 1990 Estimates of Maternal Mortality: A New Approach by WHO and UNICEF*, April 1996.

[10] The findings of this report were presented at the *Reproductive Health for Refugees Consortium's Conference 2000 – Findings on Reproductive Health of Refugees and Displaced Populations*, December 2000. The presentation abstract is available on-line at: http://www.rhrc.org/conference/index.htm.

[11] This figure is taken from the 2000 World Population Data Sheet of the Population Reference Bureau.

extremely high national maternal mortality ratio. We were told that those with delivery or post-partum complications usually arrive at the hospital too late to be saved.

Because many IDP women do not live near a provincial hospital, transportation is a huge problem. In Kuito, we were told that the roads leading to the provincial capital have only been opened since March (due to security issues), and that IDPs have had no real access to health services, including emergency obstetric services. Even when roads are opened, they are generally poorly maintained and dangerous. Bridges are often dilapidated or destroyed. There is also the risk of robbery, harassment and violence when traveling by road. There are few private vehicles and no public transportation system. Informal transportation systems are unreliable or nonexistent.

Unsafe abortion may also contribute to the high maternal mortality and morbidity in Angola. According to the UNFPA study, 19% of the women respondents said that they knew of women who had aborted unwanted pregnancies.

The majority of IDP deliveries are at home with a TBA. "Home" for an IDP may be a tent shared with another family or a straw hut with a dirt floor and some deliveries take place under a tree or in a classroom or some other structure within the camp. We heard consistently that women go too late to the hospital when obstetric complications arise – a sign of very low awareness/education of women and poorly trained TBAs. Hospitals generally have very limited equipment, few trained staff and poor sanitary conditions that lead to high rates of life-threatening postpartum infections. Some IDP women in the hospital maternities must sleep on the floor because they have no sheets to put on the mattresses and they often go without food because there are no family members to bring them meals. We were told by health facility and hospital staff that many IDP women are so malnourished they cannot breastfeed. These women may, however, just need better education and support for breastfeeding.

Family Planning

The same UNFPA study showed that 81% of the women interviewed had no knowledge of any method to prevent pregnancy, and only 2.2% of the women were using a contraceptive method. During our visit, each facility that offered family planning complained of frequent stock-outs of contraceptives. The Angolan Ministry of Public Health, with the assistance of UNFPA, is supplying the country with contraceptives. However, lack of resources and the difficulty of transporting supplies to many of the provinces are barriers to consistent and reliable stocks. Supplies are also stolen for private use or resale in the market.

Depo Provera is the most favored form of contraceptive but there were stock-outs of Depo in every facility we visited. We were told that when the rare shipment of Depo arrives, word spreads fast and the supply is expended almost immediately. During our visit, one of the few health facilities that actually had contraceptives available was a facility supported by Medecins sans Frontieres (MSF). MSF obtained the contraceptives on their own, so they are not dependent on the government/UNFPA supply. But all contraceptives have to be imported which raises costs considerably.

Agencies face logistical challenges in distribution and the obstacle of corruption when clearing supplies through customs.

Numerous barriers to family planning access exist. Often family planning services are only available in the provincial capital, which again makes access difficult. Family planning counseling may be offered in a health post or health center, but then a woman may have to go elsewhere to actually obtain the contraceptives.

Lack of awareness is also a barrier to family planning services. While 81% of the IDP women interviewed in the UNFPA study had no knowledge of any method to prevent a pregnancy, 32.8% of the women also said that they were interested to know a way to prevent pregnancy. This information demonstrates a significant need for education and awareness building.

STDs/HIV/AIDS

Lack of supplies and essential drugs prohibits the provision of quality HIV prevention and sexually transmitted disease (STD) services. STDs are believed to be extremely common in Angola and yet not a single health facility that we visited had a supply of STD drugs. Diagnoses are based on symptoms and/or physical examinations only. Persons with STDs must go to the market or a private pharmacy for drugs, and it can be quite expensive. We were also told that people rely on traditional methods of treatment that can be dangerous, causing miscarriage and/or infertility. UNFPA staff commented that because STDs are so common, some people consider what are obvious symptoms of an STD to be normal bodily functions that they cope with rather than seek treatment.

