

*A Participatory
Research Project*

Health and Livelihoods in Rural Angola

Laura Habgood

Health and Livelihoods in Rural Angola: a Participatory Research Project

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Abbreviations / Glossary

ACF	Accion Contra Fome (Action Against Hunger)	<i>adobe</i> mud
CVA	Cruz Vermelha de Angola (Angolan Red Cross)	<i>aguadente</i> locally brewed alcohol
DMPMF	Delegação Municipal para Promoção e Desenvolvimento da Mulher e Família (a merger of UNITA's and the MPLA's women's organisations)	<i>amigos chegados</i> good family friends
ICRC	International Committee of the Red Cross	<i>bairro</i> a neighbourhood comprising several residential zones
IESA	Igreja Evangelica de Angola (Evangelical church)	<i>batuque</i> drum
MINSÁ	Ministério da Saúde de Republica de Angola (Ministry of Health of the Republic of Angola)	<i>cabeza grande</i> traditional illness (potentially fatal bleeding occurs from the mouth and nose)
MPLA	Movimento Popular de Libertação de Angola (Popular Movement for the Liberation of Angola)	<i>comunidade familiar</i> family compound
NGO	Non-Government organisation	<i>desenrascar</i> to scrape around for food
OMA	Organização das Mulheres de Angola (the MPLA's Angolan Women's Organisation)	<i>kandonga</i> parallel market
UNICEF	United Nations Children's Fund	<i>kanjango</i> extended family grouping
UNITA	União Nacional para a Independência Total de Angola (National Union for the Total Independence of Angola)	<i>kimbanda</i> common term for any health practitioner; the Umbundu equivalent is <i>otchimbanda</i>
		<i>lavra</i> land distant from a river
		<i>makulu</i> used to describe illness caused by worms
		<i>muhongo</i> traditional pregnancy
		<i>naca</i> land bordering a river
		<i>olondele</i> ancestors
		<i>olusongo</i> scarification
		<i>ondjango</i> village or neighbourhood meeting place
		<i>otchitenhã</i> 'lack of rains, then hunger' (Umbundu)
		<i>pássaro</i> Portuguese for 'bird'; used to describe an illness of childhood with symptoms of convulsions
		<i>planalto</i> in-land plateau/central highlands
		<i>quimbo</i> traditional village
		<i>quintal</i> compound
		<i>santa/o</i> female/male traditional practitioner (spiritualist)
		<i>seculo bairro</i> elder or vice-soba
		<i>soba</i> traditional chief, highest authority in a <i>bairro</i> ; sometimes appointed by the Administration
		<i>tensão de gota</i> the adult version of <i>pássaro</i>
		<i>vanumuso</i> tiny devil people which appear in dreams to attack the dreamer
		<i>walunguka</i> a person with a particular capacity to understand and share an experience of life

Preface

Angola appears to be emerging from years of social disruption, during which the people least responsible for prolonging the conflict have been most affected by the poverty that results from war. Planners developing basic social services face a situation marked by high levels of poverty-related morbidity and mortality among populations returning to their homelands; scarce resources; and a lack of information to guide decision-making.

The Oxfam country programme in Angola, with several years' experience in working to meet people's emergency and long-term needs for water and sanitation, has been leading a recent shift in approach to community development in the country. This approach aims to help people identify and manage their problems, as well as to cultivate a culture of information-sharing among programme staff. The 1997 research project in Ganda which is the subject of this paper grew out of the need to gain a better insight into the lives of rural people with whom Oxfam worked, particularly into their health behaviour,¹ and use of existing health services.

Oxfam wanted to focus on the beliefs and perspectives of Ganda's communities, rather than to review health-service provision from the provider side. In doing so, Oxfam also sought to gain experience in information-gathering at community level.

This work is the result of the combined efforts of several people: those who had the opportunity and privilege of getting to know some of the many Angolans who will continue to look for ways of coping with an uncertain future, and friends and colleagues for whom such a life is 'normal'. Thank you, Virgilio Joya, Filómena Rosalina, Hilária Katumbo, Marion O'Reilly, Vincent Koch, Maria Catarina, Ana-Maria, Manuel Joca, Gustavo Manuel, Paulo Job, Avelino Rufino, Padre Adriano, Maria-Augusta Peixote, Gabriela Da Silva, Dona Maria Luisa, Manuel Gongga, Isabel Nimba, Aidan McQuade, Kate Horne, Maria Emilia Barradas, Odete Antonio, Fernanda Antonieta S de Carvalho, and the people of Ganda.

Laura Habgood, 1997

Introduction

Angola is a country devastated by many years of war. Those health and development indicators that exist reveal human suffering on a scale nearly unparalleled world-wide,² which cynically mocks Angola's potential to become one of Africa's richest nations by virtue of its vast natural resources. As a stable future seems possible, and society moves slowly from a state of conflict to one of rehabilitation and recovery, the attention of international and local development organisations has begun to focus on plans for integrated rural programmes. Because of insecure conditions and difficult access, previous development initiatives have been confined to coastal and urban areas, whose population increased rapidly as a result of large-scale war-induced displacement from the interior.³ The current population distribution within the country is unrelated to available natural resources or the basic social-service infrastructure. Moreover, further population movements are anticipated as people return to their places of origin. Planners lack experience and knowledge of rural people's lives, whether settled or displaced. In addition, they lack the information necessary to guide programme development — although they know that the war caused high levels of rural poverty. People's livelihoods were lost, and the basic social-service infrastructure was destroyed.

While a population's good health is fundamental to development, isolated interventions have little impact on improving health, which is part of a complex and ever-changing interaction of social, cultural, economic and environmental factors. Oxfam UK/I⁴ has been working in Angola since 1989 to restore access to basic facilities such as water and health-care for people affected by the war and living in poverty. Developments within Oxfam's understanding and management of programmes since then reflect and respect the changing needs and priorities of their target populations. Previously, emergencies meant that projects focused on providing handpumps or temporary latrines for displaced people. Now the emphasis is increasingly on building and supporting viable rural development schemes. This goes along with a community-

based approach, for example by using participatory problem-definition techniques. If a development initiative is to grow within the community which it aims to benefit, it must also be located within the community's reality.

Problems cannot be defined without information. The challenge is to develop tools (and experience in their use) to gather and understand rural people's vast traditional and local knowledge, and to consider such knowledge at all levels and stages of programme development. Health-related information too often consists only of formal service-providers' reports or official sources. The limitations of relying on such sources in the municipalities of Angola's interior, where the health-care infrastructure barely functions, became evident in discussions with health-service providers⁵ and in a review of written records. They revealed the lack of any coherent or meaningful system of information management at either community or facility level. A reliable health-information system (HIS) is a basic requirement for the planning and development of health programmes and services.⁶ It is based on appropriate data-collection and data-processing methods, followed by interpretation and analysis. Information generated must then be passed on to relevant actors.

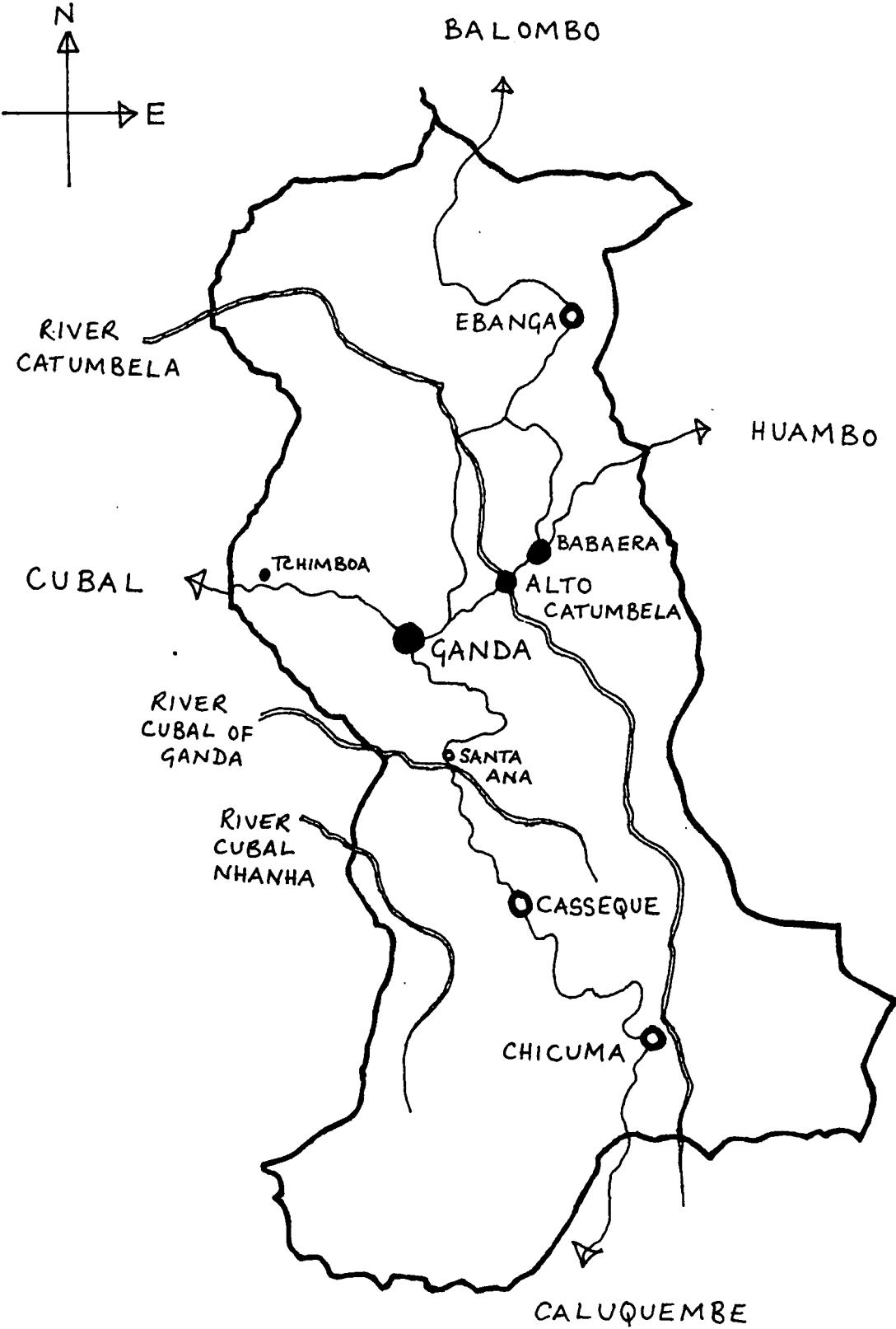
Therefore this research project was undertaken to contribute to improving people's health through the following means.

- Achieving a better understanding of the *rural household*, the target of Oxfam projects in Benguela Province. Merely targeting households will not necessarily ensure that benefits reach those they are intended for. Micro-level research is needed to understand inter- and intra-household relations, to identify inequities in distribution of power and resources at household level, and to look for opportunities to redress the balance in favour of the most disadvantaged.
- Bringing about an awareness of *health-related behaviour* which considers social, cultural, economic, and environmental aspects of people's lives as well as biomedical concepts of health and disease. Health-related behaviour must be seen in its context, taking account of both

internal and external influences, and of their constant interaction.

- Developing appropriate *methodological tools* for, and gaining experience in information-gathering and analysis at all levels. Information can stimulate communication, participation, and development through a shared understanding of the needs of target populations — when it is able to represent their entire reality, not simply one set of problems.
- Improving local health workers' *skills and capacities* to analyse the health situation of the populations they serve through joint planning, training, and information exchange. It was envisaged that, with minimal support from Oxfam's research team, the local public health team could expand its capacity to develop both facility- and community-based health information systems.

Map of Ganda Municipality



Part One: Methodology

1.1 Background

Ganda Municipality, where Oxfam has supported an environmental health project since 1994, is located in the *planalto* region of Benguela Province in western Angola. Divided by the River Catumbela, the area consists of semi-arid, forested and cultivated lands (see map). Ganda itself is a town surrounded by two high mountains and two small rivers, the Indongo and the Mbongo. The predominant ethno-linguistic grouping is Ovimbundu, whose language is Umbundu, although tribal dialects and traditions within the Ovimbundu vary considerably. The municipality consists of five districts, three of which have been controlled by Jonas Savimbi's rebel force, UNITA, since October 1992 until the Government regained control in August 1997. Oxfam's project work has been confined to Government-controlled areas. Since the Lusaka Protocol was signed in late 1994, local security has been disrupted only by sporadic incidents of banditry. However, in the months prior to the Government regaining control, tension increased in the area, with frequent rumours of impending UNITA attacks from the south, and reports of incursions into Ganda district across the nearby southern borders. The local population was nervous, talked of recruitment lists, and suspected movements of troops and heavy weapons. At one point during this build-up of tension, Oxfam staff were withdrawn from the area until security had been further evaluated and found sufficiently good for project work to continue. The area immediately surrounding Ganda has never been heavily mined, probably because of the kind of fighting, mainly by guerrillas, that occurred locally. The few landmine accidents which have occurred in the past year have been attributed to newly laid mines; local people are aware of existing unsafe sites.

A grid of tarmac roads intersects the town, but the dilapidated state of most buildings bears witness to deliberate destruction and years of neglect. Moving out from the centre of town along rough tracks, into the *bairros*, one encoun-

ters houses made of mud bricks and thatched with grass. Several small buildings are encircled by a wall to form a compound which encloses living quarters, cooking areas, a vegetable patch, and a variety of small animals — chickens, guinea pigs, pigs, and goats. Cattle are generally corralled in the centre of residential areas for security against bandits; crops are sun-dried on roofs. Small informal markets line the principal routes between *bairros*, and there is the unceasing movement of women carrying several tiers of firewood, tools, and food items on their heads, their babies sleeping on their backs. In a normal year, the rainy season begins in September, slackens in December, and peaks in February before ending in April. From then until the next rains, the weather is cold and dry. In 1996, the rains fell irregularly and heavily throughout October to December and finished early. Most of the maize harvest, normally begun during the rains, was lost as the plants dried up before maturing. The sorghum, the second staple crop to be harvested, was infested with a pest which had proliferated because there was no rain to wash the growing plants. This, and the loss of the maize harvest, prompted some people to bring forward the time of their sorghum harvest, and it was widely expected that the communities would suffer hunger and hardship in 1997. The fieldwork was carried out between May and August, when usually least agricultural work is done.

1.2 Study design and organisation

Research objectives and approach

The research project intended:

- to increase knowledge and awareness of health-related behaviour at household level and of sociocultural factors which influence the use of health services in Ganda;
- to assess the preventive health-care priorities⁷ of the community and its most vulnerable members;

- to gather information to guide the development of appropriate methodological tools and indicators with which to monitor and evaluate preventive health-care;
- to make recommendations to Oxfam concerning the direction of future programmes and initiatives in Benguela Province.

The research aimed to explore and contextualise meanings, beliefs, and behaviours surrounding good and ill health. It involved the study of potentially sensitive issues at household level such as unequal access to household resources, and of issues which might implicate participants in criticism of the Government. We chose to use qualitative research methods, which would enable us to explain, compare, and interpret findings, rather than rely on direct, potentially conflictive questioning. Qualitative research methods aim to gather information in a flexible and open-ended way, allowing for unanticipated discoveries and a wide range of sociocultural factors.

The project had begun from a general idea, without a clear definition of how the process would develop, and to what extent it would be influenced by the research team's resources and the community's priorities. Consequently, it was carried out in four phases; practical (intermediate) objectives developed in accordance with the pace and direction of the research. Also unanticipated at the beginning of the project was the development of a sub-project with MINSA Public Health staff. We were asked to plan and carry out a population survey as the basis for the development of a system for collecting, interpreting, and reporting local health information (see Appendix 1).

The research team consisted of myself (an expatriate with a background in public health in developing countries, who had lived in the study area for a year before the project started) as principal researcher, and two locally recruited women as research assistants (RAs). Additional support was given to the team by the Oxfam Benguela programme health adviser, who visited Ganda on several occasions during the research period, and by members of the Oxfam Ganda project team who work on environmental health, and food security.

Recruitment

The research project was planned to include the training of two RAs in communication skills and research methods. It was anticipated that their

developing skills and abilities would influence the process of information-gathering. Initial requirements for recruitment were:

- being part of the local culture;
- good communication skills;
- willingness to learn and adopt new skills, and to be part of a team;
- written and spoken language skills in Umbundu and Portuguese;
- academic qualifications at high-school level.

The job description expressed a preference for women over 25 years of age, because the work would focus on issues concerning household production and reproduction, which are traditionally women's responsibility. Following local colleagues' advice, job notices in Portuguese and Umbundu were distributed to the principal churches in Ganda, and the Health, Education and Municipal Delegations, and advertised on a public notice board. Candidates were asked to fill in an application form, which would assist in selecting some of them for interview with the principal researcher.

However, I soon realised that a requirement for a specific educational level was discouraging applications from otherwise suitable candidates, and decided instead to specify an ability to read and write well, with some understanding of mathematics. I had hoped that application forms would help me select candidates for interview, but in the end I had to interview all 70 applicants personally in order to clarify aspects of the job description. Many applicants were keen to join the Oxfam Health Education team, which they thought would be teaching people in the *bairros* how to keep their houses clean; some disguised their lack of writing skills by having friends fill in the forms. Most were simply desperate for a job. Most of them were unemployed young men, several were primary school teachers, but there was no one with any relevant technical abilities.

Eventually I offered the jobs to two young women from Ganda, on the strength of their written and spoken Portuguese and Umbundu, their apparent common sense, and their approachable manners. Although they clearly had the required personal qualities, this choice meant a significant change from the original concept of working with RAs who were skilled in and familiar with academic work. This change offered other possibilities to the project, in terms of developing appropriate training techniques, but by necessity defined a different starting point and pace for the research.

Training

A mini-induction course for the RAs included an introduction to Oxfam as an organisation, its international, country-wide, and local projects, and to the subject of public health. Because the RAs had had contact with NGOs in Ganda only as beneficiaries of emergency relief, it was important for them to understand that working with communities is not simply about giving and receiving handouts. Early discussions about the research project enabled me to assess the level of the RAs' knowledge and understanding, and to give them a sense of belonging to the project process. There were new words and concepts to tackle in discussing the project cycle, its aim and objectives, and in planning project activities. It was helpful to visualise the project process as a journey (see Figure 1).⁸

Training continued throughout the research project, with an emphasis more on practical than theoretical work in an attempt to break away from the model of didactic teaching with which the RAs were familiar. Angolan classrooms echo to the sound of voices reciting in unison as children learn their lessons by rote, with little opportunity to develop critical thinking or questioning skills. An atmosphere of trust within the research team was essential to allow the RAs to feel confident in their introduction to a new culture of information-sharing. Their relative youth and lack of exposure to alternative learning methods meant that a high degree of contact time was required to achieve positive changes in their ability and willingness to express spontaneous and independent thought.

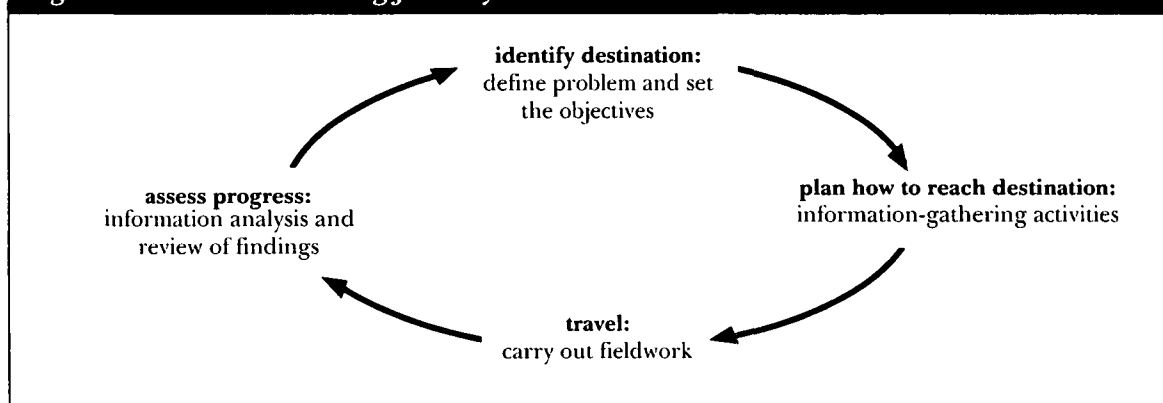
Both RAs were active members of their church congregations and had participated in initiatives to visit and assist needy people in their communities. It was useful to reflect on this

experience to draw on some of the communication techniques which they had already developed and with which they were familiar. These included choosing comfortable and suitable locations when talking to people (shade, stools, privacy), using a language that people understand, and speaking slowly, allowing time for discussion and clarification.

The importance of being aware of the researchers' own reactions to uncomfortable or difficult situations was highlighted in the early days of fieldwork. During an interview with two young women, their mumbled and monosyllabic answers clearly irritated the interviewer. Glances and aside remarks between the interviewer and note-taker did little to ease the relationship between the RAs and the informants — nor did their tendency to read out the questions like a shopping list, without checking whether they had been understood. When silences occurred or responses were delayed, the interviewer drummed her fingers on her notebook, or talked 'at' the women about the topic of the question, at one point giving them a mini-lecture on how to prepare a herbal tea for children with diarrhoea. And all this after they had carefully explained to the informants how valuable their opinions and ideas were...

On other occasions, we acknowledged the RAs' use of positive techniques, such as helping out each other by explaining questions, rewording questions from closed to open types, or changing the mood of a difficult discussion by introducing a neutral topic. Both RAs had friendly manners and warm senses of humour, and, once they appreciated their own natural abilities, were able to work on their own initiative, rather than waiting to be told what to do next.

Figure 1: The never-ending journey



Although I describe it as steps, the training was a continuous process throughout the research project, involving constant review, reflection, and considerable overlap between areas of work. Much of it was practical training, so there was little emphasis on taking notes. I decided to improve and build on existing communications skills as well as to develop new ones as a foundation for the research methods. The topics covered and, where relevant, the tools used, were the following:

- role play which focused on the positive and negative meanings of non-verbal and verbal language;
- photographs and drawings of 'good' and 'bad' situations to stimulate discussion about situational influences on information-gathering;
- tape-recording each member of the research team while conducting a semi-structured interview, and critically reviewing the interview process and questioning techniques afterwards (a very useful and levelling experience for all team members).

Building on communication skills, the RAs were introduced to the main aspects of qualitative research methods, including the following:

- interviewing techniques;
- observation skills;
- participatory methods and tools (see Appendix 2 for individual techniques and examples);
- facilitation of group discussions.

Familiarity with these skills, and an understanding of their purpose, were developed by various means:

- using different question types, listening critically to responses, probing, and following up unexpected leads (in role play and frequent reviews of fieldwork);
- practising observation-making, increasing sensitivity to surroundings using all senses;
- sharing information between all those team members who had been trained in Participatory Learning and Action (PLA) techniques⁹ at local and provincial level;
- exchanging experiences with colleagues who had used focus-group methodology when gathering information during preliminary stages of another part of the Ganda project (on environmental health).

By working through their own experiences of, say, making treatment choices, to illustrate and practise the use of participatory methods and

tools, the RAs became confident in the discussions that evolved and were able comfortably to assume different roles as participant or facilitator.

Fortunately, the office in Ganda has a large porch with a concrete floor, which is ideal for chalk diagrams and conveniently close to the garden for collection of materials. The frequent passage of staff and visitors past their work provided many opportunities for the RAs to practise new techniques and skills. As their confidence grew, they became more creative in their designs and imaginative in their use of symbols.

One of the skills the RAs acquired early on was the ability to sift out unnecessary words and phrases from their note-taking, and to record only key points and useful quotes from the discussions. Initially, they wrote in long sentences and included the complete questions in their scripts. Their slow and deliberate way of writing, combined with the simultaneous effort of translating from Umbundu into Portuguese, meant that they could not record all the points being made. We tried to review the discussions as soon as possible after each session, to account for 'missing' information before it was forgotten. The following topics were covered in training about how to record information:

- use of bullet points, short phrases, and key words;
- use of tape-recorder simultaneously with note-taking, and line-by-line translation to evaluate accuracy of written notes;
- organisation of field-notes;
- design and presentation skills to make posters and pictures representing common critical situations, which would act as discussion starters during community feedback sessions (see Appendix 3 for an example: a man with three wives, one of whom has a sick baby);
- basic introduction to computer use for word processing and designing a simple instruction leaflet in Portuguese. (The RAs are probably the only computer-literate women in Ganda.)

Analysis and interpretation of information happened in several ways. We reviewed the findings by coding information and cross-matching it by source and method. Using appropriate analytical models, we identified key themes and a range of variables. The research process was under constant review, and we evaluated our performance by asking regularly: *What were the good things that happened? Why were*

they good? What were the difficult things? Why were they difficult? How might these difficulties be overcome next time? We also asked participants to evaluate our research by presenting our findings and interpretations to them.

A range of methods to help organise and integrate research work were used:

- planning and writing weekly activity plans for wall display;
- presenting progress reports to weekly Oxfam Ganda project team meetings;
- planning, implementing, and evaluating community activities such as community mapping, in conjunction with the Oxfam Ganda team and MINSA colleagues;
- holding joint training sessions in facilitation techniques and participatory information-gathering methods with the Oxfam Ganda team and MINSA colleagues;
- sharing findings and emerging themes with the Oxfam Ganda Environmental Health and Food Security project.