The percentage of Angolans with HIV/AIDS between the ages of 15-45 is estimated to be 2.1%.[12] Due to the lack of testing and difficulty in gathering statistics, however, the reality is assumed to be higher and rising swiftly. Considering that HIV/AIDS is now the leading cause of death in Africa and that Zambia, bordering Angola to the east, has one of the highest known prevalence rates in Africa, there is potential here for an HIV explosion, if it has not already happened.

Voluntary counseling and testing for HIV is non-existent outside of Luanda. Blood for transfusions at the provincial hospitals is tested for HIV, but hospital staff complained of a shortage of HIV test kits. One expatriate doctor expressed concern at the increase in HIV she is seeing at a provincial hospital among the blood tested for transfusions. NGOs and the Angolan government are initiating HIV prevention activities and information campaigns, but condoms are not always available.

Sexual and Gender-Based Violence

> *"There are men that batter. They really pound you. Men, when they beat women, it's as if they were pounding corn to make flour."*
>
> - Young woman in Lobito, UNFPA video Nkulimbwa ("The Forgotten")

[12] This figure is taken from the 2000 World Population Data Sheet of the Population Reference Bureau.

According to the UNFPA study, 69% of the women interviewed had experienced violence from their husband or partner, 21% of the interviewees knew of women forced to have sex against their will, and 12% of IDP respondents knew of men forced to have sex against their will. We were consistently told that cases of SGBV skyrocket whenever there is an influx of the military or close proximity of IDPs to a military base.

Angola does not have any specific laws protecting women from physical or sexual violence. Greater attention is now being paid to this issue, however, with the creation three years ago of the Ministry of Family and the Promotion of Women (MINFAMU). Data from MINFAMU and the Angolan Women's Association (OMA) show that between 1997 and 1999, of the 3,550 reported cases of violence against women in Luanda 60% were domestic violence and 30% were attributed to sexual violence by a stranger or acquaintance. While these statistics are not specific to the IDP population, they do indicate that violence is a significant problem in general.

Reproductive Health & Adolescents

We did not find any programs designed to address the specific RH needs of the IDP youth in the provinces. In Luanda, however, the local International Planned Parenthood Federation affiliate Angobefa serves a young clientele and does outreach to youth in the schools. The limited services available to the IDPs are not "youth-friendly." Considering the very low quality and availability of services overall, youth-focused programming is considered to be an unaffordable luxury. There did not seem to be a very strong stigma attached to premarital sex but we were told that there is still an embarrassment associated with reproductive health services that discourages youth from accessing services in the youth centers where they are likely to see family members or neighbors.

IDP children, Luena, Moxico, February 2001

- *Safe Motherhood* - There is, as in most every part of the world, a very strong preference for boy babies. In this setting the preference is due in part to the forcible recruitment of young boys into the military (both UNITA and MPLA). Once recruited and taken away from their families, it is very unlikely they will be seen or heard from again. This added preference for boys, contributes to the already low status of girls. We saw many very young mothers in the maternities having their 3rd or 4th child.

- *Family Planning* - Unsafe abortion is said to be more common among young girls and particularly in and around Luanda.

- *STDs/HIV* – Youth tend to self-diagnose and treat without even visiting a health facility. Some rely on traditional treatments that can cause serious complications.

- *SGBV* – Health staff said that reported cases of SGBV tend only to involve very young girls (7-12 years old) but rape and domestic violence are considered to be common.

According to the Christian Children's Fund (CCF), Angola's children are especially vulnerable to psychological stress from exposure to ongoing violent conflict. CCF estimates that 82% of children in IDP camps have come under fire, more than 66% say they have seen people killed or tortured and 24% have lost a limb.[13] Therefore, psychological trauma is a significant issue among IDP youth (and surely IDPs of all ages) and one requiring much greater attention.

Kuito, Bie

Building in Kuito, Bie, February 2001

Kuito is the provincial capital of Bie. Bie province is located in the center of Angola and southeast of the capital Luanda. Kuito is considered to have suffered the most severe damage from conflicts of the civil war, particularly during an assault in 1998 during which the town was almost completely demolished. The physical devastation is still visibly evident as very few structures have been reconstructed and those few that have are housing international aid agencies or government officials. Kuito's population has almost tripled from 200,000 before 1998 to over 500,000 due to the influx of IDPs from the countryside where conditions are worse. There are approximately 20 IDP camps in and around Kuito. On the day of our visit almost 150 new arrivals came to Chissindo camps after having walked for four days from their village. The new arrivals looked ill (e.g., skin rashes, open sores), weak and were barely clothed.

There are health posts in 9 of the 20 camps. The health posts provide only the most basic RH services such as prenatal check ups. Most RH needs must be referred to the provincial hospital. In 1998 this hospital was destroyed. The hospital is already at 105%

[13] United Nations Foundation, UN Wire, April 20, 2001, http://www.unfoundation.org/unwire/archives/UNWIRE010420.cfm#7

capacity so MSF has monitoring as their main focus to avoid an epidemic such as cholera or tuberculosis.

Safe Motherhood
Malaria is one of the most common problems for pregnant women here, leading to miscarriage and death. Some of the most common illnesses among IDP babies are malaria, respiratory disease and diarrhea. The one maternity in the provincial hospital is not enough to serve the entire population within Kuito, much less the entire province. The maternity is in need of equipment, supplies and trained personnel. The maternity is from 1 to 7 kilometers from any given camp. There is only one ambulance at the hospital and this does not meet the needs of the population. The surgeon doing cesareans at the hospital is from MSF.

In relation to reproductive health, MSF works mainly out of the hospital maternity ward and also trains nurses and TBAs to recognize obstetric complications and make timely referrals to the hospital. MSF staff said the second highest reason for admission to the hospital is maternity-related. MSF wants to invest more on prenatal consultations. MSF has a surgeon in the hospital who does cesareans, amputations and trains other to do so. Nutrition is considered to be an emergency situation. MSF staff described the most common ailment of IDP babies as malnutrition and its effects. MSF works in 2 of the 20 camps, but mainly supports the hospital and monitors the overall health status of the population. MSF's camp program is mainly monitoring the crude mortality rates for under fives.

Of the 11 women in the post-partum rooms of the hospital maternity, 3 were IDPs. One of these IDP women had just had her eighth baby.

Family Planning
An MSF nurse midwife told the assessment team that family planning is not very accessible to the poorest people. The MSF staff was not sure why more women do not access services, but said it was probably due to lack of education and information. There are only two health centers that provide family planning services in all of Bie province. The midwife also said that some women rely on traditional methods that may or may not be very reliable.

STDs/HIV/AIDS
There is a Ministry of Health (MOH)-supported HIV program in Bie province but due to shortage of supplies the main activities are awareness raising among the military and civilians. This program includes the distribution of condoms and t-shirts. The program would benefit from bicycles to help with outreach to the IDP camps farther outside of town. HIV tests are only done at the hospital and only on blood for transfusions.

SGBV
MSF staff would like to have a supply of emergency contraception for cases of rape. MSF has a nurse working in the camps and she is going to do a survey to determine what agency, if any, is distributing emergency contraception. If none are, then MSF will

start. First they would have to be sure there are trained staff to administer the emergency contraception and provide the appropriate follow-up care. Rape perpetrators are mainly military who came to the area in 1998 and stayed. There is great stigma attached to victims of SGBV. Domestic violence is said to be commonplace, but as outsiders it was difficult for the assessment team to engage in candid discussions on this topic.

Malanje, Malanje

Malanje, the capital of Malanje province, is some 450 kilometers east of Luanda. Compared to Bie, there did not appear to have been very much structural damage from artillery but there have been intermittent reports of bombings. During this visit there were masses of military personnel coming into town in trucks and the hotel where we stayed was crowded with high-ranking military officials. The military influx was rumored to be in preparation for a strategic assault against near-by UNITA rebels.

The assessment team visited Kulaxito camp about 18 kilometers outside of Malanje center. This camp was established in August 2000 and now has few new arrivals, but camps further outside of the town are receiving new arrivals.