The small size of the research team and the amount of time spent together working and during breaks meant sharing gossip and personal concerns. Support given to one of the RAs during a worrying time of pregnancy-related complications, and familiarity with their home lives contributed to a high level of trust in the team. As the relationship strengthened, the RAs opened up to reveal their own traditional beliefs, behaviours, and prejudices, which they had mostly denied or ignored earlier on. This new willingness to share deeply held ideas with an 'outsider' not only stimulated recognition of the importance of interviewers developing rapport with informants, but made them appreciate that the sense of rapport must be mutual.

1.3 Study area, sample, and sources

The study area comprised a geographically defined area including all 19 *bairros* of the district of Ganda (see Appendix 6 for map), for which latest population figures give a total of almost 37,000 people.¹⁰ Of these, 19.3 per cent are children under the age of five, and 12.2 per cent are people aged 45 or more years. The figures are broadly consistent with the demographics of developing countries.¹¹ However, proportions of men to women (aged 15 years

and over) of 42.8 per cent to 57.2 per cent may reflect the excess of women in the area following years of war. *Bairro* populations range from around 600 to 3,000 people, with varying proportions of resident and internally displaced people. A *bairro* community refers to all people living in the *bairro*, although they may express differences in their views and traditions. Most of the displaced people in Ganda had moved there because of threats to their own communities during the war. Some have lived in Ganda for more than five years, but many express their intention to return to their places of origin and see themselves as temporary residents. The most recent significant movement of people occurred at the beginning of 1997, when returnees from Cubal halted in Ganda to await a secure opportunity to continue their journey home to the Chicuma area.

Sample and selection methods

The study area was stratified to represent rural, semi-rural, and urban communities, reflecting differences in the origins and subsequent development of the communities to facilitate selection of samples. Rural communities are generally small, located at the periphery of Ganda, retain traditional customs such as dance groups, and have few displaced inhabitants. Semi-rural communities grew between the 1950s and 1970s, when the workforce of the expanding local food industry required housing. The semi-rural *bairros* have remnants of some basic services, and accommodate larger proportions of displaced people than rural *bairros*. The urban community comprises resident and displaced inhabitants of the colonial-style town centre, which has some intermittently functioning services (water, energy), tarmac roads, discotheques, and a video club.

Initial fieldwork was undertaken in a rural *bairro* community because of its small size, the relative homogeneity of its members, and the support of the *soba* (local chief), who had been involved in previous Oxfam project work in Ganda. All zones of the *bairro* were included, and, unless meetings had been arranged in advance, participants were encountered during walks that started from different points and continued in directions chosen at random. Complementary fieldwork was subsequently carried out in *bairros* representing the other two strata. Informants in the city were 'selected' as the RAs followed a map with a pre-drawn random walk. The samples had originally been

selected by degree of urbanisation, but when important themes began to emerge from the initial fieldwork, we could then identify population subgroups to be targeted for further in-depth investigation. The themes that emerged included the following:

- nutrition and health;
- women's health throughout their life cycle;
- household coping strategies and vulnerability;
- management and prevention of childhood illness;
- messages and sources of health education.

These themes influenced the subsequent choice of a stratified purposeful sampling strategy, which would help to compare different social realities and health experiences within the subgroups, and to explore key issues with particular relevance to the research objectives. These were the criteria for selection to each subgroup:

- mothers with at least one child under five years of age;
- women or men over 60 years old;
- girls or boys between 14 and 25 years of age without children.

Although we recognised that men, too, have specific health experiences, the need to prioritise research resources and time precluded their inclusion at this stage.

In order to ensure that interviews in the research area were carried out in a random manner, we drew a simple map of the city's streets. The researcher started the walk at the office gate. He or she decided on which direction to take by reaching inside a container and randomly picking one of the objects placed in it: a button (*turn right*), a seed (*turn left*), or a leaf (*straight on*). At each subsequent junction, the procedure was repeated, and the path marked on the map.

Stratified purposeful sampling was achieved by sorting folded pieces of paper with the names of *bairros* into piles, according to rural, semi-rural and urban strata. For each of the three subgroups, a paper was randomly selected from each pile.

Identification of key informants relied on the research team's prior knowledge of the study area and on information received during the course of fieldwork. (A key informant was defined as someone who, as a result of holding an official or informal position in Ganda, would have detailed knowledge on a particular subject.)

For example, a particular private practitioner was mentioned during several interviews with different community members. The selection of a small number of 'typical' malnutrition cases at the Nutritional Rehabilitation Centre (NRC) for in-depth case studies, and of health-service users for semi-structured interviews, depended to some extent on self-selection by participants. To reduce bias as much as possible, we approached every 'nth' (depending how many clients were present) person seen or met as they left the consulting room and invited them to participate.

Sources of information

Information was obtained from both primary and secondary sources. Primary information sources included the following:

Community members

- women with children (six groups)¹²
- young women and young men (three groups each)
- elderly people (three groups)
- adults (12 groups of men, women or both)
- families (three)

Health-service users

- hospital inpatients and general outpatients
- women attending antenatal clinics
- clients attending other health facilities
- mothers at the NRC

Key informants (health-service providers)

- representatives of the Municipal health delegation and health personnel
- private practitioners
- traditional practitioner (herbalist)
- traditional practitioner (spiritualist)
- traditional midwives
- representatives of CARITAS and IESA mission health posts
- medicine sellers

Other key informants

- *Soba*
- representative of the Municipal delegation for women's development
- representatives of the Catholic Church in Ganda
- local project staff
- colleagues from other NGOs working in Ganda Municipality

Secondary information included observations made at health facilities, and our impressions of environmental conditions, but was generally taken from the following written sources:

- Municipal Health and Public Health Department reports from 1995 to 1997;
- Municipal Health strategic plan for 1997;
- ICRC Nutrition survey reports for Ganda;
- Municipal Administration population census 1996;
- MINSA/Oxfam population survey 1997;
- other NGO documents;
- maps of the study area.

1.4 Methods and tools

Preparing fieldwork

A number of points had to be taken into account before the start of the research and as part of every fieldwork session.

Previously established contacts with the local administration and main institutions in Ganda had afforded us several opportunities to introduce the general idea of the research before the project started officially. Subsequently, we discussed the project's objectives, methods, and progress with members of the administration, and submitted monthly progress reports. When seeking permission to work in the *bairros*, we held meetings with the *soba* and his committee of elders, at which our plans were presented and discussed. In order to prevent participants from expecting that our work would be related to a later distribution, it was crucial to explain clearly what the research objectives were, what methods would be used, what this would mean for the people in terms of time and involvement, and to explain the proposed feedback mechanisms. As there is a fashion for documentation in Ganda — everything from a lorry to a chicken requires a licence to be on the street — the RAs carried 'official' cards explaining who they were and what they were doing when they were in the field. We obtained permission from the Municipal Health delegate before we reviewed MINSA documents, and only the main researcher reviewed internal health department documents.

The team's local knowledge of people's activities and commitments meant that most field visits were timed to coincide with those times of the day when participants were least likely to be preoccupied or tired. Whenever appropriate, visits were arranged beforehand so that participants would have time to take care of their daily tasks. It was important to remain flexible and sensitive to their needs and wishes:

a miserable baby or hungry children waiting to be fed might prompt the participants to request a return visit to continue the discussion at a more convenient time.

People favoured weekend meetings, as most of their work duties had finished by Saturday afternoons, but this had to be balanced against the RAs' own family commitments. At times, key community members assisted with setting up interviews and focus-group sessions, but this well-intentioned assistance from others could have its drawbacks.

One enthusiastic *soba* insisted on setting up an interview with a traditional midwife for us. When he was eventually persuaded to leave the meeting, she admitted to us how frightened she had been to be summoned by the *soba*. We apologised to her. Later on, when we tried arrange an interview with a traditional practitioner through another *soba*, he told us that we would have to pay both an entrance and an exit fee, so that neither our health, or that of the informant, would be put at risk. We found another informant.

Facilitating the fieldwork

When people meet in an everyday setting, they exchange a formal greeting, and a general enquiry about each other's well-being and the purpose of the visit. Accordingly, at the start of a meeting, we would introduce each member of the research team, give a brief description of Oxfam Ganda, and explain the purpose of the work. We also took care to choose a suitable, comfortable site for the interview, causing as little disruption to people if they preferred to continue their work (such as sorting grains) while talking. The research team carried their own small wooden stools to avoid either the need for a 'chair-for-the-visitors search' or the upset caused to hosts by the visitors sitting on the ground. In spite of wearing long skirts, the RAs preferred to cover their legs with lengths of cloth in the traditional style during field visits. Refreshments were offered to participants after focus-group sessions and, when offered by participants, food was shared.

We obtained the verbal consent of the informants and explained that although notes were being taken, no names would be recorded, and that their anonymity was assured. Similarly, when we tape-recorded discussions, people spoke without revealing their identity. Although pictures were generally popular, some people refused to be photographed,

because they 'did not wish others to see them living in such poor conditions'.

Our methods of investigation included informal and formal approaches (see Table 1). The approach chosen depended on the purpose of the encounter and the RAs' abilities.

Investigation tools

To guide the early stages of information gathering, we devised a framework to help us to define areas of interest according to the research questions. The framework was based on the concept of a pyramid of information (see Figure 2), which is a useful tool for building up a profile of a group of people who live in a geographically defined area.¹³ It describes aspects of the com-

munity's background at a specific point in time. The pyramid is a triangle divided into layers, each of which is subdivided into different components, defining the context in which the study sample live.¹⁴ In addition to usefully organising the topics to be covered, it facilitates the choice of sources and methods to be employed for information-gathering.

Field guides, in the form of question or topic checklists, were used for individual and group interviews. The first step in preparing a field guide with the RAs was a 'brainstorm' of ideas about the topics to be explored and a discussion, based on their local knowledge, of the likely characteristics of the target sample. Practical exercises were then carried out to better define

Table 1: Research methods used

Method	Procedure	Purpose
Interviews with individual community members, groups, key informants, and colleagues	A range of procedures, from semi-structured interview to casual conversation: <ul style="list-style-type: none"> based on open-ended questioning techniques allows the informants to give unstructured answers 	<ul style="list-style-type: none"> to reveal key words which describe the range of cultural, environmental, and social factors that shape health-related behaviour to explore sensitive topics such as how households are organised to provide detailed information on the basis of particular knowledge
Focus groups	Group discussion guided by facilitator: <ul style="list-style-type: none"> makes use of participants' interaction 	<ul style="list-style-type: none"> to explore people's knowledge and experiences of health, illness, and health services to gain insight into key problems and issues put forward by participants, and to understand the meanings of words used
Observations	Unstructured recording during <i>bairro</i> visits, interviews, and visits to health facilities	<ul style="list-style-type: none"> to describe physical conditions to verify information to identify further subjects for enquiry to record information on roles and dynamics within groups
Matched case studies	Interviews with mothers of malnourished children, matched with families living in similar conditions	<ul style="list-style-type: none"> to look for differences between family responses to hardship to explore the relationship between child-feeding practices and poor nutrition
Participatory methods (see Appendix 2)	Exercises: <ul style="list-style-type: none"> introduced as planned or used spontaneously in discussion 	<ul style="list-style-type: none"> to describe patterns in time (e.g. chronologies) or space (e.g. maps), to establish perceptions and comparisons
Review of existing information	Archive reports and documents	<ul style="list-style-type: none"> to provide background information on population, health status, health service provision, policies, and plans
Formal survey (see Appendix 1)	MINS/Oxfam collaboration	<ul style="list-style-type: none"> to collect demographic data for population survey

the key issues and to devise a logical sequence in which to approach them. For example, drawing a diagram which illustrated their ideas of possible causes of childhood malnutrition helped the RAs to appreciate the complex relationship between nutrition and health, and provided them with an understandable, real framework for developing subsequent interviews (see Appendix 4 for examples of checklist and diagram).

Field guides also facilitated comparison of the same topics between different sources. They were initially written in Portuguese, and then translated into Umbundu and back into Portuguese by the RAs to increase their familiarity with the lines of questioning, and to practise interview techniques such as using appropriate and understandable words. In the early days, field guides consisted of an A4 sheet folded into a notebook which contained a series of questions under topic headings. As fieldwork progressed, the guides were reduced to a few key words or phrases to act as reminders to the interviewer or facilitator. They were modified when a review of fieldwork indicated that particular words or phrases caused difficulties for interviewers or informants. Similarly, questions or words that seemed to facilitate discussions were noted for future use.

Aside from having available large pieces of paper, chalk, and coloured marker pens, the team made up tools for participatory exercises from whatever material was available at the time. Circles of different sizes were cut out of scrap paper for Venn diagrams, and materials were collected at fieldwork sites for other diagrams. A point to note about picking up materials is that many abandoned items, in particular maize cobs, were once used as anal

cleaning materials — one soon learns to watch out for which items local people avoid!

Recording information

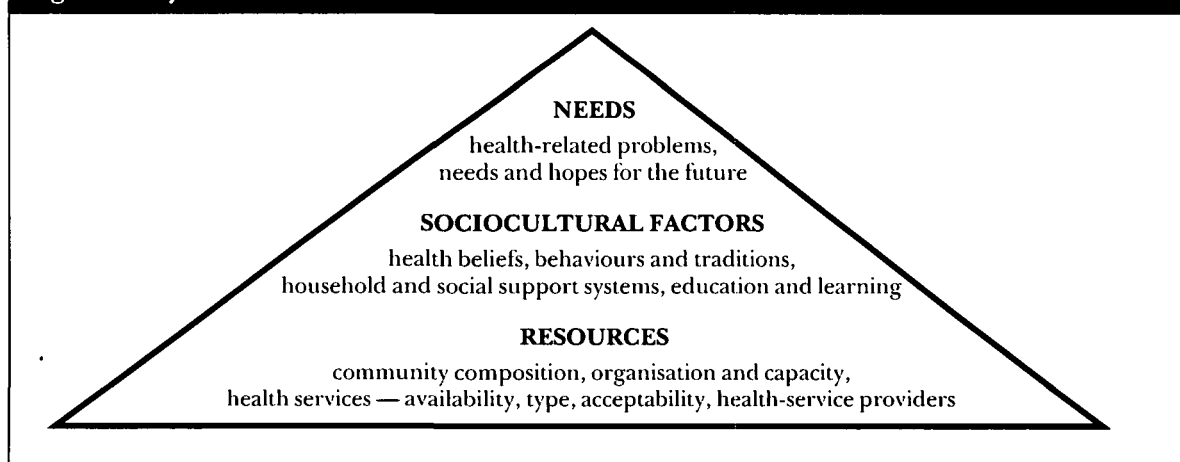
Information generated in the research process and during fieldwork was recorded in several different ways. The main researcher kept a daily diary noting the aims for each day, whether they had been achieved, what the team had learnt from the experience, and how plans for the research were affected as a result. The discipline of setting aside a few moments to note down many thoughts, comments or actions which would otherwise have been forgotten proved to be a valuable investment for later project review and analysis.

Rough field notes were written into the small exercise books that every school pupil in Angola carries; large papers and clipboards were avoided except as tools in participatory exercises. The note-taker translated from Umbundu to Portuguese and simultaneously wrote down the main points of the discussion. Relevant quotes or comments were recorded verbatim. We kept all rough notes and copies of participatory exercises, and in some cases displayed them on the office wall where they stimulated comment and discussion with visitors. Some materials began to look a little worn after several visits to the *bairros* for feedback sessions and had to be handled carefully.

Formal field notes were written up in Portuguese and English after we had reviewed and discussed the points recorded in the rough notes; they included any additional relevant information. They followed a standard format:

- a statement of the session's specific objectives;
- a descriptive introduction (site of interview, weather, number of participants, their sex and estimated age, and so on);

Figure 2: Pyramid of information



- an account of activities carried out;
- observations made, results of participatory exercises and discussions (including quotes);
- general remarks on the dynamics of session, the performance of the research team, and comments for improvement or changes.

The records were filed in chronological order and also stored on computer disks.

Tape-recordings of several focus-group discussions and semi-structured interviews were made using a mini-cassette recorder and an unobtrusive 'tie-clip' microphone, which could be placed in the centre of a group while the recording was controlled from the periphery. We reviewed most tape-recordings in conjunction with the written notes. Only once was an entire recording transcribed, which took almost four hours for a 45-minute interview.

We took photographs of participants and their activities in the *bairros* and, whenever possible, gave copies to the people involved, who greatly appreciated them.

1.5 Analysis and interpretation

Gathering qualitative information can produce rich results on which to base interpretations and hypotheses related to the research questions. It can also result in confusion as a mass of notes awaiting review accumulates. Therefore, it is important to begin analysing information as it is collected, in order to avoid losing sight of the direction of the research, and also in order to identify emerging themes for further in-depth investigation.

During the Oxfam project, we reviewed fieldwork notes regularly to pick up on key words or phrases relating to the topics in the pyramid of information. These were written on small pieces of paper which were stuck to a large triangle drawn on a poster. The papers were grouped into sub-categories within each layer, and new sub-categories added. This method provided an accessible visualisation of common themes in the findings, of possible links between them, and of areas where further investigation was needed. For instance, one important theme emerged from preliminary fieldwork because we noticed a great variety of traditions surrounding weaning babies. We later explored this topic in more depth. Using the pyramid of information also allowed us to compare information obtained from different sources, or with different methods.

Information gathered through focus-group discussions was reviewed and coded. Common themes were marked and later grouped. We compared discussions of similar topics by different sample groups. Points on which there had been consensus or disagreement were noted, as were findings which illustrated unusual opinions. In analysing the dynamics and interactions of group discussions, we considered the effects of peer pressure, of who said what, and why.

Classifications and patterns

Conceptual approaches to understanding health-related behaviour must be broad, and commonly used models do not assume a simple relationship, where health behaviours follow a pattern of rational choices. In Angola's rural areas, many people may not identify health problems as such according to the 'Western concept', nor may they respond with health-related behaviour which would be considered appropriate in a 'Western' context. In addition, there are problems inherent in the researcher's inability to detach himself or herself from a personal, outsider's perspective when trying to understand and interpret meanings of social phenomena. On one occasion, I observed that a child's red string waistband signified traditional beliefs about protection against illness. This was met with much laughter from the participants. They were amused that the *otchindele* (white person) did not know that the cord held the child's nappy in place and that, of course, vaccines protected against illness.

In order to draw from the findings the full range of factors that influence people's choice regarding the use or non-use of health services in Ganda, I used an integrated framework,¹⁵ which seeks to capture the factors in the following classification:

- characteristics of the person (for example, sex, social status and networks, assets);
- characteristics of the illness (for example, acute or chronic, beliefs about causation, expected outcome from intervention);
- characteristics of the health service (e.g. quality, costs, distance, staff attitudes).

The links between these factors and the perceived morbidity are not static, nor does a single choice result from their interaction. To further examine the process of decision-making, the findings were explored in such a way as to analyse pathways,¹⁶ illustrating the integration of central socio-cultural factors into the sequence of steps involved.

Checking validity of information

We were excited by one traditional practitioner's description of what seemed to be a traditional vaccination, with the mother of a healthy child 'buying' the measles illness of a relative's child. She would prick one of the measles spots with a needle and rub the liquid obtained on to the skin of her own child in order to prevent or to reduce the severity of a future measles illness. However, try as we might, we found no one else who was familiar with this method of illness prevention, other than one woman who suggested that it had been used as witchcraft in her family — a child with measles had died shortly after its illness had been bought by an uncle.

The strength of our research approach lay in the opportunities it afforded for information to be tested between a number of different sources, and for using a number of different methods. For example, we found out in interviews that food stocks were very low and that alternative foodstuffs were being used. We later observed cooking pots containing unripe sorghum; women returning from the fields with small bundles of wild plants for cooking; boys who had caught field rats; and empty drying racks on the house roofs — all confirming these reports. By using multiple sources and methods, we were able to develop new lines of questioning, refine our questions, and identify additional sources or methods to test our working hypotheses.

Working as information-gatherers as well as analysers made it easy to cross-check information and detect inconsistencies. In one instance, the men of one village had told us that there was no point visiting in the early morning, as nobody got up before 8 a.m. However, when we did come early, we found the village busy with people getting ready to go to their fields, women washing clothes, sweeping their yards, and milking cattle. In another instance, mothers might during interviews deny any knowledge of methods used to prevent ill health or misfortune, while their small children would be wearing the traditional red string bracelets believed to have many beneficial properties.

Statements appearing within sub-categories were tested against each other to validate or reject them. Feedback sessions with community participants and other interested groups were arranged as the analysis identified clear common themes and patterns. Where possible, visual aids focusing on a critical incident related

to the themes were developed by the research team to spark off discussion.

Analysing the validity of the research also depended on consideration of the potential influences on both the process and the findings.

1.6 External and internal factors influencing the methodology

Outside factors which had an impact on the research included people's concern for their safety and for their livelihoods. The research itself was shaped by the level of the RAs' skills and by the limited time and resources available for training.

Fears about the deteriorating security situation in some areas inhibited people to participate in group work, so that we had to make greater use of individual interviews. Access to the *bairros* was limited in an atmosphere of suspicion. Especially in the city, it was noticeable that people were reluctant to talk in groups, because they feared strangers and retribution attacks at night — as no one could be sure who had relatives 'on the other side'. In the rural *bairros*, people were more comfortable to talk in groups, as they were familiar with the backgrounds and motives of other participants. A few unpleasant incidents with aggressive and drunk men suggested an antipathy towards 'information-gatherers' in an atmosphere of heightened security awareness; at times it was necessary to carry out fieldwork within sight of our male driver. If possible, we made contact with the *bairro* authorities at the start of each field visit in order to minimise potential misunderstanding. However, we then often had to resist pressure to hold meetings in their committee building, which has powerful party-political significance.

Our awareness of people's preoccupation with the failing maize harvest and the daily search for food influenced our expectation of how much time they (particularly the women) could give to participate in information-gathering. The word *desenrascar* (to scrape around to find food) appeared frequently in discussions as people worried about how they might be able to provide even a cup of maize meal for their children. Living under such precarious conditions, and with recent memories of a devastating famine in Ganda in 1992-94, the priorities and concerns foremost in people's minds inevitably reflected their immediate needs.

It took much longer than planned for the RAs to achieve a level of skills which enabled them to make effective use of the research methods available to them, or to attain the confidence and capacity to critically review the process and findings. This meant that the research developed at a pace largely reflecting the RAs' abilities, and limited the choice of methods to those which they understood and could use meaningfully. While they might have been able to perform, for example, a circle diagram exercise, the value of doing so in terms of the time available had to be weighed against the quality of the discussion generated. At times, it seemed that progress was very slow and that the research team could not respond to opportunities generously given by participants. Although participatory methods, in their truest sense, may be seen as seeds sown for action and change, in the context of the research resources and time available, they were used principally as a means of information-gathering. The rhetoric of action for change is uplifting, the sentiments are true, but the reality has to be considered. When skills or resources do not match what is required, the honest approach is to recognise and remain within one's capabilities, rather than to risk damaging the trust, confidence, and hopes of both participants and team members.

1.7 Influences on findings

Surroundings and audiences

The arrival of the research team in a *bairro* could cause a stir. There are few 'outsiders' in Ganda, and most people's contacts with NGOs have been related to distribution of food and goods. It was crucial to explain the team's presence frequently, and to demonstrate that we were not drawing up distribution lists. Honest explanation was also important in order to create an atmosphere in which people felt they had permission to speak. The voice of the people is most often heard through that of the appointed *bairro* authorities. Consequently, an approach that deliberately sought the opinions and views of others had to be presented as above suspicion and respectful of social norms. The RAs felt that in the early days of fieldwork, discussion was influenced by the expectations of some participants, but that, with time, these diminished, as their role and confidence became clearer to them and to the communities with which they

worked. Because they came from Ganda and knew many people personally, interviews occasionally proved difficult for them. After an interview with an acquaintance, they would admit to feeling uncomfortable about probing deeply, particularly into issues such as expenditures or income sources.

It was difficult to avoid a crowd of curious onlookers gathering around when carrying out a participatory exercise, as the activity aroused great interest and amusement. But in some cases, observing the reactions and interactions of participants and audience compensated for what was lost in the quality of the discussion. A *soba*, demonstrating the relative importance of available health services with the help of a circle diagram, appeared to lose his nerve when a group of elders arrived to watch. Rather than risk appearing uncertain, he ordered them to finish the exercise. Similarly, during a mapping exercise, members of the *bairro* authority roughly pushed children to the periphery of the group and told them to be quiet, while women grouped in the background commented on what the men were doing.

Both women and men were plainly irritated when heckling from drunks interrupted sessions. Young women would appear uncomfortable and went silent during interviews or group discussions when men (of any age) stopped to listen or to contribute. We would move to a 'neutral' topic until the men left, ask them directly to leave, or thank the participants and end the session. When we anticipated that a discussion might deal with sensitive topics, we made particular efforts to find quiet and private places to talk, or to insist that non-participants stayed out of earshot. Experience showed that women were uncomfortable to talk about sexual matters in front of children and would themselves ask the children to go away. At times, when large numbers of small children distracted the participants, I, as 'observer', would take them away from the meeting site to make drawings or paper shapes, leaving the discussion to continue in relative peace. This was preferable to the offer of young boys with long sticks who wished to control the excited children in a rather more aggressive way.

At times, group involvement could be an asset as comments and prompts from the wider audience stimulated discussion among the original participants. However, the negative effects included a few loud voices dominating the exercise, participants or facilitator being

distracted, or being made to feel shy, which prevented meaningful discussion. After the main discussion we made time for anyone else who wanted to speak in order to prevent bad feelings, and to avoid leaving the participants in an awkward position with other community members. We learned to be aware of the potential effect of who was listening on what people said and on who participated.

Visiting and talking to people at health facilities required diplomatic skills, as we did not want the staff to feel that we were a threat to them, nor did we want the informants to feel uncomfortable in agreeing to participate. On these visits, we would go through formalities, introductions, and explanations; one of the staff would implore the facility users to co-operate with the research team – and then, inevitably, would choose the people to be interviewed. At this point, we would politely intervene and encourage the staff member to continue with his or her own work.

On some occasions, informants said that they wished to hold a party to thank the health staff for all their good work – inevitably when several nurses were within earshot. Even when we had secured a private setting for a discussion between health-service users, groups of people who were strangers to each other were reluctant to make comments on the quality of the health

services. They feared that any negative comments might be used against them, because ‘no one knows who has relatives working in the health service’.

Language

RAs conducted most interviews in Umbundu, although all members of the research team were able to conduct interviews in Portuguese if this was the informant’s preferred language. The meanings of key words and concepts were discussed to ensure that the most appropriate and easily understood words were used during fieldwork. Occasionally young people in the *bairros* would insist on speaking in Portuguese rather than Umbundu, but little participation would be achieved until they reverted to speaking the language they were most familiar with and in which they could communicate their ideas and experiences. A desire to use the official language could not overcome their nervousness of making mistakes. Being familiar with common usage of language was important when introducing sensitive topics into discussions. It was unusual for people to talk directly and freely of their own intimate experiences, preferring to describe situations that related to ‘a friend’. Both RAs use a vernacular form of Umbundu rather than a more formal kind spoken at church.

Part Two: Findings and Discussions

2.1 History of Ganda

The original tribal group in the area was the Munganda, whose name derives from the term used to describe cattle-raisers, *Okukanda*. They were reputedly a peace-loving people, but earlier this century, another Ovimbundu tribe from the eastern region of Huambo passed through Ganda on their way to trade rubber on the coast. They were attacked and robbed by the Munganda, who later also attacked the survivors on their return journey with the products of their trade. The area afterwards became known as 'the area of robbers'. The site of Ganda town was established with the construction of the Benguela railway line in 1912, and the town founded three years later by the first *soba* of the area, Tchilandala Kambia. His statue, bearing resemblance to that of a Greek god, remains on the roof of the now dilapidated colonial-style cultural centre.

With the development of the railway line and commercial agriculture in the 1940s and 1950s, *bairros* for contract labourers were constructed around the colonial town centre. By the early 1970s, Ganda was a significant contributor to Angola's food industry, and sisal, eucalyptus, and sugar cane plantations covered huge expanses of the surrounding land. The Munganda, living in scattered mountain communities (*quimbos*), sold some of their land to the newcomers who were contracted from outside the Ganda district and came from several different Ovimbundu tribes. People in the *quimbos* lived by traditional subsistence-farming, with some surplus production for trade. Their products generally reached the town's population via the Portuguese 'bush traders', who set up village stores in remote areas. While these provided a convenient credit or exchange service for the rural population to obtain consumer items and agricultural inputs such as seeds and tools, the terms of trade heavily favoured the bush traders.

The elderly of Ganda remember the pre-independence years as times of plenty when, with good rains, grain stores would be filled

with maize, ensuring that there was enough food until the start of the next harvest. Health services for the unemployed and the peasants were provided by the state hospital, while workers and their families were entitled to the curative services of privately run clinics. In addition, most commercial farms ran their own health posts, at which local people's minor ailments and injuries could be treated. Those living in the *quimbos* relied mostly on their own knowledge of herbal remedies and on the services of traditional practitioners. A period of famine resulted from a drought in 1915; 20 years later a devastating plague of locusts destroyed crops and, according to one elderly man, 'ate people'. But real hardship began with the escalating conflict between the MPLA and UNITA in 1974-75. There was a large movement of people from the mountains into the relative safety of the *bairros* closer to town. At the time of Angolan independence in 1975, Ganda was under the control of UNITA, and the Portuguese had fled, abandoning their factories and commercial farms. Following a year of fighting, the MPLA gained control of Ganda, and there was a temporary improvement in living conditions, although the Government's Year of Agriculture in 1978 was also known as *Otchitenhã* — 'lack of rains, then hunger' — in Umbundu.

By the early 1980s, many displaced people from the southern area of Chicuma were arriving in Ganda. There were food shortages, and as conditions deteriorated, people used to joke with black humour that even the rats hunted for food were pleading with their hunters: 'Leave us, we are displaced as well.' People were forced to sell or exchange their land for food, and there was an outbreak of cholera in which some families lost four or five members. The end of the decade saw Ganda return to normality for a few years, with 'normal illnesses, no famine, and functioning institutions'. In 1992, UNITA sporadically attacked and then captured the town, and several months of extreme isolation, starvation, and high mortality ensued. When Ganda returned

to Government control, international relief organisations arrived to provide food and basic services for the thousands of displaced people who lived in appalling conditions in the town and *bairros*. People talk of these years with tears.

2.2 Social structures

It is important to understand how relations in Angolan society have changed over the past 100 years or so. The top-down structures inherited as a legacy of colonialism and perpetuated during years of Marxist rule continue to dominate social structures. The Government's authority reaches into the heart of the *bairros* through all the social actors. While in part reflecting tradition, the municipal *soba* system imposes an artificial structure that can conflict with tribal loyalties and customs. For the past 20 years, the Government has claimed to act and think on behalf of its people, and social structures such as the *soba* system have perpetuated this attitude. As a result, people have accepted a passive, subordinate role. Few community-based initiatives have developed through which the people might gain a say in the decision-making processes that influence their lives.

The different experiences of people living in Ganda's *bairros* illustrate that the loss of traditional structures has had a profound effect on the cohesion of communities today. Those in which extended family groupings (*kanjangos*) remain largely intact retain a sense of trust and co-operation, whereas others experience suspicion and distrust between members. In an atmosphere where protective family bonds no longer exist, people believe that malignant spirits have greater potential to affect their lives, and shared interests are neglected in favour of individual agendas.

Traditional institutions

A *soba* was traditionally the highest authority in a region consisting of several *quimbo*s. He had the services of ministers, counsellors, and a private guard. Each *quimbo* had its own group of elders, who had the position of vice-*sobas*. The *soba* was a man who the people considered to be wise and clever, whose judgements they respected, and whose decisions they supported. The elders chose his successor from among his sons; if they deemed none of them suitable, they would choose one of the *soba*'s sister's sons. It was

not customary for a woman to be considered for the position. *Quimbo*s were organised in family groupings (*clas* or *kanjangos*), or according to groupings of friends who 'had the same understanding' (*amigos chegados*). All activities to do with managing the family grouping would be focused on a traditional building, the *ondjango*. This was a place of dialogue, of sharing knowledge and goods, where traditions were recorded, justice was sought, and conflict resolved.

Having been largely discredited during the early years of Independence, the *soba* system has been refashioned in both Government- and UNITA-controlled areas. Government authorities appoint municipal *sobas* on the basis of their ability to undertake administrative duties in the *bairro*. Sometimes known as *sobas de guerra* ('*sobas* of the war'), they are generally equated by community members with the Government, and while the ideas of the people might be considered, the *soba*'s authority in decision-making is publicly referred and deferred to. Where a *bairro* is composed of people from different tribal backgrounds, the appointed *soba* may not enjoy the same esteem as his counterpart in a less mixed *bairro*. However, people generally feel that the *soba*, with the support of elders, teachers, and church representatives also 'put in charge by the authorities', is 'at the front of the community'. From here he 'sees the suffering of the majority and gives a solution to it.' A *soba* has the status of a rich man, but this, according to a group of rural men I interviewed, may be a disadvantage: 'A man's riches are only for his household and children, and the rich never see the suffering of the community. They need *sobas* who do not have to work for the increase of their wealth.'

People still see the *ondjango* as a *bairro*'s central meeting point, although some now associate the building with the Government party. Difficulties that arise within or between households, often concerning bewitching, or ownership of fields and animals, are presented to the *soba* and his circle of elders. Each elder will have his say, after which the *soba* gives the final judgement, which all agree with. The judges celebrate resolution of the problem with *aguadente* provided by the person who brought the case. If the case is not resolved at this level, it may be taken to the Chief Municipal *soba* for judgement; failing that, it goes to the police, who work 'according to the law of the land'. (The present Chief Municipal *soba* is a member of the Munganda tribe; this can at times cause tension

with those from other tribes, who suspect that tribal loyalties may interfere with justice.) A case that cannot be resolved locally will eventually be heard before a tribunal in the provincial capital, at great cost to all involved.

Government institutions

Municipal delegations of the ministries of health, education, and agriculture are based in Ganda town. The administrative structure extends to the *bairros* through the *soba* system; each authority has a secretary for each *bairro* zone and a representative of the Angolan Women's Organisation (*Organização das Mulheres de Angola/OMA*). Since its inception in the mid-1980s, OMA has claimed to be the national promoter of women's rights. It was originally a mass organisation designed to transmit the MPLA party message to the people, but it has since merged with its UNITA counterpart to form the *Delegação Municipal para Promoção e Desenvolvimento da Mulher e Família* (DMPMF). The local DMPMF presents a lecture programme to communities in which it aims to promote equal rights for women and men, to inform women of their legal rights, to support sex education in schools, and to highlight the consequences of violence against women.

However, according to one person I spoke to, developing women's rights in Ganda is an uphill struggle: women who live in the *quimbo* 'don't know anything, they are backward', and only listen, 'without speaking'. The DMPMF expresses a strong intention to recruit rural women into adult literacy programmes, although the women do not appear to be 'very interested in the classes, because they have too many other worries'. Women are also represented on the management committees of the four agricultural associations in Ganda, which lack equipment and resources, but which are recognised by the Government and the people for their existence if not for their functioning. The associations were developed in the mid-1980s in response to the failed nationalisation of commercial farms, in order to support farmers in increasing their maize production for supply to urban areas. The farmers worked their own land, but membership fees paid to the association enabled them to share resources such as technical advisers, machinery, and mills.

Churches in Ganda

The main Christian churches in Ganda are Catholic, Protestant, Seventh Day Adventist,

and Tochoista. The latter is a traditional African church founded early this century, which combines conventional methods of Christian worship with traditional song, dance, and music. The Catholic Church has the largest proportion of churchgoers; because of the local Caritas organisation, people view it as the benefactor of the communities' poorest members. Operating at community level through a network of male and female catechists, Caritas distributes food and material goods. Its work is closely co-ordinated by the local leaders of the Catholic Church. The local branch of Promaica organises activities that aim to promote women's rights through the acquisition of skills such as sewing and knitting. A local Catholic widows' support group offers Bible study and advice sessions, and the chance to cultivate communal land, the produce of which is shared with the church. The pastor of the Pentecostal church holds regular meetings with groups of women from his congregation to discuss 'problems in the bedroom'. Young members of all the churches help elderly, sick, and frail congregation members with their housework. Youth groups are also enlisted by the town's administration to carry out environmental clean-ups and have been involved in preventive-health initiatives, such as anti-alcohol campaigns, through their churches.

Other organisations

International and local NGOs in Ganda support a wide range of programmes: they distribute material goods, agricultural inputs, and food; they work to rebuild the physical infrastructure; and they develop community-based initiatives to provide basic social services. Local community groups include traditional dance groups, which perform at the many official celebrations and sporting events in Ganda's social calendar, and the municipal and *bairro* football teams.

2.3 Health-service providers

Health-service providers in Ganda can be divided into two levels — those which function within institutional structures and those which work outside them, at community level. Community-level providers include *kimbandas*,¹⁷ home-birth attendants,¹⁸ sellers of both modern and traditional medicines, and voluntary members of *bairro* health committees (BHC). Providers at

institutional level include state-run, church-related, independent, and other agencies (see Appendix 6 for more details on all health-service providers in Ganda).

Some officials (for example, Government representatives) consider the distinction between health-care providers at community and institutional level to reflect a difference in quality of service. Churches, NGOs, and other institutions are regarded as legitimate actors in the health field, whereas traditional providers such as medicines sellers and spiritualists are branded as 'charlatans and liars'. The role of churches and NGOs as service providers during the emergency years means that officials consider them as *igual do governo* (equal to the Government). However, this official response may not necessarily be reflected in people's health-care behaviour and beliefs. For others, churches and NGOs form a relationship between community and Government providers, mainly by working with *kimbandas* who use modern medicines, or home-birth attendants who have some links with the maternity department of the state-run hospital.

Traditional health-care providers

The number of *kimbandas* currently practising in Ganda is unknown, because the tools of their trade are usually kept secret — particularly in the case of spiritualists, who are said to be numerous. However, people 'know who they are'. In order to differentiate between them, it is useful to consider their varying methods of practice (see Table 2).

The use of herbal remedies in health-care is not confined to recognised *kimbandas*; many elderly people and those who originate from the mountain communities retain the required knowledge. Nor are methods of practice mutually exclusive; and *kimbandas* are not

averse to experimentation — they adapt treatment to each case's circumstances and the resources available. Several people claimed that a recent useful treatment for a stiff neck was a massage with the butt of a gun. (For some, who consider themselves more 'developed' than people who believe in spiritualism, the power of a *santa* or a *santo* lies in their judicious use of herbal remedies in conjunction with ritual, which they say only serves to distract the patient.) In some cases a *kimbanda* will be known for her or his success at managing a particular health problem, rather than for using a specific method of healing. A *santa* known to treat women who have suffered repeated spontaneous miscarriages takes her patient to a riverside, where she marks a site with ash and feathers. Traditional drums are played and there is singing. The patient lies in the water and is washed with roots before a charmed cord is tied around her waist, which is worn continually to prevent miscarriage and to protect future pregnancies. A local *kimbanda* who treats children thought to be late walkers is renowned for his injections of antibiotics, dietary advice (he recommends beans, liver, and soup), and massage.

Institutions as health-service providers

Institutional health-service providers are linked to some extent, because MINSA regularly collects data from health facilities in order to record which activities were undertaken. Planning and managing vaccination campaigns also involves collaboration at this level. However, while patients may occasionally be referred from a state-run hospital to a private clinic (for example, to obtain a prescription for a medicine the hospital lacks) or to a *kimbanda* (if they find a condition untreatable by Western science), there are few other links between

Table 2: *Kimbandas* and their methods of practice

	Methods of Practice				
	Herbalism	Spiritualism	Prayer	Modern medicines	Dreams/visions
Private practitioner	*			*	
<i>Santa/santo</i>	*	*	*		*
Diviners					*
Home-birth attendants	*				
Part-time practitioner				*	

providers which would offer opportunities for an exchange of experience, joint planning, and thus for improvements in health services.

To everyone in Ganda, health services encompass those provided 'outside' the household, and those within it, concerned with matters such as cleaning and food preparation. Outside health services range from the purely curative (for example, medicine sellers) to the preventive (for example, hygiene education by BHCs or awareness campaigns promoted by church youth groups).

It is apparent from MINSA activity reports in Ganda that state-run health-service providers are interested in the promotion of a primary health-care programme. However, the fact that most elements of the programme are located at central facilities could reduce the impact and effect of the promotion of health for all.¹⁹ Some informants noted that health education, once disseminated by the churches, now reaches the people only through vaccination and cleaning campaigns, or when they go to the hospital and are given medicines with explanations about how to use them. Table 3 identifies the specific elements of primary health-care and illustrates the community's perception and experiences concerning its sources and provision.

Environmental health services

Most of the population obtains its water from traditional wells. More than 600 of these were protected with cement headstands and wooden tops in 1995. Although most of them provide a year-round supply of water, some refill slowly during the dry seasons, yielding only small volumes of turbid water; some dry up completely. Seasonal activities, such as the making of mud bricks, put a strain on water sources. Alternative water sources are the two small

rivers which intersect rural *bairros*, and a small number of working public tap-stands in the semi-rural *bairros*. Rainwater is not collected by custom, and large containers cannot easily be obtained. Water is supplied intermittently to public taps which serve urban residents.

Several hundred temporary pit latrines were constructed during the emergency period of 1994–95 to alleviate appalling sanitary conditions in the town, but there are many informal, open-air defecation areas currently in use. Despite this, young urban residents state that people in the *bairros* are 'underdeveloped because they defecate in the open air'. The huge flat rocks that scatter the landscape are popular sites for defecation as well as for pounding grains; there are separate (unmarked but well known) areas for each activity. Alternative sanitation facilities for *bairro* residents are household latrines (of a modified ventilated improved pit (VIP), soak-away, or traditional design). Sanitation in the traditional villages used to be less of a concern for people, who had 'no worries about latrines' because there was ample unoccupied land and animals to eat the faeces (chickens in particular enjoy the worms contained in them).

Oxfam Ganda, as part of its environmental health programme, has provided the means for public institutions to construct latrines. As yet, few of the schools and churches can claim to have public sanitation facilities. But institutional health facilities have responded by constructing pit latrines, some of which are maintained by dedicated employees. However, the care of public facilities is generally problematic.

The Municipal Community Services Department is responsible for the maintenance of six pit latrines located at the central market. As long as they had a 'guard', who collected a nominal usage fee and undertook daily cleaning of the facilities, the latrines were popular with the

Table 3: Primary health-care services

Intervention	Provider
Education on common health problems	Health-facility staff, <i>bairro</i> authorities, peers, family
Promotion of food supply and nutrition	Family, NGOs
Adequate water supply and basic sanitation	NGOs, Government
Mother and child health	Family, home-birth attendants, health-facility staff
Vaccination programme	MINSA
Provision of essential medicines and curative services	MINSA, church, <i>kimbandas</i> , family, medicine sellers, NGOs

market community: they were clean and had wooden doors. After the guard abandoned his post, the latrines rapidly deteriorated to a filthy state. Stallholders complain bitterly of the smell and flies that now plague the small eating places and meat stalls nearby, and of the health risk which the flies might pose. They suggest that the latrines should be torn down and new ones built, for which people would be prepared to again pay a reasonable usage fee. A protest action will possibly develop to bring the problem to the attention of the community services.

2.4 Sociocultural factors

How do people earn a living?

Most people in Ganda live by subsistence farming, although recently they have also earned money as contract workers, and although the land is better suited to grazing livestock and commercial farming. Many rural people aspire to having the ability to raise cattle. Building up a stock of small animals is the first step in this process, but recent conditions for this have not proved favourable, so that farming is now an alternative source of income. Land for cultivation can be obtained from *bairro* authorities, which allocate portions from the few remaining agricultural associations or abandoned commercial farms,²⁰ by private sale or rent, or through the family network. Displaced people in Ganda usually rent or borrow land, because their own land is too far away or continues to be inaccessible. It is not unusual for agricultural land to be located half a day's walk from Ganda. *Lavru* land (at a distance from the river) yields more than *naca* land (close to the river), because its harvest extends throughout the year from January until November, when the 'first hunger'²¹ begins and is fed by *naca* produce. The traditional staple crop is maize, although many people plant sorghum, a more resistant crop, in case the maize harvest fails. Other crops grown for sale, exchange, and consumption include beans, sweet potatoes, and cassava; vegetable gardens produce tomatoes, cabbage, and onions.

The local *kandongga* (exchange market) system provides a livelihood for some, particularly urban-based, people. At the same time, it offers rural people access to consumer goods when they have surplus produce for exchange. An urban woman uses part of her husband's wage to buy items such as soap, clothes, and dry fish in

Ganda market. She takes the goods to an exchange market on the border with UNITA-controlled territory where she trades them for maize, sorghum, honey, beans, or peanuts. On her return to Ganda, she sells these products (reserving some for her own household's consumption) and uses the profits to buy more items for exchange. In June 1997, 1kg of maize cost 40,000kzr in Ganda. A skirt bought in Ganda for 300,000kzr could be exchanged for 20kg (800,000kzr worth) of maize.

Thus, the *kandongga* enables people to increase the value of their products above their monetary value and to avoid the need or risk of storing their savings in currency. There are few openings for salaried employment or wage earnings locally, and most offer meagre incomes when compared with the prices of basic food items.

Therefore, many people make a living by combining activities that respond to changing circumstances, although opportunities to do so are more readily available to those living close to the urban trade centres. Displaced men build wooden handcarts to use as taxis between the central market and the *bairros*, and small canteens have opened along the main road. There are increasing numbers of small *bairro* distilleries producing sugar cane liqueur, and women sell maize meal. Vitamin-rich husks are sold as animal food. Although grass mats, baskets, and clay pots are produced on a small scale, there is no local handicraft industry. Some activities are seasonal: November brings the mango trees into fruit, June is the season for collecting honey. An increase in the movement of people and goods between the *planalto* region and the coast has brought other opportunities to acquire cash and goods. Possibly as a result of increased trade, prostitution occurs — largely in the town, with women working from known 'houses' or concentrated around the market place. Urban residents observe that there are increasing numbers of young girls from the rural *bairros* and *quimbos* in the town. Remittances from outside of Ganda seem to play a small part in household income, though goods in the form of clothes and other non-food items may be sent from relatives. There is no state-run social security system.

How do people manage their means?

After several consecutive years of drought and poor maize harvests, households have few

reserves left, and grain stores which would normally have lasted the year sit empty. Women especially talk of the need to *desenrascar*,²² in order to feed their children. In times of hardship, the number of daily meals is reduced — first affecting women, then children — and the variety of food is limited. Sorghum is harvested and eaten early, or staple dishes are made from alternatives such as ground hard bananas and boiled green papaw. Wild plants, and whenever possible animals, are consumed as food. The focus of the household, and thus women's daily preoccupation, is to acquire food. Protecting one's assets becomes increasingly important as the number of thefts of small animals and crops rises. Where close family members are in a position to help, they may give food directly, allow relatives to work their fields in exchange for food, or take children into their own households. (Apparently, younger children are preferred to teenagers because they help with chores, whereas the latter 'cause only problems'.) Elderly people who have no family support may beg for food and clothes in the roads. However, some rural *bairros* have communal fields, which community members farm once a week in order to provide support to their elderly and most disadvantaged neighbours.

Whenever people have surplus produce, they try to build up their assets by investing in small animals or items such as clothes, which act as an insurance policy for unexpected needs. When expenses related to ill health cannot be met by existing resources or by selling non-essential household items, a family initially seeks help from their immediate relatives, followed by more distant relatives, and finally neighbours. While there is a sense of obligation between family members, assistance from neighbours usually takes the form of a loan. In order to repay the loan in cash or kind, the borrower may undertake paid work, sell essential items, or make a small profit by trading in the market place.

The mother of a young child who had been ill and sustained a burn in a fire borrowed money from a neighbour to pay for treatment from a *kimbanda*. She planned to repay the loan by gathering firewood for sale but because she had no other means to buy food, half of the profit was spent on maize. Another woman who had nothing left to exchange for food for her young children regularly walked 12km to an exchange market, from where she carried sacks of maize back to Ganda, making a profit of 1kg in 10kg.

Although such ways of coping with poverty are in general regarded as survival strategies,

they are often simply part of resource management, or a response to changing circumstances. Selling firewood, carbon, or mangoes — which might initially be thought to represent responses to hardship — may be undertaken by choice in order to buy food to protect maize in the *lavras*, which, though edible, would have less nutritional and market value for the people if harvested while still ripening. In other instances, the prostitution of young girls to obtain the means to survive, which occurred during the recent years of war, would now be considered less socially acceptable, and might be undertaken only as a last resort to acquire means for a household. The impact of hardship on a household will largely depend on its capacity to employ strategies which could be considered reversible, such as borrowing from relatives or selling labour, and which do not increase the likelihood of being unable to recover its resources, such as selling tools, animals or land.

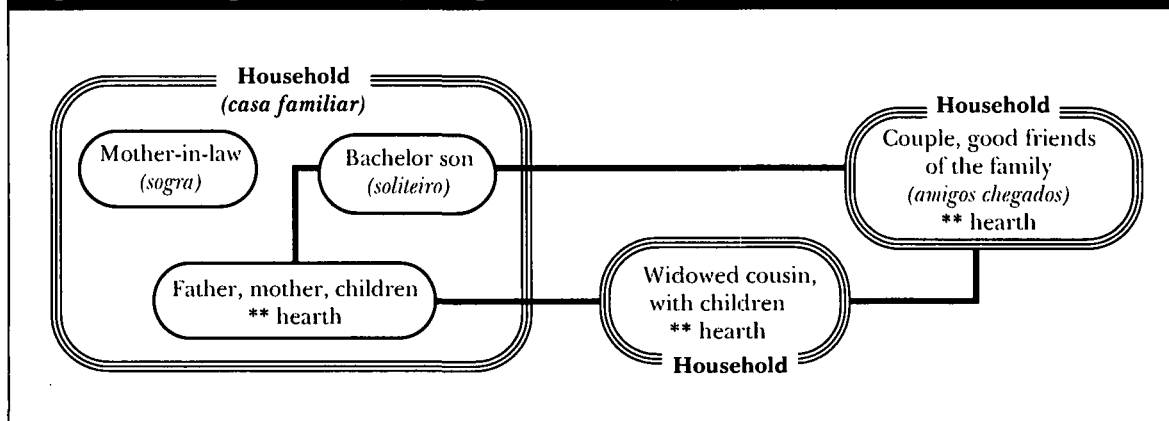
Who manages the means?