Safe Motherhood

The assessment team met with one of two trained (the others had not been trained) traditional birth attendants (TBA) in Kulaxito camp. Both TBA's were trained by International Medical Corps (IMC). Most IDP women, as in the other provinces, prefer to deliver in the camp with the assistance of a midwife/TBA. In this camp delivering at home may also be due to distance and the lack of transportation to the Malanje central hospital.

At the Malanje central hospital the assessment team visited the maternity ward. The ministry of health coordinates this hospital and UNFPA assists in the implementation of an emergency reproductive health project financed by OCHA that includes training of hospital staff in emergency obstetrics techniques. The visit was during the night and only parts of the maternity were lit with electricity while most rooms had only kerosene lamps for lighting. The hospital doctor facilitating our tour said he estimates 95% of women deliver at home. One common reason women come to the maternity is due to a retained placenta. The doctor told us that the maternal mortality ratio for the hospital last year was 4,000 per 100,000 live births. This ratio is staggeringly high and we were unable to confirm it with actual hospital records. He said that most women who die during or after childbirth at the hospital do so because they came far too late after complications arose.

The main differences the maternity staff see between IDPs and the local populations' maternal complications are that IDPs tend not to attend pre-natal check-ups, suffer more frequently from malnutrition, tuberculosis, parasites, malaria and an overall poor state of health before, during and after pregnancy.

Family Planning
The hospital maternity appeared to be the only place to receive contraceptive counseling and supplies, although we were not able to actually see the supplies.

SGBV
Cases of rape are said to rise dramatically whenever there is an influx of the military.

Luena, Moxico

Luena is the provincial capital of Moxico in the southeast of Angola bordering the Democratic Republic of the Congo and Zambia. Luena is considered to be one of the most isolated provincial capitals in Angola due to the heavy military presence in this province and complete lack of road access. Other than the small amount of food that can be cultivated in gardens and small fields within Luena, all food and supplies must be flown in, making everyone in the province extremely dependent upon the World Food Program flights' food deliveries. This makes Luena, despite its rural and simple environment, a very expensive place to live and visit.

Safe Motherhood
The assessment team visited the central maternity. This maternity is separate from the hospital. It is a beautiful new building, freshly painted, very clean, airy and with many windows that provide ample natural light. Despite the outwardly impressive appearance of the maternity, we found that there was a serious need for supplies, staff and staff training.

All maternity patients are expected to provide their own sheets in order to have one of the beds/cots and food must be provided to patients by family members. This means that IDP women, whether pre- or post-partum, may lie on the floor and may go without food during their stay at the maternity. Maternity staff said the IDP women with delivery complications often arrive too late at the maternity for help. This is due to the lack of trained TBAs to recognize complications in time, as well as a lack of reliable transportation that may delay their arrival.

J is 17-year-old internally displaced Angolan who has just had her second baby. She came from the IDP camp where she resides to the hospital in the provincial capital of Luena after what appeared to be obstructed labor. She had to travel 7 kilometers to the hospital. Upon arrival at the hospital maternity she was assisted by the nurses to safely deliver a baby girl. When the baby did not take easily to breastfeeding the nurses told J that she was likely too malnourished to provide her baby with breastmilk, despite the fact that it is only in acute cases of malnutrition that breastfeeding is not possible and J appeared to be only mildly malnourished. The nurses then began to feed the newborn baby a pablum of millet flour and sugar water. Although the baby was born 6 weeks ago, she appears to be only a day or two old by her very small size. She is lathargic and unresponsive to her mother's continued attempts to breastfeed. J is lucky to have a bed as other IDP women are forced to stay on the floor while in labor and post-partum because they often do not have sheets to put on any of the available mattresses. Because meals are not served in the maternity, many IDP women must go without food because they have no family and friends able to the visit them from the IDP camps.