When describing a household, most people refer to a unit that includes all those who eat together around the same fireplace (*lareira*).²³ Members of a household are also said to share a plan for economising resources and the same worries in difficult times. Several households can exist within a compound, because by living in a *comunidade familiar* (family compound, see Figure 3) with family members or close friends, people feel they will not be 'exposed to the vices of strangers, nor will they be responsible for breakages.'

It is widely accepted in rural areas that the man who owns the house (or is married to or partner of) the woman living in it is responsible for making decisions about economising resources, although most questions will first be discussed with household members. The process of discussing problems is important, as is an 'understanding' between a couple; but as one woman said, when times are hard 'no one needs to discuss, because everything goes straight into the pan.'

Ultimately, however, the man will decide whether an item of clothing may be exchanged, an animal sold or killed, or resources pooled to buy food. He generally decides which seeds should be planted in the fields, and whether and how payment may be made for medical treatment. Although his wife may have physical control of the money to avoid it disappearing on

Figure 3: Example of a family compound made up of three households



drink, if she disagrees with her husband, she must sacrifice her own belongings, for example her clothes, to pay for what is needed. In the opinion of a group of rural men, 'The woman only has the care of the children, the house, the clothes, and the food for all the family in the house. The man is able, say, to have five women; the decisions of these households depend on him — food, clothes, health.'

A man with more than one wife, although he is absent from the house, is consulted about all decisions apart from those which concern the household routine (such as when to fetch water, go to the fields or prepare meals). Among men, polygamy confers stature, as a man demonstrates that he has sufficient means to support more than one household. As in most rural subsistence societies, in Ganda men are seen as the primary providers, while women are responsible for carrying out the most labour-intensive activities which maintain their households. Elderly household members, women in particular, are often expected to work in the fields, or to care for children and the sick during the day. Younger members are also expected to contribute to the income of rural households, either through working in the fields when not at school, collecting water, or sharing profits made from trade, although they are not obliged to do so. They recognise that their input entitles them to their parents' good care and concern, who in turn expect to be cared for in their later years by their children in return for the investment made in their upbringing. A group of young rural children planning their professional futures outside Ganda agreed that they would one day return to help their parents farm.

Obligations to one's immediate family are strong and, in some rural households, stronger

than those defined by conjugal ties. When times are hard, in-laws are sometimes the last ones provided for in a household, and even if a woman's husband's family lives nearby, she considers herself alone if her own family is distant. In past times, a man might have considered his sister's children closer to him than his own children, because they were of his family bloodline. Maternal uncles were often responsible for the counselling and support of their nephews and nieces; it was also said that they had the right to sell them into slavery. Laws of inheritance still ensure that a large portion of a man's property is returned to his blood family after his death, although his children — female and male equally — occasionally benefit. His wife can be forced to return to her own family with her children, having been stripped of her home. If a woman dies, however, her husband and children inherit her property. The following anecdotes, told by young women, illustrate the apparent lack of confidence and commitment surrounding conjugal relationships:

At times a man arranges traditional medicine for his wives to remain friends and not to make trouble or fight between themselves, but there is always disagreement between them.

Sometimes, a woman arranges traditional medicine to make her husband stay with her and forget other women. At the beginning, there are no problems, but later the husband becomes like a donkey in his infatuation for her, as the medicine kills his heart and he does everything the woman says, washing the children's clothes and dishes. The medicine fills up the abdomen and contaminates the body; the man's head is broken, and he forgets and neglects his own family, and dresses in dirty clothes. With the correct medicine [given by his family, who

realise what has happened to him] he is able to vomit everything out [and be saved].

A change in a woman's menstrual pattern can indicate that she has a *muhongo* (traditional pregnancy), which lasts longer than a normal pregnancy. As monthly bleeding continues, the 'baby' cannot develop properly, and the so-called pregnancy sometimes lasts for up to five years, until the woman takes traditional medicine. Her abdomen swells and shrinks, but the baby never actually appears.

Because the concept of *muhongo* allows for an unpredictably long pregnancy, and the actual date of conception could therefore vary quite considerably, it also provides a convenient way of explaining a real pregnancy that results from a non-conjugal relationship.

2.5 Health beliefs and behaviours

What is health?

Good health for people in Ganda almost universally means having food and being able to eat well. Good health is having water and soap to wash oneself and one's clothes at least every day. Good health is found in the hospitals and health posts, which should have a plentiful supply of medicines to treat all illnesses in people of all ages. Good health is not to have to worry about any of these things, to *estar a vontade*, and to have everything 'in conditions.' These are sentiments expressed by men and women, both young and older, displaced and resident in Ganda, although women apply the conditions to their children rather than only to themselves. For a group of rural women, to 'visit relatives and have communication between them all' was necessary for the health of a family. After having survived so many years of shortages and social disruption, it is hardly surprising that, for the moment, Gandans equate health with the security of having enough food, water, and health-care to meet their needs. Urban-based young people, whose basic needs are more likely to be satisfied, might add that good health for them also means having the possibility to play sport, to study, love, dance, and gossip.

What are the causes of ill health?

When people talk of ill health, they differentiate between 'normal illness' and 'traditional illness',

although the categories are not apparently distinct and what begins as a normal illness can become a traditional illness, depending on the nature of its development or chronicity. Normal illness is described in terms which stress the physical nature of the sensations experienced — headache, fevers, and chills — and often each of these is considered as an illness in itself. It is unusual for people to refer to a group of symptoms (such as that indicating malaria) or a syndrome as a single illness, or to attempt to explain the cause of a normal illness. Table 4 lists the causes commonly given for some 'normal illnesses'.

Causes largely reflect most people's living conditions; overcrowding has resulted in the appearance of 'new' illnesses (particularly among displaced people) such as yellow jaundice, measles, and cholera. The presence of faeces in the road causes smells and attracts flies, which in turn provoke vomiting in children, as 'the smell affects their hearts'.

Threadworm is the literal translation of the Umbundu term *makulu*, but the life-cycle and effects of *makulu* are quite different from a Western understanding of threadworm infection, in which transmission is effected via unwashed hands, and the infestation causes only symptoms of peri-anal irritation. A *makulu* infestation results from eating dry bread or leaves cooked without oil, or from sitting on the damp ground, or from the union of a male and female roundworm present in a person's abdomen, which breeds thousands of worms. Once *makulu* has eaten everything inside the sufferer's stomach, it moves through the body to the spine, which it climbs. When it reaches the person's neck, the bones of the neck become weak and break. Death follows.

The origins of some episodes of ill health are, at their outset, unknown, and only become apparent as the patient either recovers (with or without treatment) or gets worse. For example, a healthy child who fails to thrive after an episode of diarrhoea may have been bewitched by another mother, who was secretly envious of the child's previous good health and cast bad thoughts. The misfortune of a household whose children suffer repeated episodes of illness such as fevers and diarrhoea might have its roots in an unresolved interpersonal conflict, between people and their ancestors or between inhabitants of the living world. Ancestors used to form a constant and crucial part of people's lives. *Olondede* (the forebears) accompany their living descendants, advising, chiding, and consoling

Table 4: Perceived causes of some ‘normal illnesses’

Illness	Cause
Headache	Threadworms, nasal congestion, fever, carrying heavy weights on the head, many thoughts and worries
Backache	Sitting on the ground all day, working in the fields, fever, threadworms, carrying heavy weights on the head
Cough	Salty food, dry fish, carrying heavy weights, cold weather, hunger (causing tuberculosis)
Fever	Threadworms, nasal congestion, wounds, mosquitoes, climate change
Nasal congestion	Smoke, new grass, dust, climate change
Abdominal pain	Indigestion from sweet potatoes, beans, raw or badly cooked food, wild plants, maize from mill, threadworms
Simple diarrhoea in children	Weak breast milk, eating wild plants every day, sorghum, change in diet during rainy season

them. If traditions were not properly respected, and the *olondele* felt offended or disregarded, the individuals or households in question would be punished. The punishment was bad luck, ill health or even death, unless reconciliation and appeasement was sought. Although people say that the influence of the church encourages them to disregard such beliefs, the deep need remains to understand and to explain why some people suffer more than their fair share of misfortune.

Conflict between a husband and wife can induce a ‘nervous illness’ in the woman, which is manifest in apathy, withdrawal, a twisted face, and even, at times, a uterine prolapse. Similarly, lack of harmony between the parents of an unborn child, or the father’s infidelity, can harm the pregnancy, the delivery, or the child’s subsequent health and development. Envy of someone else’s good fortune can also lead to health problems, because the aggrieved person either uses intermediary agents such as poisoned flies sent to settle on the other person’s food or body, or administers traditional substances:

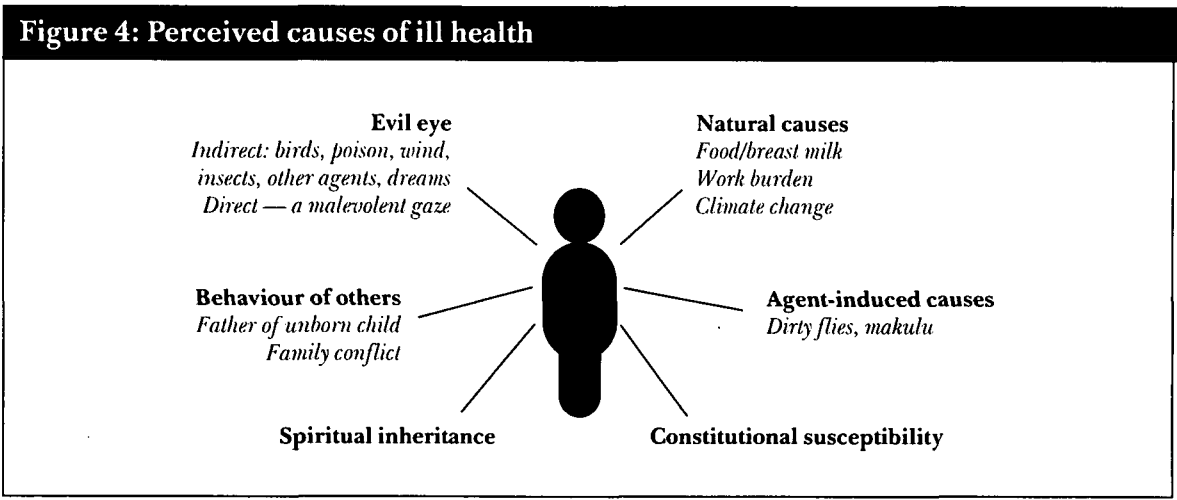
An urban man who was so fortunate as to have a paid job began to experience a change in his lifestyle. He took to drinking in local bars and to generously entertaining his friends. His household suffered as his earnings disappeared, but he refused to listen to their warnings and pleas. At times, he beat his wife. Fearing that he had been bewitched, his family tricked him into taking a remedy against the spell by explaining that he needed treatment for jaundice, as his eyes were yellow. Only when the

medicine caused him to vomit out all the ‘illness’ did he realise what had happened to him. He and his family blamed his behaviour change on a poison placed in his food or drink by someone who wanted to benefit from his loss of control and decline into alcohol dependency.

Some illnesses are more likely than others to be attributed to a traditional cause, and the circumstances surrounding their onset will be considered as part of the explanation. Convulsions in children are attributed to the harmful influence of a bird that has passed overhead and caused the illness *pássaro*.²⁴ If the child survives, any subsequent convulsions will be attributed to the continued effect of the illness.

Harmful influence may also be exerted through dreams, in which a vision appears of the person casting a spell, or in which *vanumuso* (tiny devil people) appear to fight with the sleeper, using a sharp stick or a knife. On waking, the dreamer experiences a sharp, localised pain in his body or coughs up blood — indications that an injury was sustained. Not everyone, however, is susceptible to the effects of traditional illness, and those who escape it are said to have a body and blood with certain characteristics. Entire families appear to be immune to traditional illness, because inherited characteristics offer them protection.

People use complex explanations of illness, which are sufficiently flexible to take changing circumstances into account, to make sense of their health and that of those around them (see Figure 4).



The disruption and conflict which resulted from the war have led to an increase in the incidence of illnesses related to evil eye in some communities. Family groupings have been separated; there is hate and suspicion between people; and a few thrive while others continue to suffer. The familiarity with which people talk of well-publicised illnesses such as cholera, measles, and TB suggests that even if people do not know the microbial cause of these illnesses, they are aware of the environmental conditions in which they spread. While some causes of ill health are perceived to be avoidable, for example, by having sufficient and appropriate food, others are probably not avoidable, such as illness induced by evil eye. Explanations of some forms of ill health, such as that caused by alcohol dependency, are, perhaps conveniently, used to abdicate responsibility.

2.6 Health-related behaviours

When describing health-related behaviour, people differentiate between three categories of behaviour: behaviour which helps maintain good health; actions taken specifically to prevent illness; and actions taken to restore health.

Actions taken to maintain health

These broadly cover what people describe as 'health services within the household', and include care of living space, care of food and water, and personal hygiene. People from all backgrounds and age groups recognise that for certain individuals and at certain times of life, special care must be taken to ensure that good health is maintained. Special care is considered

important for young children, the chronically ill, and pregnant women. How well these groups are cared for depends on the availability of health-care, which varies according to the degree of urbanisation.

Care of living space

The first task of the morning for the women and girls of a household is to clean the compound and living quarters. Girls are introduced early to the traditional female role as carers within their households, undertaking tasks appropriate to their ages. Blankets (if people have any) are hung out in the sun and dishes washed 'so that the flies are not able to provoke illnesses.' Sweeping out rubbish is said to reduce the nuisance of flies and dust; cutting back grass and vegetation removes hiding places for snakes and scorpions; and clearing away children's faeces reduces bad smells. When the ground is not too hard, faeces is buried. Household rubbish is buried in pits, although most plastic bags, bottles, and tins are reused.

Cleaning is generally seen as each household's responsibility, and some people claim not to know what others do, but a woman who tolerates a dirty or untidy environment will be talked about by her neighbours. Displaced men feel particularly aggrieved that the disruption to normal routine and the overcrowding of their living conditions has resulted in a neglect of cleanliness and in negative effects on people's health. An accumulation of rubbish outside the compounds, in communal spaces and roads, suggests that shared spaces are no-one's responsibility, unless the work is undertaken in a clean-up campaign organised by the authorities. Notably absent from discussions with rural

people was mention of latrines, perhaps because they are still familiar with the custom in traditional villages of allowing natural degradation or removal of excreta by animals.

Care of food and water

The desirability of providing a diet that includes a staple, plus vegetables or meat cooked in oil, is well accepted by women, men, and children, regardless of background. When families live on stomach-filling rather than nutritionally valuable food, it is because they lack the money or opportunity to provide good food, not because they are ignorant about nutrition. At times, 'good food is anything that appears'. Some mothers believe that a child's hunger pains indicate an organism living inside its stomach which is beginning to eat into the child's body.

Maize porridge, which provides vitamins and energy, is served to all age groups, as a thin gruel for infants and as porridge for the sick. Depending on the stomach and age of the person, it is eaten with or without husks; for example, maize milled with its husks is thought unsuitable for children. Women are responsible for deciding who eats what according to custom and for ensuring that leftovers, if there are any, are boiled before eating. The ability to feed others at social occasions such as weddings, funerals, and during times of mourning is perceived as an important indicator of a person's (particularly a man's) position in society and of his or her commitment to family obligations. In anticipation of such occasions, and because chickens are valuable as offerings, exchange, and food, eggs are kept for breeding rather than eating.

Water is carried from source to home in various containers, usually plastic or metal basins and pans. Boys and girls help their mothers and, in rural areas, spread large leaves on the water's surface to minimise spilling it. Once inside the house, water is occasionally transferred to small clay pots which are kept raised off the ground for cool storage, although it is rarely allowed to settle before drinking. Despite widespread knowledge that drinking water should be boiled, particularly for children and the sick, this is not a common practice because of the amount of pans, fuel, and time involved.

Personal care

According to young urban boys, 'girls have more hygiene' as they bathe three or four times a day, compared with their two. Young urban

women consider the urban areas to be more developed than others because they have a water system and washrooms. Women in rural *bairros* prefer to collect water once, late in the afternoon, to wash their children 'who spend their whole life playing with the soil', because without bathing, 'they will not sleep'. Soap is a highly valued commodity for everybody, without which washing is considered ineffective. Washing in public is disliked by men and women; if the compound has no washroom structure, they prefer to wash at a secluded riverside, where clothes can be washed and laid out to dry, or after dark in some privacy. Displaced men worry that women who are not able to wash pose a health hazard to their children.

Personal care also refers to how one controls one's body. Young people, especially those who live in towns, say that they ought to resist the temptation to take drugs, to smoke, 'which burns the lungs', and to drink strong alcohol, 'which leaves the head mad and the body without strength'. Young people also say that they ought to control their sexual behaviour by not having many partners, which can lead to serious problems such as gonorrhoea and AIDS — which come from men and sex, or women and sex, depending on who is talking. According to a group of young women living in a semi-rural *bairro*, 'a boy's first girlfriend (the one he is likely to marry) may drop him if he sees other girls, because she doesn't want to get illnesses... she may speak with him first to advise him not to get an illness. She says that other girls have sexual illnesses and she is going to leave him'. They mention HIV/AIDS information campaigns on the radio and at hospitals before the war in 1992-94 and are open about their concerns that they might be at risk of infection. However, they say about condoms that only 'the more developed, open, and unmarried young men would be able to use them'.

While young urban women consider it undesirable to become pregnant 'before the right time' or to have many pregnancies 'rapidly', how many children a woman has, and when they are born, is in 'God's hands'... and depends on the orders of the man. There is a belief that the preordained number of children in a woman's abdomen must be finished, the 'true number sometimes being 14'. But rural women feel that in reality their circumstances cannot support having many children. If there is 'an understanding' in the household, a woman may be able to tell her husband that she is 'near her time' and thus postpone sexual

intercourse. In the absence of calendars, women calculate their cycles by the phases of the moon, which may or may not coincide with their times of ovulation. Some young rural women believed that being 'near their time' meant that they were about to menstruate and sex was therefore unsafe. They were eager to gain a better understanding of their bodies and to learn how to work out their own calendars. They also anticipated that their knowledge would enable them to help their women friends, and to speak with more authority to their boyfriends. Contraceptive pills, which are not available in Ganda, are believed to ensure that, if there has been 'contact', the fertilised egg leaves a woman's body with menstruation. Young urban women know of locally available 'barrier' contraceptives (for example, pastes made from a plant mixed with soap and lemon, or tablets of aspirin, chloroquine, or penicillin which are used intravaginally before having sex).

Early years of childhood

Breast-feeding usually begins immediately after birth. The act of sucking ensures that the yellow milk is removed quickly to allow the 'good' white milk to flow. Some older rural women prefer that the yellow milk be expressed, although younger women try to speed up the change in the milk by washing their breasts with warm water. The baby's first green faeces are a sign that the yellow milk has passed through the child's body together with the remains of the food which the woman ate during her pregnancy. Baby-feeding bottles are uncommon in non-urban areas, although from the age of one or two months almost all babies are fed a thin maize gruel in addition to breast-feeding, which women from all backgrounds say should continue for two years. If a mother believes that her breast milk has become weak through lack of food and weak blood, she will immediately eat raw cassava and roasted dry fish, if she can afford it. Feeding a baby with weak breast milk is believed to cause it diarrhoea and ill health, and this combination of factors often precipitates early weaning. As women who describe their milk as weak usually appear to be reasonably healthy and with a good supply of milk, they might adopt such a strategy unconsciously to balance the many demands on their lives; it gives them a legitimate excuse to stop breast-feeding.

It is also widely believed that breast-feeding should stop when the mother becomes pregnant again, because each pregnancy has its own support system within the mother's body — placenta, blood, and breast milk. An elderly

rural woman explains that 'some children die because they have fed on the milk of another child. Having babies rapidly means that they take the milk of the child before, and if the situation continues, all may die because they lack their own milk. There used to be a traditional medicine for the woman to take to continue breast-feeding — it was normal for a woman to have children close together, because the elders knew which traditional medicine could help. But nowadays, without traditional medicine a pregnant woman is not allowed to continue breast-feeding when she is pregnant again, but the baby depends on the mother's milk. Some women are clever and wean their child as soon as they see their menstruation has stopped; but there are some who are ashamed to say that they are pregnant again and do not wean; others know, but they don't accept it and continue to breast feed until the new baby dies.'

There are no traditional weaning foods; but cessation of breast-feeding is said to be accompanied by the passage of all the milk from the child's body, who then needs four or five meals a day to recover his or her strength. A child who has been displaced by another pregnancy must also be protected from the heat of the mother's body and is placed to sit apart from her.²⁵ In some rural families, the child is rubbed with a cloth that has been used by its mother to clean herself after having sex with the child's father. The massage is believed to strengthen the child's bones and ensure good health.²⁶ Likewise, bathing the new-born while it is strapped on its sibling's back minimises jealousy and strengthens the relationship between them. Heat, semen, and blood all have a powerful influence on health. Young urban women talk of a common practice to rub a child's joints with its mother's first menstrual blood, while thin new-born babies are given sips of their own bath water to drink, as it contains the heat from their body.

Chronic illness

Sufferers of common and chronic illnesses such as *pássaro* and its equivalent in adults, *tensão de gota*, must observe certain rules in order to maintain their health. They are not supposed to stay near open water, in crowded spaces, or near the fire. Neither are they allowed to eat meat from male animals, fresh fish, meals cooked in blood, and certain red or sweet foods, such as tomatoes and honey. They and their carers should not visit a house where there is an unburied corpse, as the heat from the body is capable of exacerbating the illness, nor should

they request embers from the fire in the house of a deceased person. This demonstrates that people feel their actions can in some way influence the course of an illness, even if they believe it is almost incurable.

Pregnancy

Women are very sensitive to their pregnancies and to influences on the developing baby. Interviewees from all subgroups talked of the importance of care during pregnancy. For a group of semi-rural women, antenatal care should be undertaken because 'every baby has its own bed in the mother's abdomen, and the quality of the beds changes as the first ones, the best, leave with each delivery; after the third or fourth the mother's body changes, she suffers many illnesses and births are difficult'.

Younger women tend to link their care with services provided by the midwives at the hospital, where they are given vitamins and medicines, while older women are more concerned with the kinds of food they eat and the heavy work they do. It is considered normal to carry 40-50kg, but they believe this should be reduced to 20kg in pregnancy in order not to provoke an abortion, a premature or a difficult delivery, or an unhealthy baby. Some women believe that hospital midwives are able to see from the shape of their abdomens that they have been doing heavy work, and will scold them, saying they will not have the strength to deliver. During pregnancy, the baby is said to have its own tastes, and although green vegetables and fruits are widely recognised as suitable foods for pregnant women, food that disagrees with the baby will make the mother feel nauseous and vomit. Eating rabbit is prohibited, as the baby will be born with a face 'torn like a rabbit'; eating tortoise meat will prolong the length of time the child crawls on its belly.

Some rural traditions, especially in relation to a traditional pregnancy (*muhongo*) involve the pregnant woman placing a stone or stick, or banging a rattle, at any crossing in the road that she passes, to ensure that the baby does not 'stay there'. The parents may also talk directly to the unborn child, or the father carries out a ritual before leaving the house to protect the unborn baby in his absence and not to 'take it with him', i.e. cause an abortion. A commonly available plant may be taken by the mother as a medicine throughout a normal pregnancy, to protect the unborn child from the harmful effects of its father's relations with other women. As with the issues surrounding weak breast milk, while

women feel responsible for the well-being of their child, they are also liable to be blamed if something goes wrong with its health and development. But rural people believe that ultimately the outcome of a pregnancy is outside human control, because 'there is an organism within the woman that bites the baby before it delivers and leaves its water in the body of the baby without a mark; the baby dies aged a few months or years'.

Actions undertaken to prevent illness

Health-care providers and community members explain that in order to prevent an illness, one must know the nature of the threat in order to institute appropriate measures against it. There seems to be a trend for people in Ganda to associate preventive actions with health-care providers, so that the actions are the result of users' and providers' combined efforts.

Vaccination

While people do not generally understand the microbiological working of modern preventive interventions, they have credibility because they are linked with diseases well-known to be major causes of child illness and death. A vaccination is said to protect the child from a certain illness, or to ensure that the child suffers only a mild form of the illness. The local vaccination service and periodic campaigns have raised levels of awareness among both the displaced and the resident population. However, rural women say of those still living in remote traditional villages: 'The women are not used to vaccines as they have never had them and now don't give any value to them'. All subgroups of the population talk of the need to vaccinate children several times from the first day of life until the fifth year, until they have had all the necessary jabs. A newly delivered baby will often be taken by relatives and friends from the *bairros* to hospital for a first vaccine, but some confusion was reported among mothers, because 'the nurses now say vaccines should begin at three months'. Interviewees know that each vaccine treats a specific illness and has its own name, and name vaccines for measles, tetanus, fevers, diarrhoea, and whooping cough. After receiving a vaccination, a child is feverish, cries at night, and its arm is swollen — signs that the medicine is working in the body.

Young urban women relate their attendance at the hospital antenatal clinic to the availability of vaccines 'to prevent problems' and 'to avoid certain [unspecified] illnesses', but others who

have had uncomplicated deliveries in the past feel there is no need to consider vaccines. The belief in the power of the needle is greatly exploited in the practice carried out by some young urban men, who privately receive courses of antibiotic injections to protect against various illnesses, including fevers and sexual illnesses.

Traditional methods

Modern and traditional methods of illness prevention are not mutually exclusive, and many children who receive vaccines also wear traditional protective tokens. Traditional methods of protection are also called upon when children suffer from chronic ill health, and this custom is not necessarily confined to rural areas. A red cord bracelet is said to protect a baby from rashes, and often carries a tiny piece of wild animal hide to guard against illness caused by envy, evil eye, and the wicked intentions of others. It can also help to thwart the effect of a harmful wind that makes a healthy baby lose weight. A small bag attached inside the baby's clothes, containing the baby's dried umbilicus mixed with herbs and a piece of a feather, is supposed to guard against the illness *pássaro*, which is caused by a bird's harmful influence. Usually, the tokens and medicines are provided through the services of the elders and spiritualists. As part of a consultation, a *santa* prescribes traditional protective medicines, which the patient and his or her family place at strategic places in the home — for example, around door frames, close to sleeping mats, or near the fire.

Recovering health

When people talk about treatment, their first response is to refer to the medicine that is required, whether it is modern (tablets, ointments, and injections) or traditional (herbal). However, treating and managing illness means more than a simply a cure with medicines: patients and their households take actions which aim to prevent the condition from worsening and to promote rapid recovery.

A child who is suspected to have measles is placed in the sun, so that the heat will quickly draw the illness in the spots out of the body. During the cold season, the child should be dressed in red clothes for the same effect. Using special instruments 'to look inside the child's body' (these appear to be auroscopes), some private practitioners can diagnose measles before the spots appear, giving an opportunity for appropriate measures to be taken. The inside of the body — including the bones and

intestines — is affected to such an extent that wounds form in the throat, which closes, leaving the child unable to speak or eat. Once the spots have appeared, the child is not allowed to leave the house, nor should its mother attend the funeral of a child who has died of measles, for fear that the heat from the death will exacerbate her child's illness. When the child begins to recover, a paste of maize husks is rubbed on the skin to encourage exfoliation. To open the wounds in the throat and recover lost strength, the child is given a thin maize porridge to eat, as well as young chicken meat if the family can afford it.

Early symptoms of illness are interpreted in the context in which they occur. According to the perception of the sufferer and those around her/him, a decision is reached on whether there is a health problem, and second, whether it needs treatment. Diarrhoea in adults during the rainy season — when diets change and food is scarce — is so common that it barely merits attention. So, too, is eating sand, which rural women and men consider a normal reaction, by adults and children alike, to the smell of the earth after the first rains. The desire to drink water early in the morning may be a sign that the afternoon will bring a fever, and lying in the sun may help to draw the fever out of the body. If someone wakes to a dream in which *vanumuso* have appeared, the sleeper must not wash his or her face, for fear of forgetting who sent the dream. Sometimes the onset of an illness is so dramatic — as with *cabeza grande*, a traditional illness in which potentially fatal bleeding occurs from the mouth and nose — that there is no doubt about the need for rapid traditional treatment.

There appear to be preferred treatment-seeking patterns for the most commonly experienced 'normal' illnesses across all categories of the population. Children with simple fevers should be treated at the hospital with the appropriate medicine. Likewise, adults with fever and headache will in the first instance seek treatment from a hospital, health post or clinic. But if a fever is accompanied by a convulsion, the initial treatment sought in most cases — particularly in rural areas — is traditional. In these cases, modern medicines (including injections) are believed to prejudice recovery, if not actually cause harm to the patient. Simple diarrhoea can often be treated at home, with potions made from the leaves of common trees, roots, special stones, or mango bark, mixed with warm water and given in sips several times a

day. Few people mention giving oral rehydration solution specifically to increase fluid intake during an episode of diarrhoea, although some young urban mothers cited water and salt as a possibility. Sugar is difficult to obtain locally, and available alternatives, such as honey or fruit juices, are not mentioned. A maize gruel is fed to patients, and treatment mixtures change with the symptoms. Every illness is believed to have its own treatment, but the initial treatment in almost all cases of illness involves some form of ingestion, purging, application, or inhalation of a remedy — whether it be modern, traditional, or a combination of both.

Optimising conditions for recovery involves both patient and family in an understanding of how and when the treatment is to be administered, and what rules they should observe regarding the patient's diet. Several health-service users of all ages and backgrounds mentioned that they had not been given dietary advice during their consultations with a health-care provider. Such advice is considered indispensable, as 'a remedy taken without food may become like a poison', and an incorrect diet might prejudice recovery. Patients' expectations that recovery will begin within a day or two of treatment seem to be higher with modern treatments than with traditional ones, but an alternative treatment may be sought soon after the first one appears to fail.

A young urban man who was diagnosed with malaria was still feverish after the first day of taking the prescribed medicine. He visited an elderly relative in a rural *bairro*, who gave him a herbal remedy for the *makulu* which the patient believed was causing the fever. A common alternative treatment for *makulu* is peri-anal or vertebral scarification, after which the bad blood containing the *makulu* is expressed and medication is rubbed regularly into the wounds to heal them.

Spiritualism and divination are not often the first choice of treatment for most illnesses which present with physical complaints, although some ritual may be involved (for example, in managing convulsion-related illness). Yet when a person or family suffers repeated episodes of ill health, a prolonged or debilitating illness, or when there is a history of interpersonal conflict, help from the spirit-world may be sought to understand the cause of the problem and to guide treatment.

2.7 Why do people make the choices they do?

Health-related behaviour — the process of decision-making — can be seen as an interaction between three predominant elements: information, access to resources, and beliefs. Each of these elements is in turn shaped by a range of factors. The dissemination of information is influenced by the sources and means of transmission. Costs and seasonal effects determine people's access to resources. Beliefs about health-behaviour are influenced by concordance of views, personal benefit, and ability to make changes.

Information

The belief in the importance of family ties is strong in Ganda, particularly in the more rural communities. Tradition held that young people learned from their elders, and that the extended family was the source of one's support and counselling. Girls still learn through accompanying their female relatives in the care of the household, while boys cluster around the *ondjangos* to hear the rural elders discuss their lives. Within the family, one person — young or old — may be thought of as a *walunguka*, a person with a particular capacity to understand and share an experience of life, gained through careful observation of his or her surroundings (rather than through inherited powers). A *walunguka* has the courage to speak out on issues relating to the solution of household problems, courage which others lack through shame or embarrassment, and his or her advice will often be sought.

Young people, particularly in rural communities, view the elderly as valuable sources of knowledge with regard to traditional practices and herbal remedies, and elderly women are valued for their experience gained in years of assisting at childbirth. However, people who have been separated from their own families in the disruption and displacement caused by the war say that they feel lonely and isolated, and are at times unable to seek help from their in-laws and neighbours. The suspicion and mistrust that now pervades some communities has erected barriers between people who consider each other strangers, whose motives cannot be understood. In some circumstances, there is a tendency to see representatives of official structures as punitive rather than supportive; catechists who deal with naughty children, *sobas*,

and teachers who punish the young. The difficulty sometimes experienced in the relationship between health-service providers and users is expressed by young rural mothers, who had 'felt shamed and annoyed by nurses who spoke rudely to them and blamed them' for their children's ill health.

Much of what people learned traditionally from the elders was transmitted through storytelling which took place in the *ondjangos*. Without books and pictures to refer to, they spoke of the real pictures in their heads. A low level of adult literacy, a paucity of written materials for those who can read, few opportunities to reach secondary-level education, and the concentration of the few existing radios in town, mean that information is perhaps still most reliably conveyed by word of mouth. Women today sing songs telling stories of the war years while they pound their maize. Dramas are acted out with dance. The small, indistinct health-education posters stuck high on the walls of some health facilities are less attractive and effective. People say they are more likely to trust information if they hear it repeated from several different sources which they respect, and if the information is consistent. This is illustrated by community members' explanations of the success of some childhood vaccination campaigns in Ganda. Staff at the health facilities give prior warning of an 'oncoming illness or health problem' to the *bairro* authorities, who then deliver the message to people in their *bairros*. Other *bairro* members who visit the health facilities receive the same information from staff and relay it to friends and family. Another announcement may then be made via a microphone or, occasionally, on the radio.

However, some health-care providers' tendency to talk of health issues in terms which imply a superior biological and technical knowledge puts others at a great disadvantage. This is one of the potential barriers to developing relationships in which health knowledge is respected and shared. While brief lectures are held for waiting patients at health facilities, there is little encouragement of discussion and questioning, which could be an important part of the learning process. Likewise, health-care providers who reduce people's complex understanding of what causes illness to a single explanation — such as blaming microbes for diarrhoea — will be treated with some scepticism, because people's views have been formed by years of experience and rationalisation in order to arrive at satisfactory, meaningful

understandings of their changing world. This is not to say that local people are unwilling to learn, or that it is impossible, with an appropriate approach, to build on their existing knowledge of factors which influence their health, and explain their relevance to their lives.

Access to resources and costs

State-run health services are provided free, although transport costs (by wheelbarrow or, rarely, by vehicle) are incurred by the families of seriously ill patients, the frail elderly, and women in labour. The time people spend travelling to obtain free modern health care must also be considered, as should the time spent waiting for a consultation — an average of three or four hours. Although the state-run children's health services are a preferred first treatment option for most 'normal' childhood illnesses, their use as a preventive or positive health service could be restricted by the many other demands on women's lives. Mothers visiting the clinic rarely have someone at home to help with their work while they are away. This has implications for the effectiveness and completeness of vaccination schedules, and limits the opportunities for learning more about healthy children's development — they only come in when they are ill. The non-monetary cost of treatment also increases the pressures on some household providers, particularly women. When faced with long-term hospital treatments for themselves or their children, they have to balance the knowledge that the illness is serious with the needs of their households. In the words of one young displaced woman, who abandoned tuberculosis treatment in Cubal as soon as she felt better: 'I needed to cultivate my fields.'

Women, more than men, talk of the advice and care provided by close family members, elders, and friends which often concern reproduction-related health problems, such as failure to conceive and sexual illnesses. The price for a 'sexual illness' consultation is twice that of any other at one private clinic in Ganda. However, even where elders would once freely have given advice on traditional remedies, a lot of them now demand payment, perhaps a reflection of the difficult economic conditions in which most people find themselves. As few people in Ganda, except perhaps traders, have immediate access to cash, the ability to pay in kind or to pay on credit is an alternative appreciated by most rural and semi-rural users of fee-paying health services. For them, most

traditional consultations are undertaken as a second stage of treatment when home or hospital management of a normal illness appears to have failed. Providers of fee-paying services record a decrease in patient attendance at times between payments of Government workers, and when trade with coastal towns slackens. They have noted that, but cannot explain why, the number of consultations per week throughout the year has declined by more than a half, although no corresponding increase in absolute numbers is recorded at the state-run facilities. By contrast, services offered by herbalists and spiritualists often do not require payment until a cure has been effected. This offers advantages to both parties: it allows patients to spread the costs of treatment over time, and reduces expectations that a cure should be immediate because they pay up front. However, a goat or cow is then required as payment for apparently successful treatment of *cabeza grande* or *tensão de gota*.

A 15-year-old girl from a rural *bairro* presented to a private clinic with her mother, with whom she lived alone. She had a six-month history of chest pain, 'as if there was a wound inside', and a painful body. She had been treated with home-made herbal remedies many times, had attended the central hospital on several occasions, and had made three consultations with *kimbandas* in the *bairros*, paying 1 million kzt, 700,000kzt, and 50kg of maize (maize at 50,000kzt/kg, July 1997 prices). She had also visited the Catholic sisters' health clinic on four occasions, with costs totalling almost 3 million kzt. She was now attending the IESA clinic, where she received four packets of tablets and six injections. In order to obtain money, her mother had sold sugar cane and maize from their fields, all their chickens, and some of their fields. They were about to sell their mud-brick house to live in a smaller grass hut in the compound.

The father or husband of a household has the last word on critical decisions about the management of household resources and their consumption. While a woman may, for example, appreciate that a latrine in her compound could reduce the nuisance of smell and flies caused by faeces, she would be unable to have one without her husband's co-operation. In some circumstances, a woman managing her household resources without the influence of a man is less disadvantaged than one who is married and has no such control over the means which are primarily provided by her.

In addition, patterns of perceived health problems change throughout the year, together with the changing demands on people's lives which follow the agricultural calendar and opportunities for trade. This influences not only how people respond to ill health, but also how much time and resources they have for preventive and positive health-care. The dry months are normally a time for making repairs to the compound, for making mud bricks and for accumulating goods through the *kandonga* system. The rains bring the time of most intensive agricultural labour, with some women spending up to ten hours a day away from home. They worry that their children are more likely to be sick at this time, requiring more care when there is less time and energy to give it. The type of foods available change, and their variety is reduced. Women also say it is the worst time to be in the late months of pregnancy.

Beliefs

People's general health knowledge and their understanding of how their healthy bodies function influence the actions they take to maintain health. This is illustrated by the explanation of many women in Ganda that each of their pregnancies exists with its own support system. Some believe that the sharing of breast milk between infants is undesirable, while others see an increased need to give extra care for higher-parity pregnancies. The belief that much traditional illness is caused by some form of contamination, by an organism or other agent, means that traditional remedies are based on expulsion of the cause or the 'rubbish', through purging, bleeding, and exorcising. Thus a combination of modern and traditional remedies, to treat both the 'illnesses' and their causes, can be very successful.

People's focus on chronic problems such as recurrent pregnancy loss or failure to conceive suggests that these are important psychological as well as physical concerns for both women and men. From a medical point of view, this may partially reflect the consequences of inappropriately managed sexually transmitted diseases and of chronic undernutrition, particularly in women. However, people's preference for traditional spiritual and herbal care is also explained by their need to apportion blame for what appears inexplicable, and to embark on long-term care in which they, through the rituals they undertake, are part of the process of healing. The process of healing chronic illness

often involves important members of the patient's social network, whereas the management of a simple, symptomatic condition which is perceived to respond to modern treatments will not require the mobilisation of friends and families to the same extent.

External and uncontrollable factors, such as those imposed by years of drought and insecurity in Ganda, have contributed to people showing increased signs of resignation and passive acceptance of fate. But the existence of beliefs that certain actions can prevent or maintain health indicates that most people (particularly women) still feel that they have control over some aspects of their lives and those of their household members. Some urban youth clearly express the desire to avoid 'vices', such as alcohol, smoking, and early pregnancies, in order to maintain health; but for other subgroups of the population such issues remain largely unaffected by individual actions. People's expectations of individual benefit influence whether certain health-related activities are undertaken. Some women decide to attend antenatal clinics at the hospital in order to receive an attendance record card, without which they feel they will be punished by maternity staff, if they eventually require a hospital delivery.

2.8 Health needs

Major felt needs

There is an almost universal desire expressed by people in Ganda that there should be more medicines and more health posts available to all members of the population. Gandans are also generally dissatisfied with the current prescription services. Tablets that are given in fractions are believed to be less effective than whole ones, and treatments that consist of only one type of medicine are not thought capable of curing the several illnesses that the patient may have presented at the consultation. This does not necessarily mean that people wish to replace their own systems of coping with traditional problems, but that they consider the institutional health systems inadequate for conditions which require specific modern treatment. Such an expression also implies that people wish for a kind of health-insurance system, for the security of knowing that adequate and appropriate treatment will be available should they need it in the future. Frequent references to the loss of the

knowledge of traditional practices and herbal remedies which the elders have held for centuries are rooted in similar concerns about traditional health-care systems, threatened by family separation, economic hardship, and a lack of opportunities to pass on knowledge. Some people's concern about health services includes not only medicines, but also the quality of care on offer. Before the war, 'patients were never left in pain', an elderly woman explained; and 'there were not many maternal deaths, perhaps one a year died in childbirth. The nurses and midwives treated the patients and women well; there was more love between them [but] now there are negative cases where the babies or mothers are dying in the hospital. A woman arriving at hospital with pains has her whole body massaged and the baby is born dead. Because of the war, there is only hate and envy'.

'Illnesses' are a significant problem in the lives of most respondents, and much of it is perceived to be related to insufficient and inappropriate food. Having the ability to produce food in the present context of Ganda takes priority over primary needs such as water, sanitation, and education. While people are aware that the food situation does not compare with the years of starvation during the early 1990s, there is a real sense — among displaced people in particular — of the precarious nature of their lives and of the daily preoccupation with providing or obtaining food. As one elderly respondent commented: 'If the stomach is empty, how can the head learn new things?' Learning new things, such as how to manage their own business, is a way in which young women traders seek to improve the security of their livelihoods and open up opportunities. A common theme of comments made by young men from all backgrounds is the wish for a peaceful life, without war or gossip.

Institutional health-care providers' concerns focus on the population's high demand for curative services and the providers' inability to meet this demand in a way which maximises their scarce resources. If increased material support were available from other agencies, old networks of MINSA traditional birth attendants and health promoters in the *bairros* could be reactivated and additional public health activities, such as communicable-disease education, could be carried out by centrally based mobile health teams.

Evidence from other countries shows that the degree of community participation in the

development and implementation of community-level health initiatives is essential to their success. Generally, national initiatives which lack clear policy, a real commitment to community involvement, and the long-term financial support to ensure training, supervision, and monitoring, have been less successful than small-scale programmes,²⁷ which have been largely supported by NGOs. However, while such programmes do contribute to the development of community-level health services in some areas, an absence of clear Government policy and commitment to services will result in unequal provision of health-care, lack of accountability, and fragmentation of the health services.

Some health workers, notably private practitioners, appreciate that the continued judicious use of traditional, herbal remedies is complementary to other forms of health-care, and should be supported by focusing on other aspects of care such as dietary advice. Others think that using traditional medicines should be discouraged by means of community health-education programmes, because there are too many unknowns in terms of safe dosages and understanding of pharmaceutical effects. At the community level, curative health services are clearly more lucrative than preventive or positive health services, but informants typically feel that health-care providers at all levels need to co-operate more, by means of shared training opportunities and feedback.

Real health needs

It is clear that the main health needs in Ganda reflect a high level of poverty, as in other societies which have been socially, economically, environmentally, and politically disrupted for many years. And as in other societies, poverty manifests itself for the most part in health conditions that can be prevented if the primary needs of all members of the population are met. The most commonly diagnosed medical condition — throughout the year, in all age groups, and at all institutional facilities — is malaria. It is the diagnosis made in 40-60 per cent of paediatric consultations and in a slightly lower proportion of adult cases. By comparison, *pássaro* is also cited as a common childhood illness at community level; clinically, the

convulsions described in many cases are probably a manifestation of the fevers and cerebral complications caused by a malarial illness. A combination of factors relating to the proper diagnosis and appropriate treatment of malaria may be responsible for the recent emergence of local cases, which appear to be resistant to all commonly available antimalarial medication.²⁸ This has important implications for all health services. Other frequent diagnoses in adults and children are respiratory infections, gastrointestinal infections, and conjunctivitis, which accounts for approximately 20 per cent of 'emergency' consultations. However, with a wide range of diagnostic categories — up to 50 items in one month of health-facility consultations — and varying degrees of diagnostic skill in health-facility staff, interpretations must be made cautiously.

Although a large volume of health data is regularly recorded and reported in Ganda, it is difficult to interpret, which limits its usefulness for improving our understanding of local health trends. Without the possibility of comparing reliably gathered figures from all levels with an accurate demographic base, opportunities are lost for the development of monitoring systems and for better-informed health-service planning. Age and sex-specific indices of mortality and morbidity, which might reveal crucial differences between levels of health experienced by subgroups of the population, can only be guessed at. Certainly the frequency with which local friends and colleagues request assistance with wood and nails for coffins, the regularity with which funerals are held, and the personal histories of multiple child and infant deaths, are indications that deaths are too common. Likewise, birth assistants speak of a 'high number' of spontaneous abortions and premature deliveries which occur as pregnant women carry heavy loads or trade between markets. But communities' actual levels of morbidity and mortality are not clearly known, as there are no functioning verbal or other information-gathering systems. The involvement of community members themselves in the collection of health information aims to increase their opportunities for participation in the planning, provision, and monitoring of health services,²⁹ according to their own needs.

Part Three: Conclusions and recommendations

3.1 Health-related behaviour and the use of health services within the sociocultural context of Ganda

Sociocultural context

Ganda is considered rural in the wider Angolan context, but within Ganda the experiences, beliefs, and behaviours of those who live in towns and those who live in traditional villages differ markedly. Returnees from other areas have added to the variety of perceptions and practices. Urban/ rural differences are reflected in the way households manage and prioritise their affairs and in the degree to which they focus on individual or community 'survival'.

In community organisation, power and authority are wielded in a vertical, top-down way, and most of the structures which touch people's lives, including international NGOs and churches, are perceived to be backed by the authority of the Government. There are few examples of social mobilisation through issue-based community groups or other community-level initiatives in Ganda, but some communities retain mechanisms for communication and problem-solving through traditional structures such as the *ondjangos*.

The years of conflict and social disruption have generated an atmosphere of mistrust, suspicion, and envy. This is felt more deeply by people who live in communities comprising many unrelated households, and it has the potential to provoke accusations of witchcraft, blaming others for misfortune, and to hinder development.

Smaller, more traditional *bairros* tend to have overlapping household networks, which can function as an informal social support system and increase household security. *Bairros* with a high proportion of isolated households have links and responsibilities outside of the community in which they are based.

Men exercise power at all levels in society. Men are seen as controlling the household's resources (whether they are present or not);

women cannot make critical decisions. Yet the survival of a woman's household depends on a her skill as resource manager and primary provider throughout her life.

Most people in Ganda are poor in terms of inadequate reserves, capital assets, and nutritional opportunities, but they are extremely experienced in and capable of managing with what is available. Women in particular have a vast knowledge of how to earn a living by combining activities, planning, taking risks, and using the *kandonga* system.

At times of stress — when social obligations through family blood-ties override those created through sharing the same cooking hearth — the household proves to be a valued but fragile structure. Such obligations can hold back some individuals' or households' capacity to develop, but recipients of such support can avoid other coping strategies which carry long-term costs, such as selling essential assets.

Young people tend to view their relationships with people in positions of authority (teachers, catechists, health staff and so on) as punitive rather than facilitative; much critical learning takes place through informal contacts with peers or through close family relationships. Many young Gandans are involved in trading from an early age, but the dearth of local opportunities for higher educational or vocational training in Ganda means that they cannot easily acquire useful professional skills.

Health services and providers

Health-service providers exist at institutional and community level in Ganda. There is a wide range of community-level, non-institutional providers, using a variety of methods of practice, and functioning largely independently from each other and from institutional-level health-care providers.

Health-service provision in Ganda focuses on the plans and resources of institutional health facilities rather than on the community's perceived health needs or on observed changes in their health status.

Preventive health-care at primary level is provided mostly by women and mothers within households, but also by health-care services (for specific interventions, such as vaccinations) and by traditional practitioners. State-organised primary health-care (PHC) initiatives such as health-promoter or traditional midwife systems receive little recognition within communities, and nor does their role in illness prevention and the promotion of good health.

A tendency among health-service providers at institutional level to manage PHC as the delivery of services *from provider to community* puts at risk the essence of the PHC approach: that there should be a visible and effective partnership between both. Such a partnership would make it possible to recognise and appreciate existing health resources in Ganda, such as local people's knowledge and beliefs about health matters.

People are already paying for some curative and preventive health services, in terms of fees paid to individual providers and at private facilities, and in terms of non-monetary costs, such as time. They appear to be willing, though not necessarily able, to contribute towards what is perceived to be an effective service.

While most people in Ganda have reasonable access to water all year round, it is not consistently available at the sources closest to people's homes in sufficient quantities to meet their perceived needs.

Family and public latrines which offer privacy are acceptable sanitary alternatives to defecation in the open air for many people. Some, however, have kept the customs of life in the traditional village, although the relative overcrowding and lack of space in the *bairros* do not allow for safe and natural degradation of waste.

Health-related behaviour

Health-related activities form a continuum from the seeking of health-care to the maintenance of good health, with a common perception that people are responsible for and capable of influencing some aspects of their lives, both when healthy and when ill. This perception is reflected in taking special care of vulnerable people, especially children and pregnant women; in rules around the care of people with chronic illness to prevent a worsening of the condition; in knowledge of nutrition and eating habits (such as food for different age groups, food in pregnancy, food in illness and convalescence, and food taboos).