Maternity staff said that their greatest need is for even the most basic equipment such as stethoscopes, speculums and forceps. Due to the lack of equipment and qualified doctors, there is no surgery at the maternity so women must be referred to the hospital for cesarean sections. The assessment team toured the surgery facilities at the central hospital. Here, too, supplies and equipment were very much lacking. Hospital staff are unable to properly sterilize surgical instruments which leads to high rates of post-partum infections. The hospital doctor reported that just the week before a woman had died as a result of such an infection and we saw an IDP woman in the recovery room with a post-cesarean infection whose baby was still born. MSF used to have a doctor posted at this hospital but removed the doctor because it was determined that the supplies and equipment were not adequate to perform safe surgeries.

The hospital has no refrigerator to store blood so can only call upon donors when blood is immediately needed for transfusions.

33% of the population of Luena is internally displaced but only 10% of hospital patients are IDPs. This suggests that IDPs have little faith in the services provided and the treatment they will receive. Many IDPs, having come from very rural areas, are unaccustomed to accessing health services and think of a hospital as a place where people go to die, rather than to be healed.

IDP girl with malnourished baby, Luena maternity, Moxico Province February 2001

MSF has a safe motherhood program in Luena but it is limited to prenatal care and vaccinations for children and infants. The MSF safe motherhood program does not include family planning (e.g., to support birth spacing). The MSF representative in Luena explained:

> *"Family planning, is always nice if someone can do it, but it won't be us."*

Family Planning

At the maternity the assessment team visited the family planning consultation room. This is the only family planning center for the entire province but family planning services are also sometimes provided in two camp health posts and one general health facility as well. The consultation room consisted of an examination table, a stack of posters communicating messages regarding use of condoms and prevention of HIV, and a metal tray – nothing else. When asked to see the contraceptive supplies we were shown to a room down the hall. They had stock outs of Depo Provera (as in every other health facility we visited) but did have supplies of pills, IUDs and male and female condoms.

Maternity staff said that women much prefer Depo to any other method, though, so they wait until supplies of Depo arrive rather than using other methods during Depo stock-outs. This visit took place during the week and the family planning center was empty of clients. Maternity staff said that the vast majority of the clients they do have are local women, not IDPs.

A ministry of health representative said she had conducted an awareness raising campaign for the female condom in Luena in August 2000. The maternity staff were trained as trainers in how to use the female condom and expected to train others in the community and inform people to go to the maternity to obtain the condoms. The trained staff did not keep records of the condoms distributed and the program was not evaluated to determine how effective the training had been.

During this MOH training the maternity was also supplied with emergency contraception but all these supplies were gone. The maternity staff said that the emergency contraception was mainly used by local women who had had unplanned sex (perhaps women married to military men who have boyfriends when their husbands are away), rather than for cases of rape.

IMC will be starting a family planning project for IDPs and the local community.

STDs/HIV/AIDS

There are no STD drugs available in any of the camp health posts. Patients must get a prescription and go to a pharmacy in town, the cost of which is prohibitive for most IDPs. Even the hospital lab is unequipped to test for STDs and HIV and there are no STD drugs at the hospital, even for syphilis. The hospital can only guess at STD diagnoses by observation and symptoms and then treatment must be bought at the pharmacy or in the market.

The hospital doctor believes that the rate of STDs is high and that HIV is steadily climbing. He believes the spread is due to the forced movement of so many people around the country, as well as the influx of refugees from the Democratic Republic of Congo. He added that now movement is restricted but when the roads finally open and people begin to move freely about, there will be an explosion of STD and HIV transmission.

SGBV

MSF said that they had facilitated the relocation of one of the camps further outside of town for safety reasons. Usually camp residents are very reluctant to move – especially to a remote area - but in this instance they welcomed the relocation. It was discovered that there was a military base very near the camp and that many IDPs had complained of harassment by the military. This is expected to be the reason for the IDPs' eagerness to relocate to an even more remote area further from town and necessary services.

Huambo

Huambo is Angola's second largest city, and was an industrial center in the past. Currently, the many large factories sit roofless and empty outside the city center. The economy is at a standstill, in large part because transport of raw and finished materials by road is impossible and air transport is far too expensive. As is the case in other towns, renovated buildings house NGO offices; the physical effects of offensives on the town, notably a 30-day siege several years ago, are visible in the semi-destroyed buildings used as homes and commercial sites.