Women of all age groups, particularly those living in rural communities, currently depend on support from their family, friends, and neighbours for health-care. They lack direct access to resources within their households and risk losing personal assets to pay for treatment. Women's entitlement, as individuals, to effective health-care is undermined by the manifold demands on their time, by social pressures, and a lack of services which specifically address their health needs.

Many health beliefs and some child-care practices which are potentially harmful (such as early weaning as a result of another pregnancy) include the concept of blame. Because women both assign blame and are blamed for health problems, they are under considerable social pressure to conform with these beliefs and practices.

Every illness is believed to have its own treatment: some are clearly recognised to require traditional management (for example, *pássaro*), others are initially treated with modern, allopathic medicines (for example, fevers and headaches) although herbal remedies for such illnesses are available. The cause of illness is often defined by people in terms of the patient's response to certain types of treatments.

Some health problems that are believed to require specific, non-allopathic interventions, such as 'nervous' illness, are attributed to a lack of harmony in interpersonal relationships; help is therefore sought from appropriate sources. A perceived increase in the prevalence of 'traditional' illness in some communities is related to the negative influences on people which have resulted from years of war and social disruption.

Chronic illness and ill health is often attributed to traditional causes, and although a condition such as tuberculosis is commonly understood to be a serious illness requiring specific treatment, its symptoms and long-term effects are not widely recognised. The burden of care for the chronically ill falls on women in their role of household carers and providers, and on non-institutional, community-level health-care providers.

Patients' expectations of recovery are influenced by whether, how, and when they pay for treatment. When people are charged fees for health services, they expect to receive sufficient medication to treat all the illnesses they present, while deferred payment might allow a longer time-scale for recovery — as is the case in treating traditional illness.

3.2 Preventive health priorities of the communities and their most vulnerable members

Vulnerable households are headed by a single adult, separated from their close family, lack land, and have few options for earning a living. Within a vulnerable household, sustenance of children will often take precedence over that of adults; when resources are scarce, the elderly are respected but not generally protected.

Displaced households are not homogeneous: some have more opportunities to earn an income, for example as paid labourers and traders, than others who remain isolated. In the current political climate, the threat of losing assets, such as cattle and crops, through theft renders many rural households vulnerable.

People want their needs for food security, water supply, and curative health-care to be met first. The impact of any additional interventions, such as health-education and sanitation, is likely to be increased if planners consider how best to meet primary needs alongside these.

The concept of prevention is well established in Ganda, as is illustrated by the importance placed on the care of people at vulnerable stages of life, on diet and nutrition, childhood vaccination, and on maintaining a clean living environment. The study highlighted the emergence of specific concerns — about young people's reproductive health, about nutritional advice at times of ill health, and about women's health and reproductive health — which suggest that Gandans have an interest in and feel a need for opportunities to improve their knowledge of preventive health-care.

It appears that people's health-care priorities are curative services, whether from traditional, spiritual, or allopathic sources; patients understand that each of these curative services makes an individual contribution to health, and that they are not interchangeable. In general, allopathic services in Ganda are unable to meet people's expectations due to lack of resources.

Allopathic services seem to be predominantly concerned with managing preventable illnesses, which has led to both providers and users demanding more curative services. Obviously, repeated ill health due to preventable illnesses such as malaria or intestinal infections reduces individuals' and households' capacity for productive work, depletes scarce resources, and increases people's vulnerability to further hardship.

The potential positive effect of preventive health-care activities such as vaccinations could be diminished because external factors stop people from using them effectively: children are often taken to central health facilities only when they are sick, because there are other demands on women's time and resources, and inconvenient clinic hours or long waits further discourage routine visits for vaccination and growth-monitoring.

3.3 The development of appropriate methodological tools and health-status indicators

A qualitative approach was appropriate for the exploratory phase of this study, which was intended to collect information covering a range of beliefs, knowledge, and behaviour. It allowed people to express their opinions and knowledge in a non-threatening, informal atmosphere and identified issues which previously 'outsiders' might not have suspected to be community health priorities.

We counteracted the problem of interpretation bias within the research team by working with local research assistants who shared the study population's beliefs, cultural background, and language. With time and growing confidence, the RAs were able to discuss findings and felt comfortable to be probed deeply on some sensitive issues, which would have been more difficult with participants.

However, the study was affected by limited time and resources both in the research team and the local community. Ideally, we would have liked to complement the qualitative findings with quantitative research, in order to increase their explanatory power and generalisability, and with further in-depth work to explore the associations between qualitative and quantitative approaches.

Thus far, the research methodology has highlighted areas for further investigation and provided a model that can be adapted to guide future research initiatives. It accommodates the need to create an atmosphere of trust in working relationships, the realities of project resources, and the legacy of a top-down approach to information-sharing in Angola.

This project was planned specifically to gather information rather than to initiate interactive processes and community action. However, experience gained from training

assistants in and applying participatory research techniques shows that such projects open up opportunities for real dialogue. Good facilitation skills, a clear understanding of their objectives, and frequent evaluation of personal performance are essential in order not to waste these opportunities.

It was difficult to monitor and evaluate the impact of local health-related interventions. Health-care providers and planners seldom attempt to define and agree on expected outcomes with beneficiaries in a way which reflects their understanding and experience of health matters. They have also failed to take into consideration the long-term and multifactorial causes for the most frequent illnesses in Ganda.

Although routine health data is collected in abundance at health facilities, its usefulness in monitoring the health status of the population and of specific subgroups is diminished because no recognised corresponding system of routine data collection exists at community level.

3.4. Recommendations to Oxfam concerning programme direction and initiatives in Benguela Province

Approaches to communities

The following points should guide how communities are approached both at the start and during the course of a project:

- Start off with small initiatives which develop confidence on the part of the communities and project staff, and which consolidate existing field skills and information-gathering techniques. Think about what people are saying and why, and take the information back to them in a form that invites further discussion and shows respect for their own ideas and initiatives.
- Use research findings to define starting points for further discussions with communities. These may validate or reject your findings, or highlight issues and differences which require further exploration in order to contribute to a better understanding of the communities.
- Demonstrate the ability and willingness to involve a range of community members, including the least vocal and visible, in identifying community needs and in developing solutions acceptable to all subgroups. This will increase levels of trust and open up possibilities

for information-gathering between staff and partner communities.

- Respect people's priorities and take into account other demands on their lives. Make sure you recognise when particular interventions are appropriate; for example, address diarrhoea treatment in the rainy season and promote locally available products to prepare oral rehydration solutions with.
- Identify and work at project level with those individuals (for example, from Government services) who show initiative and potential with regard to approaching communities, to identifying their needs, to solving problems at community level, and to encouraging the development of communication and analytical skills.
- Maintain good relations with the local authorities to keep open communication channels and to maximise opportunities for lobbying and advocacy.

Programme content and development

Oxfam should work with and develop local groups in order to meet the basic needs identified by the community, such as building and managing water points, or organising agricultural associations. Projects should aim to enable communities to support themselves by meeting the basic needs of displaced people returning to their homes, by increasing opportunities to make a living, and by providing technical and organisational training. It is important to look at feasible cost-recovery mechanisms, so that community initiatives will be sustainable. For instance, a group of women borrowed money to start a bakery in a traditional village on credit and will use the bakery's profits to repay the loan.

Oxfam must remain prepared for emergencies. The political situation in Angola is still precarious, and most people's reserves are severely depleted or threatened by continuing local insecurity and theft. In order to react quickly when people's livelihoods are threatened, we need to develop systems to monitor people's income which are context-specific. One effective system in Benguela Province would measure the proportion of time that women spend during a week collecting firewood as an alternative or as the only source of income.

Health-care projects should make positive use of the community's existing practices and beliefs, for example, working with women's experience and pride in maintaining a healthy

environment for their children and households. Project workers should discuss with women and men, separately and together, how women's workload can be reduced, look for where ideas meet, and create sufficient trust in their relationship with the community to challenge harmful practices.

Food-security projects which address nutrition ought to make use of the knowledge that people, especially women, already have of food production and resource management. Rather than repeating standard nutrition and health messages, extension workers ought to know and talk about what people are growing in their fields. They also ought to use familiar language and concepts. For instance, people consider smell and flies as tangible evidence of something unhealthy; telling them theoretically that latrines reduce diarrhoea contradicts their experience of its causes, and they cannot see any evidence for it. At the same time, workers ought to avoid reductionism and simplification of messages, such as 'flies cause diarrhoea', by maintaining diverse approaches in discussion.

In order to promote consistent, positive messages about health matters and reach the widest possible audience, Oxfam must work with central sources of information such as churches, youth groups, schools, teachers, and other agencies involved in environmental health. It must also lobby staff at health-care facilities to use illness episodes to increase patients' knowledge and awareness of preventive health-care measures.

Rather than use standard indicators of health status and the success of health-education activities which may be confounded by many factors and different interpretations, Oxfam's projects ought to develop and use indicators that reflect people's perception of health status and can chart a process of change. Such indicators should examine an individual's or household's perception of their well-being; people's sources of information and ways of learning about health-care; changes in the proportion of people who believe that community health is the responsibility of others; changes in the proportion of women who would continue to breast-feed if pregnant; and changes in young men's and women's awareness and knowledge of locally available methods of contraception.

Project workers ought to consider working with youth groups as peer educators on environmental health matters. This could broaden

health-education activities around specific important issues such as reproductive health by training and developing young people's skills, with minimal input of extra resources.

A priority in Angola is to increase the availability of curative care across the country; Oxfam should promote and/or lobby for a system that utilises existing health-care resources (such as knowledge of herbal remedies) and collaborates with traditional practitioners, while also meeting people's expectations for improved allopathic curative care.

Further research to gather household-level information about livelihoods should examine the following topics:

- resource flows within and between households;
- opportunities for women to both manage and control resources;
- changes which would reduce women's workload but which men would consider beneficial to the household;
- how people balance options and risks when they do have choices and when they don't have choices (for example, selling maize seeds or hoe from distribution);
- at what point social obligations override family or household obligations (for example, when payment for a relative's funeral takes precedence over children's school fees);
- how appropriate credit schemes are in the context of exchange-based systems and in the current security climate.

These household-level data can inform future debates on user-fees for health services, because it sheds light on seasonal variations in access to resources, and on the low relative value of money compared with the value of assets surrendered to obtain health-care. It will also help to identify subgroups who should be exempted from paying fees.

Project management

In order to ensure that the research carried out as part of a project will be useful in the long term, researchers should keep in mind the following points.

- Make field-notes, keep diaries, record what people are actually talking *about* (rather than simply that they say), so that this valuable information can be shared within Oxfam and with other local organisations, and used for learning about the process of development in post-conflict situations.

- Monitor the level of skills within the team, and make frequent use of opportunities to discuss constructively with others their experiences and what they have learnt during and between specific projects.
- Within programmes and together with agencies or organisations, identify points of action through which links can be developed. For instance, if a food-security project also works to meet the community's identified water needs, this increases the population's level of interest in the intervention, which can then promote a more comprehensive health-care package including food security, environmental health, and health education.
- Formalise an exchange of information with other agencies and health-service providers through regular meetings. A greater awareness of topics such as local eating habits and women's daily activities could be useful in improving services such as supplementary feeding programmes.
- Develop Oxfam's role as an intermediary, enabling people to demand basic rights by increasing the community's awareness of opportunities to address and resolve problems. Develop specific resources at project level to support local lobbying and advocacy activities, and promote information exchange on a wider level by delegating an advisory team to other organisations or Government agencies.
- Assess what decisions have been made as a result of the research project. One way of doing this is to draw up an action plan, for example at workshops, and follow it up at local, organisational, and inter-agency level.

3.5 General recommendations for working in communities

External project staff must try to understand and respect the differences between and within communities. Rather than using project 'blueprints', they ought to develop strategies for their work which demonstrate consideration for and an understanding of the community's composition and structures.

Before starting the project, it is useful to gather information from different sources such as local authorities, other agencies working in the same area, and important non-institutional community figures. Project workers should make efforts to maintain facilitative and honest relationships with local and Government

authorities, which will also open up avenues for lobbying and advocacy work at a later stage.

Project staff should be open to learn about traditional structures such as the *ondjango* and, where appropriate, use them as a base for initiatives, instead of creating new ones which might be less long-lasting. Being sensitive to a community also means identifying how, and by whom, information can be disseminated at community level in a way that respects traditional mechanisms. Project workers should 'listen to the *batuque*'³⁰ (respect and consider other people's knowledge) and emphasise existing positive health-care behaviours and practices, rather than reinforce blame by focusing on what is not done. The community might develop their own systems of sanctioning perceived unhealthy behaviours once their awareness of and responsibility for their own well-being is increased and their control of the future enhanced. This can be achieved, for instance, by strengthening a community's capacity to make decisions about its own health priorities. It is vital to encourage individuals and communities to take responsibility for positive health-care without forgetting that there are things which are unavoidable or beyond their capacity to change.

Methods of information-gathering, analysis, and feedback should be adapted to match communities: while a more 'authoritarian' approach may be appropriate for initial contacts with communities where individual agendas predominate, participatory approaches would be more acceptable and transparent to more cohesive communities. In every case, the project's aims and objectives must be clear to all, because the involvement of community members from the start of planning is important for later monitoring and evaluation of interventions.

The needs of young people ought to be addressed specifically. Researchers should look for opportunities to determine young people's needs in terms of information and skills, and develop material which is suitable for them. Peer-education networks and participatory techniques — unlike some health-care settings and other relationships that are viewed as authoritarian — offer young people the chance to grow more confident, to deal with a range of problems within their communities, to find support from others in similar difficult social situations, and to learn through constant discussion and questioning.

Men should be encouraged to identify and understand the problems that affect women's

lives, because new initiatives are more likely to grow if men also benefit in some way. Bringing people together at community level will enable them to recognise shared problems and to discuss opportunities for their solution. Community action may also have a role in the recovering confidence and trust, and in rebuilding disrupted social support networks.

Lobbying and advocacy

NGOs and Church organisations can play a significant part in lobbying for an effective, appropriate, and officially recognised structure (for instance, a network of community health agents or workers) which facilitates communication, health-service development, and information-management between community and institutions. A lobbying agenda should include the following points:

- the public health sector's focus should be widened to include existing non-institutional community level health resources;
- Government policy should be clear and include a firm commitment in terms of finance and support to make such a structure part of the public health sector;
- within such a structure, health workers' status, and roles as well as their relationship with other levels of the health sector must be clearly defined;
- Government and NGOs must collaborate to ensure effective use of minimal resources (for example, the integration of parallel health programmes, such as those supported by Caritas and CVA).

Oxfam and others have to realise the limitations of Government institutions in the current political climate. They must continue to lobby for the provision of basic services by Government in the knowledge that local and outside organisations will function more or less autonomously for the near future. Once the options and extent of possibilities of collaboration with state-run institutions are clear, NGOs can support state-run services by:

- developing alternative strategies for service provision;
- supporting the development of clear Government policies, as an essential component for work with all Government institutions;
- providing in-service training for public service staff in order to improve practice and use scarce resources effectively;
- encouraging collaboration in defining status indicators which will be useful to determine the impact of services and interventions at all levels;
- promoting community organisations which offer opportunities to voice needs, and by improving the negotiating power of community organisations with institutions (for instance, through *bairro* health committees);
- improving the health-service base by employing existing resources in rural areas. For example, traditional practitioners could be trained to recognise syndromes for common illnesses such as TB or sexually transmitted diseases; market medicine sellers could receive basic pharmaceutical training.

Appendix 1: Population survey

When Oxfam met staff at the Angolan Ministry of Health (MINSA) during the initial preparation of our qualitative research project, they asked us to plan and carry out a population survey as the basis for the development of a system for collecting, interpreting, and reporting local health information.

Planning

The first stage of the sub-project that developed with the MINSA Public Health team had several specific objectives:

- to carry out a population survey by age group and sex in order to establish useful population denominators for the Government-controlled area served by Ganda Municipality health services;
- to train a core team within the MINSA Public Health Department in data-collection methods and analysis of survey data, and to carry out verification procedures using participatory techniques such as community mapping;
- to feed back information generated on methodology and results to all levels and relevant actors;
- to identify health-information needs in order to plan and develop a facility-based health-information system;
- to identify with MINSA staff and with community authorities opportunities for the development of a community-based health-information system.

The core survey team consisted of the MINSA Public Health delegate and three members of the Public Health staff representing the vaccination, sanitation, and health-education

programmes. The Oxfam Public Health research team provided support in the form of technical advice, visits to *bairros*, and some logistics (transport and stationary items).

Using a map of Ganda Municipality, the Government-controlled area was divided into three sections: the first covered all 19 *bairros* of Ganda, the second the outlying villages, and the third the Babaera District including Alto Catumbela. A simple A4-size data collection form was drawn up to gather the information needed for MINSA health-monitoring activities, and to collect baseline information for future quantitative research. Each form could accommodate information on 35 houses. A decision to define a 'house' by physical structure was based on the assumption that the community secretaries and those carrying out the count would have knowledge of who lived regularly in their areas of coverage. They would thus be aware of men responsible for more than one household, and would thus include them only as members of the house of the first wife. Members of the MINSA team felt strongly that people associate lists of names with distribution lists, so collecting names was avoided. This approach, combined with clear explanations, would diminish people's expectations of an imminent distribution of food or goods and their accompanying tendency to exaggerate population numbers.

Implementation of population census

Working systematically from south to north across the first section of the survey area, a member of the Public Health team visited each of the *bairros* to arrange a meeting with the *soba*,

Table 5: Example of a data-collection form

house #	# men > 45 years	# men 15-45 years	# women >45 years	# women 15-45 years	# children 5-14 years	# children 1-4 years	# children <1 years
1	I		I	II	I	II	
2		I		I	II	I	I
3		I	I	I	II	I	

to which he and his committee of zone representatives and secretaries were invited. It was possible to arrange two or three meetings each day. The survey team then visited to address the meeting, explaining the reasons for undertaking the census and the methods to be used. The *bairro* secretariat discussed how and when to carry out the data collection, after which an initial sample of houses was surveyed by the team, together with secretariat members, to demonstrate how to fill in the forms correctly and to identify any difficulties. For example, to record the number of children in each age group, the informant would be asked to list all the children by age because asking 'How many children of age... are there in this house?' would result in more errors. This form of posing the question evolved after the survey team attempted to document the members of their own houses — they concluded that counting numbers of children is difficult. Each house, when accounted for, was marked with coloured chalk. The team felt that paint would not be acceptable to house-owners, and during the dry season, chalk would be fine. A sufficient number of forms, chalk, and pencils were left in each *bairro* and proposed data collection days were noted by the survey team. Where the survey team members anticipated that there might be difficulties with the accuracy of the data collection, they tried to accompany the zone secretaries during the count to monitor their progress.

Data analysis and verification

Once the forms were returned, the patterns of data were briefly examined to check for any gross discrepancies. If any were discovered, the survey team returned to the zone or *bairro* in question to discuss the forms with the respective authorities, and the count was repeated. To further process the data, the forms were counted by two independent counters. The results were compared and recounts were carried out if there were discrepant results. The results were aggregated to give totals for each category by zone and by *bairro*.

One set of data from a small rural *bairro* was identified as clearly erroneous, having two or more members of each category living in every house. A member of the survey team returned to the *bairro* to talk with the *soba*. Together with other members of the *bairro* authority the count was repeated, with very different results. The 'discovery' of the false results was resolved

amicably, but it took a degree of diplomacy and tact to deal with an embarrassing and potentially confrontational situation.

Verification of data was planned by means of community-mapping exercises, during which information on the houses and the number of adults living in each would be collected and compared with data from survey forms. Initially, five *bairros* within Ganda were targeted in collaboration with the Oxfam environmental health and sanitation project, which was developing links with the communities of the *bairros* through participatory work. It was felt that the project and survey teams could usefully work together on the process of community mapping, in order to minimise the amount of disruption to the communities and to maximise the learning experience for all the team members. Before beginning fieldwork, a joint session was held to evaluate previous experiences of participatory methods and to incorporate lessons learnt into the planning of the community mapping.

Outcomes

The majority of *bairros* within the first section had completed and returned their data-collection forms to the survey team within two weeks of the initial visit. At the time of writing, final counts have been completed for these and for the *bairros* of the third section. As a result of the improved local security situation, it became possible to survey the villages close to UNITA areas, and plans for similar surveys in former UNITA-held areas of Chicuma, Casseque and Ebanga are now developing. There is currently a lack of demographic information for these areas. Evidently, the better security climate also encourages displaced people to return to other areas, giving more weight to the need for a system which monitors population changes as well as providing isolated 'snapshot' totals. Work is now in progress to feed back the survey results to *bairro* authorities via the MINSA Public Health team, and to explore with them the possible mechanisms for ongoing data collection at community level. This involves some training sessions with the survey team on information presentation, use, and interpretation, to identify the most effective means of communication and the information needs of both the health services and the communities.

Verification of the data by mapping has not been completed. Following an unsuccessful attempt to map a large zone in one of the semi-

urban *bairros* with members of the community, the team learned several lessons. Participatory mapping is time-consuming, particularly when the participants have other demands on their time. In planning such a project, you must consider that what people expect to get out of the exercise will inform what they put into it. For the benefit of both facilitators and participants, the purpose of the exercise — be it to gather data for operations, for research, or a

combination of both — and its expected outcomes must be made clear. If there are several expected outcomes (for example, to collect demographic information, to discuss quality of services, and to develop activity plans) it is sensible to select a manageable area or unit for mapping and to work with those residents only. Later on, you can select another, building up a picture of the community rather than attempting to do everything at once.

Appendix 2: Participatory methods and tools used

The participatory techniques used were adapted from those used in the Participatory Learning and Action method. They were combined with other research methods such as semi-structured interviewing to achieve a more complete appreciation of local characteristics, processes, and perceptions. Techniques were repeated with a range of individuals or groups of people, and results presented in visual form to encourage discussion and facilitate comparison. Most activities made use of locally available materials such as small stones or mango cores to develop diagrams on the ground, which were later copied onto sheets of paper.

Broadly speaking, the techniques learnt and used in the research can be divided into four groups, according to the purpose for which they were used (see Table 6).

Table 6: Use of participatory techniques

Purpose	Technique
Descriptive diagramming	Community mapping
	Household-linkage mapping
	Birth histories
	Daily activity charts
Chronology	Timelines
	Seasonal calendars
Comparison	Matrix of options and criteria
	Wealth-ranking
Perception and explanation	Circle diagrams
	Cause-and-effect diagrams

Mapping

A community map showed the physical layout of a *bairro* with zones and roads, resources, and services (water points, schools, and so on), the location of key community figures (*soba*, health-care practitioners). It also included areas where individual houses were identified by name of the woman who lived in it for a later wealth-ranking exercise. A household-linkage map seeks to illustrate relationships within and between households, and to indicate the type and quality of the relationships.

Family histories

To facilitate discussion of birth histories or of family composition, stones of varying sizes were used to indicate each pregnancy or family member. Verification of facts is made easier for both informant and facilitator by providing a visual representation.

Daily activity charts

These aim to illustrate the relative use of time, facilitating comparisons between different seasons or community subgroups and aiding analysis of where the main constraints or opportunities for change may lie.