Safe Motherhood

The provincial hospital in Huambo is a spotlessly clean facility managed by an energetic Angolan physician. The hospital handled 2,270 deliveries in 2000, 12% (264) of which were cesareans. The maternity wards were clean, though bed frames were rusty and in bad repair and many lacked mattresses. Simple incubators were available for infants; low birth weight is reportedly a problem.

It is notable that 29% (661) of the women delivering at the hospital in 2000 were 14-19 years old. This group made up the largest single 5-year age group, and the number decreased steadily as age increased. The staff were not sure why this was the case but it would appear that there is a perception among the population that young women should deliver in the hospital but that it was not as important that older women do so.

Antenatal care is offered at the hospital, as it is in some of the health centers in the province. All complications, or problems of any kind, are referred to the hospital.

Family Planning

The hospital is virtually the only source of family planning services in the province. For example, Sao Pedro Government Health Center, another site visited, has not provided family planning since 1998. The staff there report that women (and men) are indeed interested in family planning and that they refer them to the hospital, a distance too far to walk.

At the hospital, all methods except male sterilization are offered – this includes female condoms and emergency contraception. There were 2,843 family planning consultations in 2000, with 822 new acceptors. Almost half of new acceptors adopted the pill and 21% accepted condoms. Besides problems with stock-outs of supplies, there was some concern among staff that injectables are not appropriate for younger women interested in spacing since the return to fertility is longer than with other methods. They reportedly use injections primarily for older women who want to stop having children.

The staff does not actively promote family planning in deference to what they identify as the conservative population they serve. They fear that any bad publicity will harm the program.

STDs/HIV/AIDS
STD treatment is done in the family planning clinic. The most common infections are gonorrhea and cervicitis, though overall the numbers of clients seen is low. As with family planning, the staff recognizes the need for community education and outreach but fear a negative reaction from the conservative population.

SGBV
When asked about rape and other forms of sexual violence, the hospital staff reported that it is common, and due mainly to the social dissolution brought on by conflict. The perception was that sexual violence is, in fact, so common that adults rarely bother to report it and this explained why they saw few adult patients in the hospital. The cases of sexual violence they see tend to be in children, for whom families might seek care in order to collect evidence. The staff cited a recent case of a 3-year old girl brought in for this purpose. Since pregnancy is not a concern for the very young patients they see, emergency contraception was not seen by the staff as a service relevant to rape survivors.

Viana, Luanda
Viana camp is on the outskirts of the capital city Luanda. The IDPs living in this camp come from Malanje, Bie, Moxico and Huambo provinces and there are also refugees from the DRC. Many traveled by foot and others by road. IDPs from Moxico established the camp in 1992 and IDPs from the other provinces followed. The camp is divided by province. The assessment team met with the chief of the Malanje quarter of the camp who walked to the camp from Malanje in 1999.

There is one health post in this camp run by an Italian NGO named COSV. The nearest health center is three kilometers from the camp in Viana town and the nearest hospital is 30 kilometers away in Luanda. The camp health post is only open during the day Monday through Friday so there are no health services available in the camp when the post is closed. The women we spoke with said they are treated well at the health post but at the hospital, if they are identified as IDPs, the services they receive are worse. These women said that the health services they receive here are still better than those they received in their home province Malanje.

Safe Motherhood
Most women deliver in the camp with a TBA. The main problems for pregnant women are malaria, spontaneous abortions and premature births. There is an ambulance available during the week at the camp health post but when the ambulance is not there they must pay for transport or find a ride some other way.

Family Planning
The assessment team was told that women have 8-10 children on average. Most people see having many children as a blessing, but they still want to be able to space their children and lack of resources can be a reason for families to want to limit the number of children they have. The Malanje chief said that men do not concern

themselves with family planning because they think this is a women's issue. Depo Provera is the preferred method of contraceptive here, as in every other province we visited. Women told us that they are expected to pay for contraceptives, likely due to corruption of the health workers who are either not getting paid at all or are paid very little.

STDs/HIV/AIDS
There have been several HIV workshops in this camp so knowledge about HIV is fairly good. However, we were told that men do not like to use condoms and often refuse to do so.