Figure 5: A household map drawn up by a young woman from an urban *bairro*

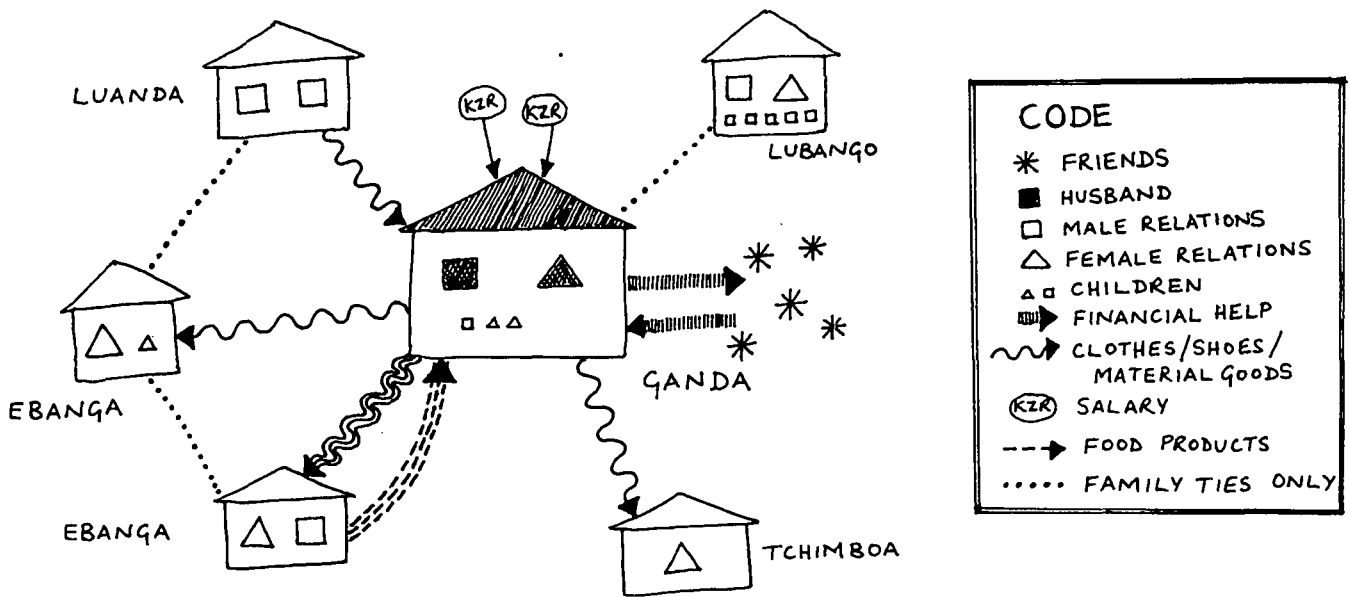
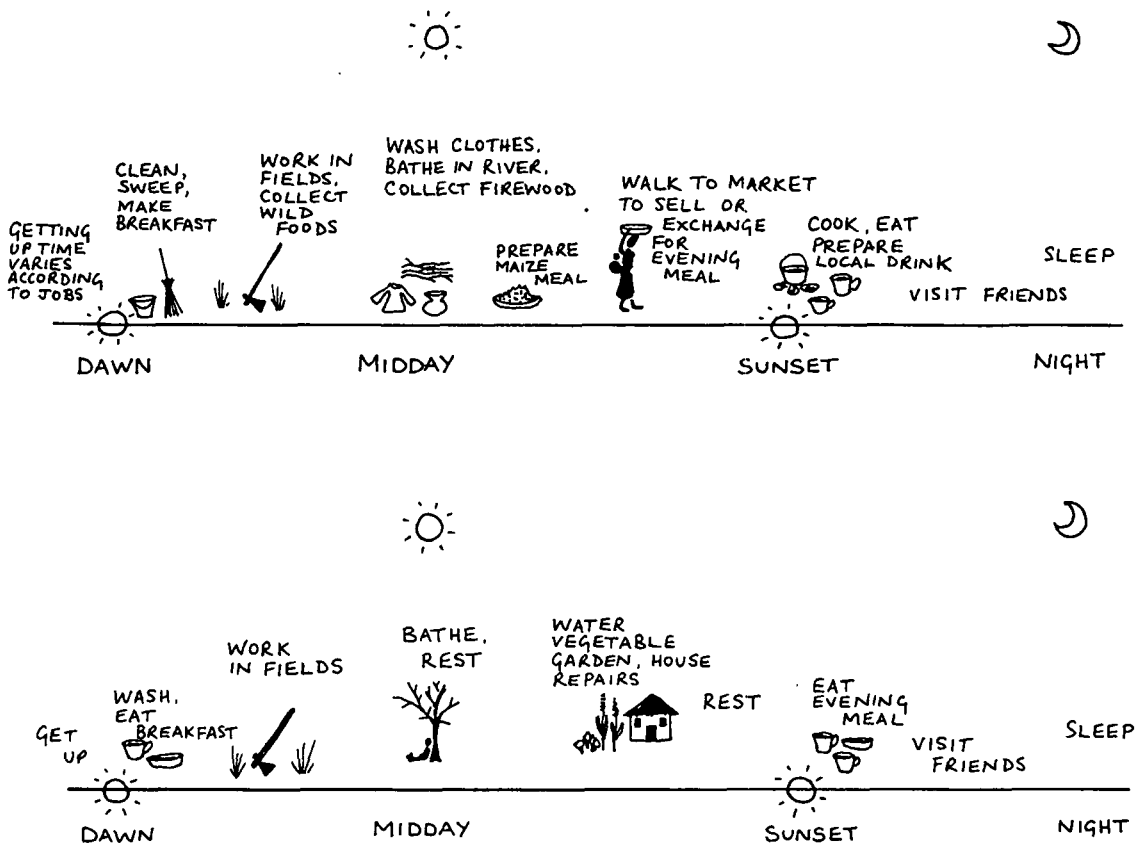


Figure 6: Daily activities during the current dry season for women and men who live in a rural *bairro*



Timelines

These were developed from the discussions held with older community members. Information was cross-checked between sources, and a profile built up which detailed significant events in Ganda's history including natural

disasters, population movements, and local political and military events. The old people described changes in living conditions, health-service provision and people's general health status, and gave reasons or explanations for the changes.

Table 7: A timeline of Ganda from 1912–72 according to a very old man in a semi-rural *bairro*

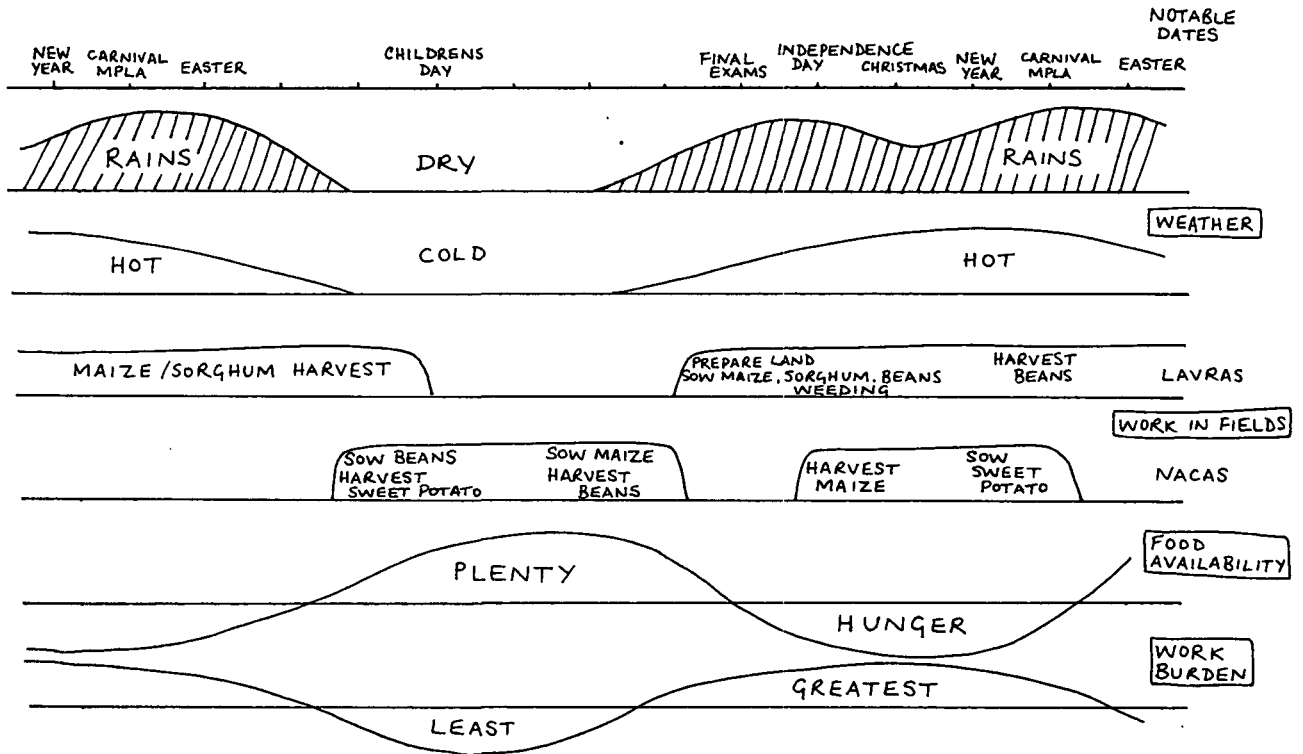
1912	Construction of the Benguela railway line
1915	Foundation of Ganda, in the name of the traditional <i>soba</i> , Tchilandala Kambia, who came from Kuma
1915	<i>Otchitenhã</i> (drought): there was much hunger and no water
1927	Foundation of the Saletina's Mission
1936	Plague of locusts which ate maize and people
1938	Construction of a new <i>bairro</i> in Ganda to house workers for the railway
1952	Establishment of food industry in Ganda with large farms and processing plants
1960	Arrival of Sr. Lomunba (a legendary Angolan hero) in the Ganda area
1970	Ganda had one state hospital and two private hospitals
1972	Movement of people employed from outside Ganda; Government built houses in new <i>bairros</i> ; many farms and industries producing for export

Seasonal Calendars

Seasonal calendars visualise an 18-month cycle charting month-by-month changes in climate, local agricultural activities, food availability, and illness patterns, and quantifying their effects. They help to understand potential links between

different components of life in Ganda for various community subgroups. They are also intended to balance informants' tendency to focus on those problems or aspects of life which are most current and pressing.

Figure 7: A seasonal calendar of a normal year (no drought, no war) drawn up by a group of women in a rural *bairro*



Options and criteria matrices

The first step when developing a matrix was to identify a range of options available to participants. This was achieved by discussing the topic

of interest, and drawing up a list of criteria based on participants' reasons for choosing one of the various options over another.

Table 8: Options and criteria relating to health facilities in Ganda, described by young women in the city

options criteria	hospital	private practitioner	herbalist	spiritualist	market seller	Catholic health post	Evangelical health post
confidence							
instruments							
medicines							
injections							
diagnostic equipment							
no payment needed							
works day and night							
able to treat minor illness							







MOST PREFERRED

Which health provider is preferred overall and why? Hospital, because it is able to treat many illnesses.

An adaptation of the matrix was made to facilitate the discussion of sources of advice or support for various groups of people, given different situations, and to elaborate on house-

hold decision-making responsibilities. In these latter diagrams, there was no quantification of preferences, simply an illustration of choices that prompted further explanation.

Table 9: Main sources of advice and support for young boys in a semi-rural *bairro*

Adviser / Problem	priest	teacher	catechist	soba	father	grand-parent	uncle	mother	cousin	brother	god-parent	aunt	friend
love affairs 						•			•	•	•	•	•
building a house 					•		•			•			•
avoiding a pregnancy 					•					•	•		
gifts for girlfriend 										•		•	
money matters 					•		•	•		•	•		•
health 	•				•	•	•	•	•	•		•	

It is interesting to note that initial discussion brought out the 'official replies' (that the priest or teacher are the main source of support); only subsequently, as real situations and preoccupations were explored, did boys disclose their actual sources of advice.

Of all the participatory techniques introduced, options and criteria matrices proved the most conceptually difficult for the RAs, in particular the recognition of differences between positive and negative criteria. The use of

representative piles of pebbles was easier than numerical scales when comparing preferences, so it was necessary to repeat the exercise several times before they felt secure in its application and interpretation.

Wealth-ranking

During a community-mapping exercise, houses in a defined area were marked individually, and the name of the woman of the house was written on a small piece of paper. The papers were then divided into piles according to the participants' criteria for having 'possibilities for a good life'. They also identified reasons why some houses

were considered the least well-off. This was a time-consuming and potentially conflictful exercise, and required a great deal of explanation. When we followed up one ranking exercise with other research (observations made in the same community) it revealed interesting relationships between people's perceptions of poverty and their actual circumstances.

Table 10: Wealth-ranking results in a zone of a rural *bairro*

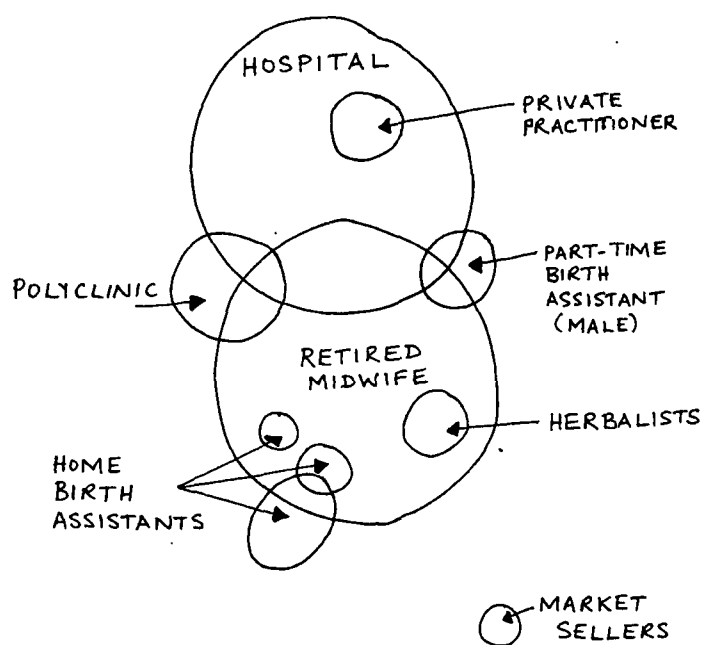
Ranking: possibility of a good life	Most possibilities	Some possibilities	No possibilities	Difficulties	Many difficulties	Poorest
Reasons	Cattle breeders, people whose extended family owns cattle	Those who own a few cattle	Couples (including polygynous relationships), young or middle-aged with children but no cattle	Separated woman or man left with small children, widow or widower	Old people and the widowed	Orphans

Circle diagrams

This exercise makes it easier to discuss the relative importance of different health-service providers to participants during a defined period of time, because pre-cut paper circles are a tool to represent their ideas. Once the

comparison was made and different-sized circles assigned to each provider mentioned, the informants placed the circles in a way which indicated degrees of linkage between the providers.

Figure 8: Circle diagram made by a group of women in a semi-rural *bairro*

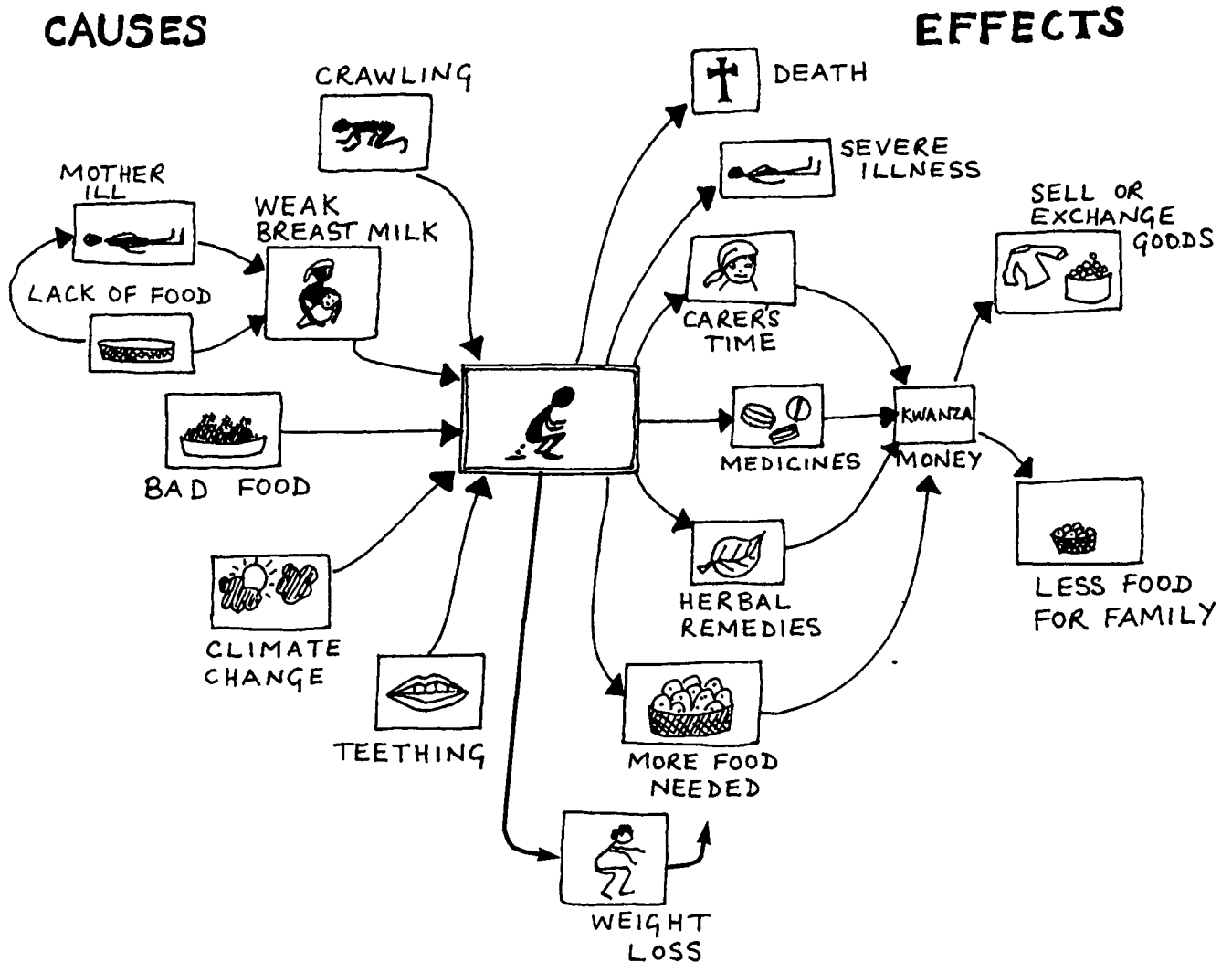


Cause-and-effect diagrams

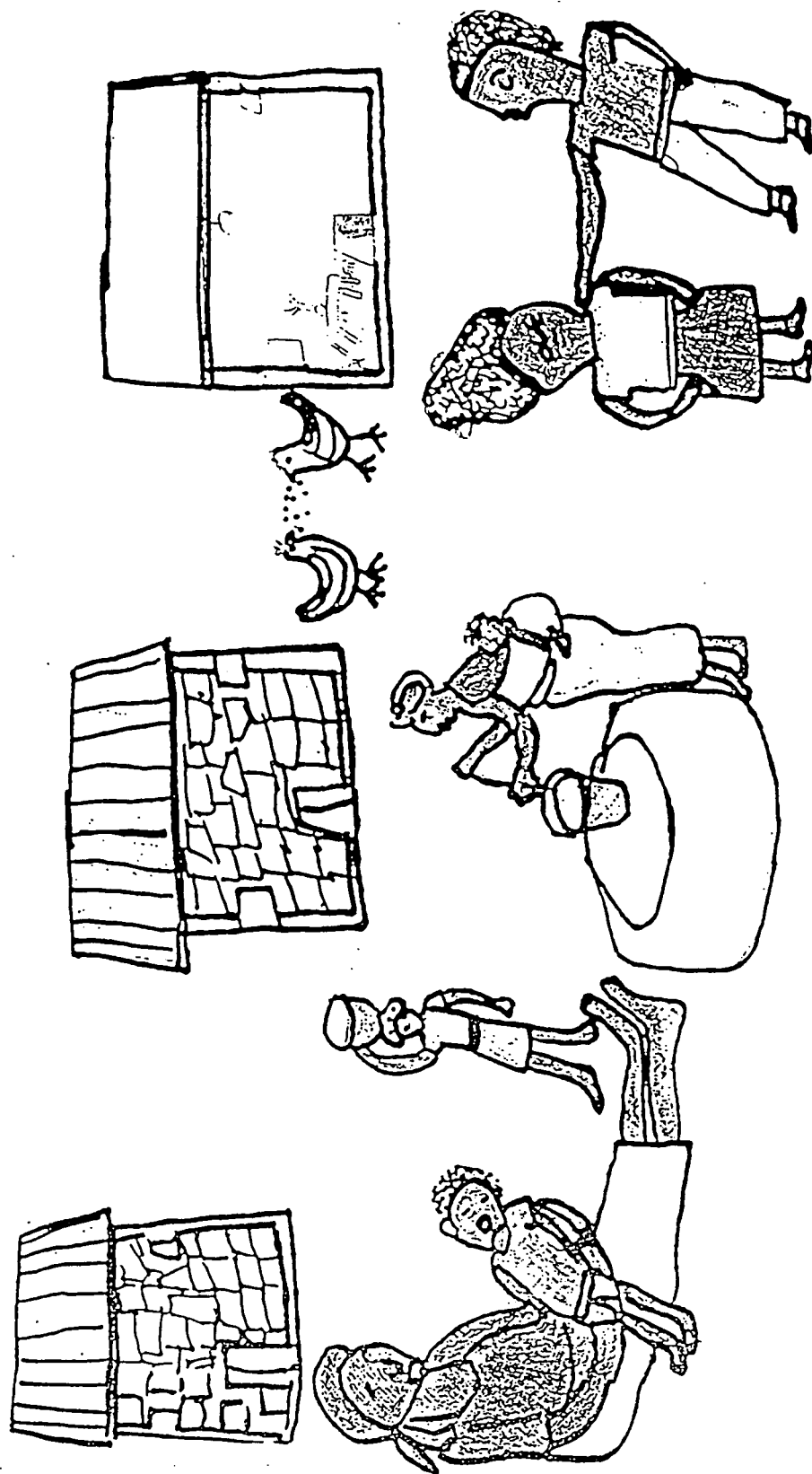
These were used to connect ideas about the origins of certain problems with their effects, and to explore the sequences of events that might follow from a certain situation. They usually started from a focal point and provided opportu-

nities to review and check information that was given by participants. Wherever possible, symbols were used in place of words, but researchers as well as participants need to be imaginative and have a good memory for symbols.

Figure 9: A cause-and-effect diagram showing a child with diarrhoea as starting point



Appendix 3: Example of a drawing used as a discussion starter by research assistants



Appendix 4: Causes of Malnutrition

Guide for interviews with mothers of malnourished children

General information

Name of village

Age of child

Household composition

Relatives living in same village, in Ganda, or outside of Ganda, and type of links between them

Child's history

How was the pregnancy?

How long was the child breast-fed, and when was maize gruel started?

Why was breast-feeding stopped?

Previous illnesses and how did the family treat them

Feeding during illnesses and why certain foods were chosen

How the current illness started and what was done at home to treat it

What was the provocation of the current illness?

When did the child receive the first vaccination?

Health of other household members

Health of other members, in particular the mother

If there have been recent illnesses, how were they treated?

If there have been other children with the same illness, what happened to them?

Information about household resources

Do they have fields, what products are grown, how is this year's harvest, how was last year's harvest, what do they sell, what do they store?

Ownership of animals, household members with professions

Who works in the fields?

Who is responsible for care of food, including conservation, preparation, and distribution?

How many times a day did the household eat each day before admission of the sick child, how many times did the child eat, what was eaten?

How does the household overcome problems related to feeding?

How do they deal with the children when there is little food?

What can the mother do when there is a poor harvest?

Where does food for sale or exchange come from?

Who works the fields when there is illness in the household?

What opportunities do the household members have for obtaining food? (For example, what is exchanged, do they collect and sell firewood, do they work for others, do they ask for credit with family/neighbours, and on what terms is credit granted?)

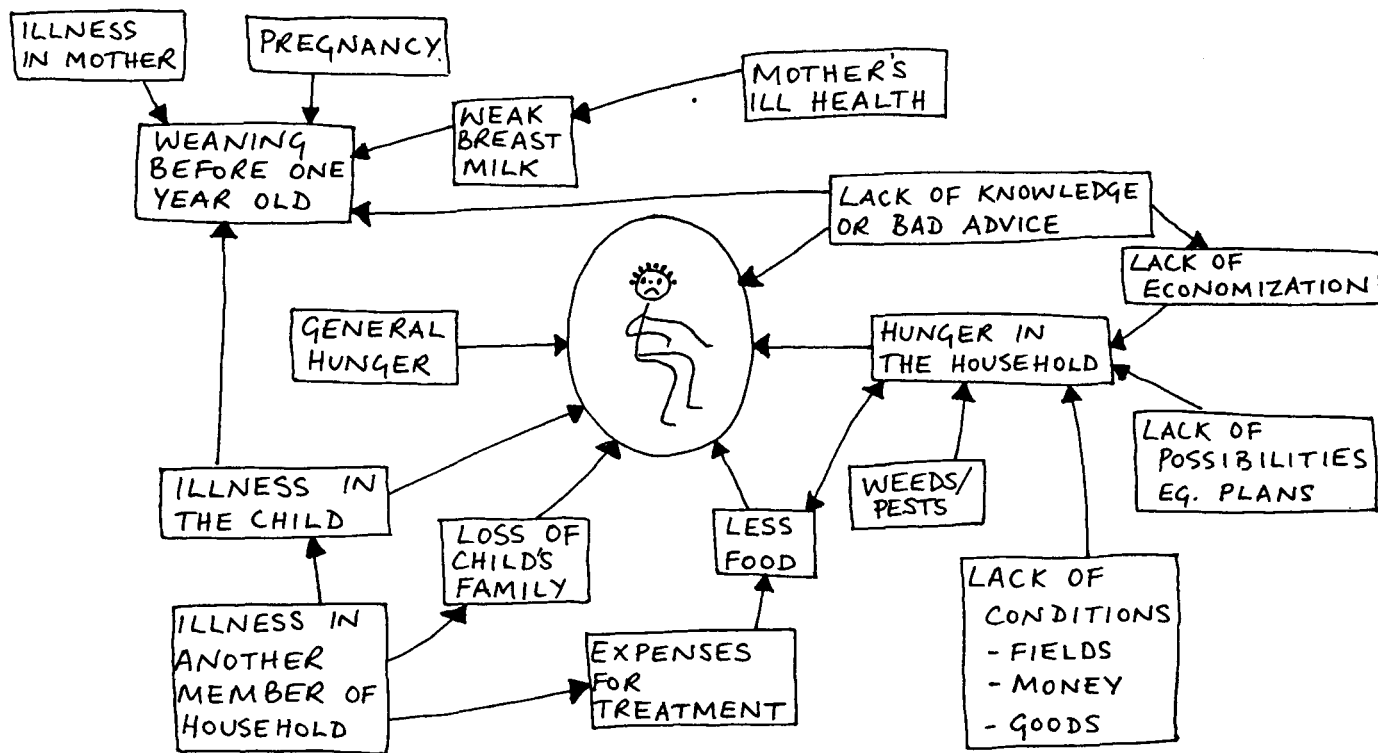
Ideas about prevention of this illness

Where does the information come from?