SGBV
The IDPs we spoke with told us that SGBV is not a problem in this camp. It was difficult during our short visit to determine if this is true or if perhaps people were just uncomfortable discussing this issue with us.

Conclusions and Recommendations

The main difference between the local population and IDPs is that locals are much more aware of RH and are, therefore, more likely to seek out available RH services. Most IDPs are from very rural areas where there were no health services so they are unaccustomed to seeking out services. Therefore, much outreach, awareness raising and education needs to be done with the IDPs.

IDPs need far more blood transfusions than the local populations. The needs for IDP transfusion are primarily anemia, gunshot wounds, landmine accidents and surgeries such as cesarean sections. A family member typically provides blood but many IDPs do not have family members available to provide a donation. The hospital will not turn an IDP away if a family member cannot donate the needed blood supply, but the delay in finding a volunteer donor can be life threatening.

Biggest problems: 1) STDs (prevention, diagnosis, treatment) – many people self diagnose and self treat buying medicines in the market (that may or may not be the right treatment for their STD) or by traditional means that can be very harmful; 2) emergency obstetrics – women come too late with complications, deliveries take place in unclean conditions, no neonatal tetanus.

Greatest needs: 1) reconstruction and re-supply of the health facilities destroyed in heavy fighting (e.g., Kuito, 2) improve referrals, 3) family planning/contraceptives, 4) more ambulances/adequate transport options, 5) qualified/trained professionals, and 6) essential drugs.

Recommendations for improvement of RH services:

- Awareness and education – IDPs from very rural areas have never had information about reproductive health or access to reproductive health services. They need and

want to be made aware of the services they can and should be accessing. Awareness activities should include men, women and adolescents. Radio is a viable medium to promote awareness and education in all the provincial capitals. Food for Work programs are being used to support agricultural programs in Angola so perhaps a similar programs could support the work of a community health worker program. Additionally, awareness and education activities could be conducted in collaboration with food distribution as so many IDPs are dependent upon the WFP food deliveries and take part in the distribution.

- Targeted services for adolescents – 45% of Angola's population is under 15 years of age.[14] As in any country, young people represent the future. To neglect the significant needs of young people for health, education and psychosocial services will result in a bleak future.

- Supplies and equipment – Luena, Moxico has a lovely new maternity but no drugs, contraceptives or even simple equipment like stethoscopes or forceps, stock outs, no transport/ambulances. There is a great need to strengthen the logistics system for timely distribution of supplies and equipment.

- Training – staff in health posts and TBAs want and need to be better trained.

- More financial support and technical assistance is needed by the local NGOs in order to build local capacities. Based on a recent Refugees International (RI) assessment of the response to refugee and IDP conditions in Angola, RI recommends expanded donor support in Angola because "Sensible investments now could end the need for aid later."[15]

Near empty supply cabinet in IDP camp health post in Luena, Moxico. February, 2001

- The Angolan government needs to allocate more resources to health and education. This is one of the richest countries in the world in natural resources and yet the government has only committed 5.5% of its budget to health. We were told that so far this commitment is on paper only and that the actual contribution will likely be much less. Regardless, 5.5% does not come close to meeting the needs of Angolans for health services. It is quite discouraging for international NGOs to maintain or increase the social services they are providing to the Angolan people (including IDPs) when there is no reciprocal effort being made by the government.

[14] National Institute of Statistics, 1998.
[15] Refugees International, *Angola: New Efforts To Build Local Capacity*, April 2001. Web-link: http://www.refintl.org/bulletins/ag_042701_01.htm

Conclusion

Until the conflict in Angola is resolved and health, education and social services are reestablished and prioritized by the government, any sustainable improvement in people's lives is unlikely. Donor support is wavering, and yet for reproductive health services to improve in Angola, it is crucial that donors continue to support the international and local agencies that are working so hard to meet some of the urgent reproductive health needs of the population.

Despite the lack of material goods, the Angolan people are extremely resilient, resourceful and self-reliant and they are ready, willing and able to be trained to provide the necessary social services to the displaced and local populations. Increased donor support could ensure that these Angolans receive the training and support they need to build their capacity to care for themselves. The greatest hope for Angola lies in its human resources.

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