What can a household do if they have the problem often?

How can a household promote good health for its members?

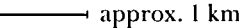
Figure 10: Diagram illustrating the causes of malnutrition

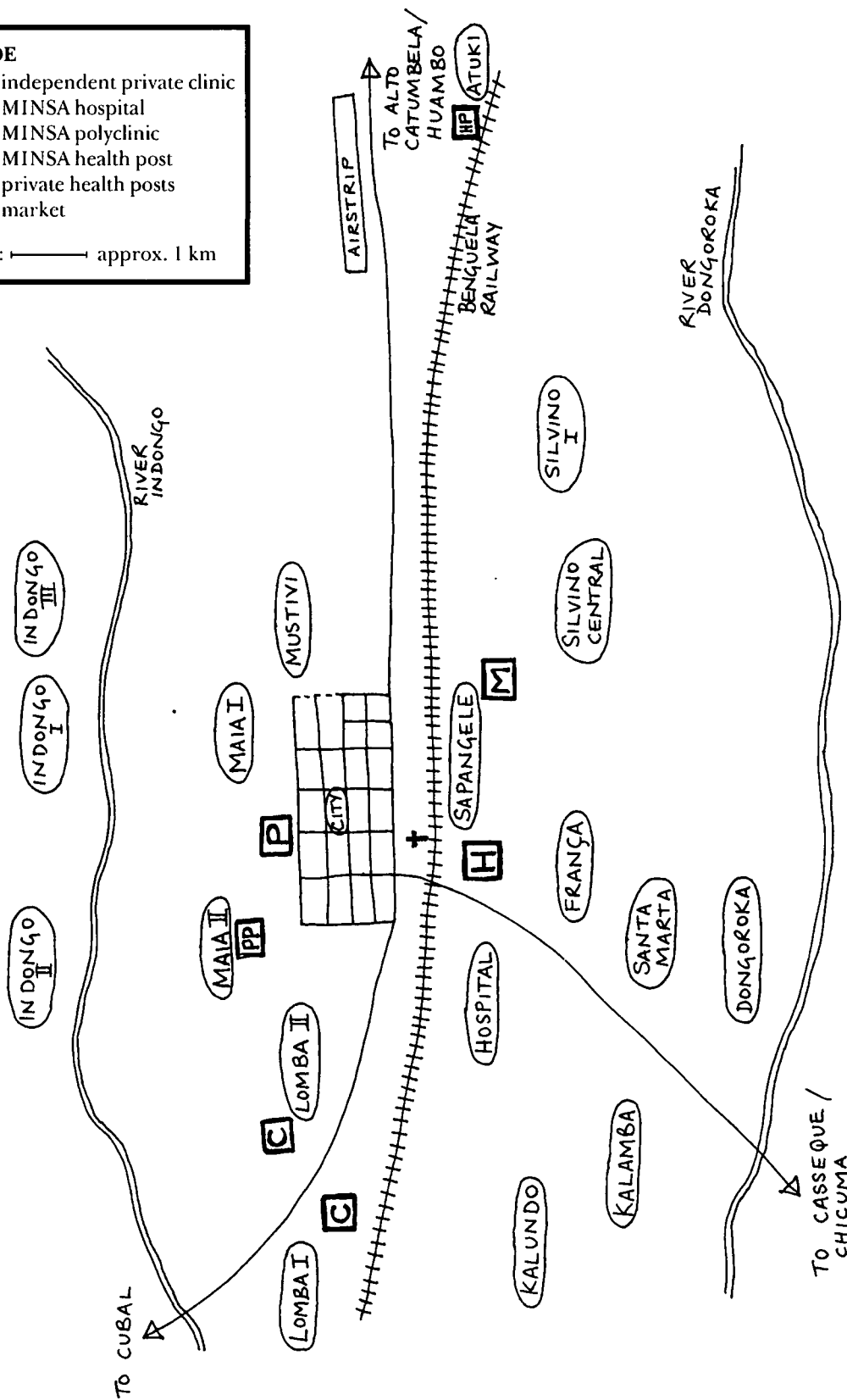


Appendix 5: Map of Ganda district with *bairros* and institutional health facilities (June 1997)

CODE

- C independent private clinic
- H MINSA hospital
- P MINSA polyclinic
- HP MINSA health post
- PP private health posts
- M market

scale:  approx. 1 km



Appendix 6: Health-service providers in Ganda

Community-level, non-institutional health-care providers

These may be regarded as a first point of contact with a health-care system. I exclude home- or self-treatment such as relatives performing scarification or prescribing herbal remedies.

Traditional private practitioner

A *kimbanda* (private practitioner) generally works from home, providing a range of curative services for all age groups. Some practitioners specialise, and are known to have particular skills for treating certain traditional illnesses, while others tackle anything from childhood ailments to childbirth. He or she may use allopathic medicines (injections and tablets) acquired from the market place, herbal remedies collected from the fields, or a combination of both. Herbal remedies consist of fresh or dried plant parts, barks, stones, and animal skins or excreta. Although private practitioners sometimes take notes on patients, describing symptoms and treatment, they keep no register of attendance figures or of diagnoses made. There is little work-related contact between the practitioners and other health-care providers, nor do they work with official recognition from the state.

Most herbalists acquire their understanding of remedies and procedures through experience and *ad hoc* training with older relatives or friends. While many ordinary people are able to perform procedures such as *olusongo* (scarification) and operations to remove threadworms from the anal margin, the in-depth knowledge and understanding of herbal remedies is widely recognised as a skill nowadays mostly held by the elderly. Previous personal experience of a health problem that has been successfully cured, such as infertility caused by a 'shut womb', adds to the credentials of a traditional practitioner. Some practitioners have received basic technical training in the state health system or in religious missions, while a few have previously worked as health monitors in the outlying villages, and provided first-aid services to the commercial farm workers during colonial times. Some have more dubious qualifications;

one learnt his maternity practice from a cousin who had been a health assistant in the army. Payment for services is made in cash or in kind, and prices often reflect the severity of the condition treated. Sometimes charges are not collected in full until the patient recovers as treatments can be prolonged.

Traditional spiritualist

Healing with the assistance of the spirit world is largely the domain of the *santas* and *santos* (male and female spiritualists). Their powers may be inherited from relatives, derived from dreams, or from the ancestors, most often on the maternal side and sometimes jumping several generations. A person may not know that she or he has such power until falling ill with a malady that fails to respond to any form of traditional or modern treatment. An experienced spiritual healer can diagnose the cause of the illness and reveal its nature. After elaborate night-long rituals beside a river with singing, drumming, and feasting on sweet foods, the *santa* takes her novice to the bush to instruct her or him on how to find and use herbal remedies. Others, who also have these powers, may be drawn to the site by the sound of the drums. During the war, such rituals had to be held at dawn because of the night-time curfews.

Santas and *santos* work primarily as mouth-pieces for the spirits, entering their world and calling to them for help through rituals involving water, perfumed soap, bowls, white cloth, plates, and cups. Patients visit the home of the *santa* or *santo* with a group of close friends and relatives. A typical patient might be a woman who has developed a severe pain in her chest and believes that a distant, jealous relative has caused the illness. The *santa* prepares the patient and her instruments, places water in a basin and dissolves soap in it. In the froth, the *santa* can see the spirit on whom she calls for assistance. As the *santa* falls into a trance, the words of the spirit flow from her mouth, giving instructions to all present on how the illness must be treated. Each of the patient's companions concentrates hard to remember the details, clapping and chanting with her, because they

know that the *santa* will not recall her words once the spirit has left her. Suddenly the *santa*, in a frenzy, splashes the soapy water on all present, and sinks into silence. The spirit has gone.

Prescriptions may involve the use of herbal remedies, some of which are ingested, and some of which are used to massage the affected part of the body; others are placed in strategic places in and around the patient's home. A less experienced *santa* or *santo* may refer difficult cases to her or his mentor, or request help when an unusual remedy is required. Some *santas* may also invoke the help of God, blessing their instruments and placing a crucifix beneath them. In addition to curing ill health, *santas* can discover who might be the cause of an illness by calling upon the spirits to create an image of the perpetrator in a bowl of water. Having done so, the *santa* may also offer to provide a medicine or counter-spell against that person for a higher fee.

When a spirit enters a *santo's* head, he is drawn into the bush to hunt the wild animals that appear to him in a vision or dream. After he kills them, his assistants help to carry the animals back to the *ondjango* in the compound, where a feast is prepared. The animals' fur is displayed on the *santo's* waistband, and he hangs red or white cloth alongside his bow and arrow on the walls of his sleeping area. Solutions to his patients' problems appear to him in dreams. He is able to advise them about the appropriate treatments and actions for cure, although one former patient said: 'Whether he is able to treat depends on his head and the luck of the patient; when he starts to tremble perhaps the explanation will come or perhaps through his dreams.'

Diviners also use visions to solve problems and to receive instructions for remedies which they communicate to their patients. They sometimes use a piece of glass or a mirror in which images appear to them.

Traditional home-birth attendants

Female relatives and close friends often perform as *home-birth attendants*, as they have done for generations. A young woman 'with a good head' who witnesses deliveries and their management might be interested to learn more, and gradually builds up her knowledge and expertise by accompanying older women, who are highly respected in their communities. Rather than undergo formal midwifery training in the Western sense, these women learn by seeing and doing, through stories of how previous problems were resolved, and through their own experiences as mothers. Some receive under-

standing and guidance through dreams. An experienced birth attendant can predict the course of labour by examining the shape of a pregnant belly, and prepare for anticipated problems with traditional herbal medicines. Payment may be offered for the services provided, depending on the relationship between the women. A neighbour who has been called to help, but who is not 'close', is likely to be paid money. There are certain routine practices that should be respected during childbirth, and possible complications that should be dealt with according to traditional practices. For instance, the umbilical cord should rarely be cut until the placenta has been delivered, unless it is tied to a stick in order to prevent the cord from re-entering the womb and harming the mother. A placenta which is slow to deliver may be gently pulled from the uterus with one finger, although the first action is to force the woman to retch by placing a stick in her throat. If a baby is born still inside its sack, this must be opened in the correct place behind the baby's head to prevent the baby from drinking the water inside the sack, which will kill it. At times, an extra 'cord' may appear after the placenta is delivered. This may only be removed from the womb by singeing it with hot ashes, because it would otherwise re-enter the womb and cause harm. It can be a sign to others that a woman has not looked after her pregnancy well.

Part-time private practitioners

Health staff working at state facilities may work part-time as *private practitioners*, offering out-of-hours services, usually from their homes. Private consultation and prescription of a range of oral and injectable medicines offers a convenient service for some patients as well as a supplementary income for staff, who say that they have economic difficulties. They may also attend complicated home deliveries, for example by giving powerful injections to stimulate delivery.

Bairro health commissions

Since early 1996, Oxfam has worked to develop links with MINSA health-education and sanitation programmes. Health-education training courses focusing on environmental health and communication techniques were undertaken with central community figures, such as *sobas*, members of the national women's organisation (OMA), technical supervisors, church and education representatives, and MINSA health promoters. Participants committed themselves to work as voluntary members of *bairro* health

committees, which Oxfam continued to support by providing education materials and training at community level. With the development of the environmental health programme, it became apparent that the commitment with which members represented their communities varied considerably. Communities and staff met to discuss how much time volunteers could realistically give and what the specific local environmental conditions were, and decided to revise the composition, structure, and function of the committees. They now work in groups of volunteers who plan their activities carefully, taking into account everyday demands on their lives, especially women's lives, in Ganda. Most volunteers are women, although a few interested and 'acceptable' (to the women) men represent smaller 'familiar' areas rather than whole *bairros*.

Medicine sellers

Traditional and herbal remedies are available for sale in the central market place in Ganda. Their uses are many and varied, ranging from the treatment of constipation in children to strengthening of a man's 'power', and protection from death. The sellers who collect them from the bush often travel far to find them, avoiding unsafe areas. They say that when the fields are burnt prior to the beginning of a new planting season, leaves are destroyed, but roots are undamaged. Old people in Ganda say that before the war, modern medicines could only be bought from the pharmacies in the town. The traders today come from coastal cities and are known as 'official traders', but in general they have no formal health-related qualifications. The cost of two tablets of a simple analgesic is equivalent to a kilogram of maize; ampoules of injectable medicines cost five times as much, excluding disposable needles and syringes which are more difficult to acquire. Although the medicines are generally sold within their expiry dates, the lack of storage facilities may negatively affect their quality.

Institutional structures

State-run

The 80-bed hospital offers free in-patient adult and paediatric services, a maternity department, a dental clinic, and a nutritional rehabilitation centre for malnourished children. Routine minor surgical procedures, such as treating abscesses, are performed, and the local MINSA staff have the experience and skills to deal with trauma cases where immediate intervention is needed

to save lives. When transport is available, complicated or serious cases are evacuated to the privately run Hospital Chabungo in Cubal 50km away, or to Benguela, which is a journey of 200km. Suspected cases of tuberculosis are also transferred to Cubal, where they must remain as patients for the required months of treatment. Although the hospital maternity staff are female, most other staff members at all levels are male. The hospital's laboratory was destroyed in 1992 and has not functioned since.³¹ There is a day and night 'casualty' service for urgent cases of all ages, and outpatient clinics for adults are held each morning — patients arrive at dawn in order to register. An 'ambulatory treatment' service provides daily follow-up doses of medicines/injections after initial consultations, but patients do not hold their own treatment cards. Approximately 3,500 outpatients are seen each month, about half of whom attend as out-of-hours or emergency patients. The hospital is rarely full with inpatients. Walking to the hospital from the peripheral *bairros* takes about two hours and involves crossing a gully and negotiating potholed paths.

Polyclinic

The polyclinic *Centro de 26 de Julho* is situated 1km across the town from the state-run hospital. It houses the Public Health department, the child health clinic, the central pharmacy and the Municipal Health department offices. Children under 15 years of age are seen at the polyclinic which opens only on weekday mornings. The one 'fixed' vaccination post for the Ganda Municipality is based at the polyclinic, where all vaccines are administered, including anti-tetanus jabs for pregnant women, although ante-natal clinics are held at the hospital.

The MINSA public health department is responsible for co-ordinating health-education activities at central and community levels; their staff give daily health-education talks to the assembled patients before consultations at all facilities. Themes include the care of water and the importance of boiling water for drinking, correct care of food and personal hygiene, cholera, the use of oral rehydration solution, and vaccination. After this, mothers go through weighing, vaccination, consultation, and treatment. First doses of treatment are usually given on site, and pharmacy staff are responsible for demonstrating how to prepare subsequent doses.

MINSA health posts and health promoters

There are MINSA health posts in the rural *bairro* of Atuque and in the communes of Babaera and Alto Catumbela, and small health posts in the outlying villages of Chacuma and Tchimboa. Health posts offer curative services, and Alto Catumbela has a small maternity department at which ante-natal clinics are held. The supply of essential medicines from the central pharmacy in Ganda to peripheral health posts depends on whether enough has been received to cover the hospital and polyclinic services.

There are, on record, 11 MINSA health promoters, most of them men who were involved in local training courses undertaken by ICRC in 1994/95. (When the original concept of primary health-care promotion at community level had taken its form in the national health-promoter network, the number was double. Several of the remaining promoters had been recruited and trained by MINSA seven years before; others were recruited through the *bairro* authorities.) After the ICRC training, the promoters were provided with printed health-education materials and a small kit of essential drugs. They worked voluntarily, and their activities were monitored through monthly reports and follow-up training sessions. Although support from ICRC ended when the organisation withdrew from Ganda in 1996, the health promoters are officially reported to continue providing some services at community level, and to play 'an important role in raising awareness and giving hygiene-education lectures in schools, churches, and at Party committee buildings.' In addition to their roles as educators, they were also trained to treat common conditions such as malaria, worms, anaemia, and minor injuries in the community. More serious cases are referred to the health facilities. However, the few health promoters who remain in the health sector at present appear to be seconded to work at the hospital and polyclinic facilities, and all levels of health staff say that the MINSA health-promoter programme has failed because of lack of material support and incentives.

Traditional midwife (TM)

A state-recognised TM programme was started in Ganda in 1989 following an initiative by the national health department to expand primary-level health services. Province-wide training seminars paved the way for a local midwife trainer to recruit women from most of the *bairro* communities. Most of them were chosen through the OMA system with the support of the *bairro*

authorities. The TMs underwent three months of formal training to learn how to supervise safe home deliveries, following standard, Western-style hygienic procedures, to recognise complications arising during childbirth, and to refer such problems to the hospital maternity department. The training was based at the hospital and comprised lectures in Umbundu and practical sessions. The women were provided with basic birth kits containing scissors, aprons, and so on from UNICEF and OMA, supported with other material incentives. The small number (six) of TMs who continue to work on a 'voluntary' basis report their monthly statistics to the maternity department; in return, they may receive soap and occasionally disposable gloves. They do not expect financial reward from patients, but may accept payment in kind. In general, TMs only attend complicated deliveries and do not offer ante-natal care services, but some have knowledge of herbal remedies for treatment of fertility-related problems.

Community services: environmental health and sanitation

Teams of women, paid a small monthly salary by the Municipality, work with the *Community Services* to sweep the streets of the town. Men follow to collect the piles of rubbish, or work in the municipal gardens and lido. The large piles of rubbish that accumulate in the market place are collected less regularly, which causes discontent among the market traders. The central water supply is regulated by Community Services; the main pipelines and system have suffered from deliberate destruction and neglect, so most residents of the town and parts of the semi-rural *bairros* rely on intermittent daily supplies to public tap-stands. The town's sewage system was also destroyed, although some buildings retain septic tanks which at present lack regular maintenance. The Community Services Department is mandated to carry out sanitary inspections at *bairro* level.

Church-related

The Catholic and Evangelical (IESA) mission run two private, fee-charging health posts staffed by trained personnel in one semi-rural *bairro*. They work under the auspices of the Municipal Health Department and submit regular reports of service activity. The health posts charge fixed prices, equivalent to several kilograms of maize, for consultation and treatments. The money earned goes towards the purchase of medicines and materials. Payment for consultation may be

received in kind, or, in the case of the Evangelical mission, may be deferred until such a time when the patient is able to pay. Curative services are provided with consultations, dressings and injections, although neither post has in-patient facilities. Diagnostic equipment is basic, but the IESA staff have access to a simple instrument to analyse blood, which is prominently displayed in the consulting room. Complete oral treatments are dispensed at the time of first consultation, and patients return daily for repeat injections as required. Clinics are held during the mornings only, and neither facility offers community outreach or specific preventive health-care activities. Individual counselling takes place during consultations; for instance, patients presenting with sexually transmitted diseases are advised to trace their sexual partners. Pregnant women and mothers of young children are told to attend MINSA health facilities for vaccinations, which are not provided at the mission posts.

Independent private clinic

Situated in a semi-rural *bairro* is a private clinic run by a mission-trained practitioner of more than 20 years' experience. He works with two members of his family. The fees paid for consultation and treatment services cover the costs of buying medicines and materials. Because the clinic has official recognition from MINSA, it has access to subsidised supplies. Prices charged vary according to treatments given, and are often calculated once treatment

is complete, but they are generally cheaper than at church-run health posts. Those unable to pay, such as orphans and the elderly poor, are treated free, while others pay in kind or defer payment. Regular activity reports are submitted to MINSA, and health-education talks are occasionally given to assembled patients by staff before the day's work, but most advice is given on an individual, *ad hoc* basis during consultations. The practitioner focuses on diet as part of treatment and recovery of strength after illness, and advises the use of herbal remedies where appropriate to complement prescribed allopathic therapies. He gives detailed instructions to the patient's carers.

Other agency support to health facilities

The hospital and polyclinic have recently received assistance from Accion Contra Fome to repair their buildings' damaged and deteriorated physical infrastructure. They provided furnishings and equipment, and currently support the central MINSA facilities with two expatriate health personnel. ACF also supply the essential drug stock for all the state-run health facilities in Ganda and have organised in-service training for facility-based local health personnel, to cover elements of primary health-care such as vaccination, maternal and child health care, and management of common health problems. UNICEF and ORA International have supplied drugs and supplemented equipment in the past, and the former continues to provide vaccines and medicine kits.

Appendix 7: Research-project schedule based on intermediate objectives

Phase one (six weeks)	Phase two (eight weeks)	Phase three (14 weeks)	Phase four (20 weeks)
<ul style="list-style-type: none"> • Preplanning and contact with local authorities • Formulation of job descriptions and local recruitment of two research assistants (RAs) • Induction and initial training of RAs in communication skills • Discussion of research activities and data-collection framework • Preparation of interim report 	<ul style="list-style-type: none"> • Training of RAs in research methods • Fieldwork with initial information-gathering and review • Identification of central issues and sources of information • Selection of focus groups • Review of secondary information • Discussion and planning population census with MINSA public-health staff • Preparation of interim report • Participation in strategic planning 	<ul style="list-style-type: none"> • Continued training of RAs • Carrying out matched case studies • In-depth focus group work • Interviews with key informants • Review and analysis of information • Population census • Feedback to participants and verification of findings • Preparation of draft report of research methodology • Health-education workshop with RAs' participation 	<ul style="list-style-type: none"> • Validation of findings and interpretations • Documentation of findings and conclusions • Continued training of RAs • Presentation of report to all interested parties • Discussion and formulation of recommendations • Writing up and translation of report • Dissemination of final report

Notes

- 1 'Health-related behaviour' (HRB) includes health behaviour and health-seeking behaviour — those actions taken to maintain good health and to restore health when ill.
- 2 UNICEF(1997): 'Angola: Socio-Economic Indicators Data Sheet'.
- 3 IUCN The World Conservation Union (1992) 'Angola: Environment Status Quo Assessment Report'.
- 4 In 1998, Oxfam UK and Ireland became Oxfam GB and Oxfam Ireland.
- 5 'Health-care providers' includes those at all levels who provide health services to the population of Ganda.
- 6 Curative and preventive health-care services.
- 7 'Preventive health care' encompasses the prevention of ill health and death by controlling communicable diseases, maintaining mothers' and children's health (with improved care before, during, and after pregnancy), monitoring nutrition and breastfeeding, carrying out immunisation, and maintaining young people's health.
- 8 Hubley, J *Communicating Health: An action guide to health education and health promotion*, The MacMillan Press Ltd, 1993.
- 9 Pretty, Guijt, Thompson, and Scoones *Participatory Learning and Action Handbook*, International Institute for Environment and Development, London, 1995.
- 10 Oxfam UK/I/MINSA population survey, Ganda 1997.
- 11 Vaughan JP and Morrow RH *Manual of Epidemiology for District Health Management*, World Health Organisation, 1989.
- 12 The number of group participants ranged from two to 17, most commonly from five to eight.
- 13 World Health Organisation: 'Guidelines for rapid appraisal to assess community health needs' (WHO/SHS/NHP/88.4).
- 14 Werner D and Bower B *Aprendiendo a Promover la Salud*, Fundacion Hesperian, 1984.
- 15 Kroeger A 'Anthropological and Socio-Medical Health Care Research in Developing Countries', *Soc. Sci Med.*, Vol.17. No. 3, pp. 147-161, 1983.
- 16 *ibid.*
- 17 A term commonly used to denote any health practitioner; the Umbundu equivalent is *otchimbanda*.
- 18 This term refers to female relatives, friends, and neighbours who assist at home deliveries.
- 19 Macdonald, J *Primary Health Care: Medicine in its Place*, Earthscan Publications Ltd, London, 1992.
- 20 Under the present Angolan Land Law, *sobas* are permitted to do this with the consent of the municipal administration.
- 21 'First hunger' describes the period during the rainy season when food stocks are generally at their lowest while agricultural activity is at its most intense.
- 22 Literally, to scrape around for anything to eat.
- 23 Translated as *oxiuri* in Portuguese.
- 24 *Pássaro* is the Portuguese word for bird: a child having a convulsion is said to look like a flapping bird.
- 25 A pregnant woman may bathe her child twice in water that has remained overnight in a pan that had been used to prepare *pirão*; she then transfers a string that has been worn by the child from her waist to the father's waist to take away the child's attention from her (Balombo, personal communication).
- 26 A similar practice in Balombo aims to bond a small child with the new boyfriend of its mother.
- 27 Health Systems Trust (1997): 'Community health workers in South Africa: information for policy makers'.
- 28 ACF Ganda, personal communication.
- 29 Oranga, HM and Nordberg, E 'Participatory community based health information systems for rural communities' from *Participatory Research in Health: Issues and Experiences*, Zed Books, 1996.
- 30 The *batuque* is a drum; the saying reminds people to listen to others.
- 31 ACF plans to open the laboratory to perform essential diagnostic tests.

