Martha Decker - Angola - Summer 2004

Forced migration, war, and vulnerability:
Implications for reproductive health in Angola

Forced to flee their homes due to war and violence, internally displaced persons (IDPs) often lack the most basic necessities such as water, food, and health services, and rarely have any access to reproductive health resources such as family planning and treatment of STIs. In fact, the Plan of Action from 1994 United Nation's Conference on Population and Development specifically stated that "migrants and displaced persons…in many parts of the world have limited access to reproductive health care and may face specific serious threats to their reproductive health and rights" in their "often powerless situation". Consequently, even after war ends, individuals continue to suffer from the destruction of infrastructure, lack of trained personnel, and the loss of social networks and support.

This summer, I spent a month in Angola to research the linkages between forced migration and reproductive health in a post-conflict setting. I conducted semi-structured interviews with women in the peri-urban settlements outside of Luanda, the capital, to learn about their experiences and needs. Additionally, I spoke with international donors and NGOs to gain a better understanding of the types of programs currently offered as well as the challenges in addressing reproductive health needs.

Angolan context

Since 1974, Angolan civil war has devastated virtually every aspect of Angolan society. Fighting left the country in death and devastation, and even the onset of corruption created huge disparities in wealth and access to services. One report recently found that roughly $4.22 billion in state oil revenues were unaccounted for from 1997-2002, while total government, private, and public funding for social services totaled $4.27 billion (Human Rights Watch 2004).

Although Angola is now enjoying relative peace, it still must recover from this combination of war, corruption, and neglect. Angola ranks near the bottom of virtually every health and development indicator and the reproductive health (RH) situation in Angola is especially dire. In fact, the *Reproductive Risk Index* ranks Angola as the second worst country in the world (Chata et al. 2001). Yet, while Angola's estimated HIV rate of 5.5% is considerably lower than other countries in sub-Saharan Africa, some researchers and policymakers fear that it may be at a critical juncture in the epidemic with the countrywide movement of returning refugees, IDPs, and military personnel (Eisenstein 2003; Miles and Song 2001).

Research experience

This research I conducted complements a much larger study focusing on war, vulnerability, and HIV conducted by Dr. Victor Agadjanian of Arizona State University and Dr. Ndola Prata at UC Berkeley. I interviewed twenty women in the same two

communities, Samba and Viana, where the other study previously occurred. Each community of about 80,000 residents consisted mostly of migrants who escaped war that was ravaging other parts of the country.

The basic themes of the interviews included: migration histories, gender relations, family and village life, health service use and access, reproductive health experiences and needs, and post-conflict plans. The respondents ranged in age from 18-45 and most came from the worst war-torn regions of the country. None of the women I interviewed had ever used family planning, although several had heard of Depo-Provera and were considering using it. Everyone had heard of HIV/AIDS, in large part because of a radio campaign, but nobody knew of anyone who was HIV+. Furthermore, all of the condom advertising strictly promoted usage as a means of preventing HIV, not to prevent pregnancy. Therefore, the women not only had only the vaguest of notions as to where a condom could be purchased, but none would consider using one with their partners. The women all said they regularly had prenatal visits during their pregnancy, but all of them delivered in their own homes. Interestingly, some midwives were available in the communities, but charged about $100 for delivery.

In order to gain a perspective on possible responses to the needs of these women and their families, I met with representatives from several international non-governmental and governmental organizations. Because NGOs were illegal until the 1990s, most local NGOs that work in the health sector either partner with an international organization or are run by Angolans who also have political positions. USAID continues to be a major donor for both emergency and development assistance, spending $8.7 million in 2003 for health, of which $.5 million was for family planning and $3.5 million restricted to HIV/AIDS. Unfortunately, PSI's focus with their condom campaign remains exclusively to prevent HIV and they do not market any other contraceptive method.

Both Pathfinder and Management Sciences for Health (MSH) are partnering with the Ministry of Health to provide maternal and child health and basic RH services. Although they have 3 clinics in Viana, I was unable to find them and they were unfamiliar to the women living in the neighborhoods I visited. Médecins sans Frontières continues to provide contraception at all of their sites and has recently begun a program for survivors of domestic and gender-based violence. Due to travel difficulties, I was unable to meet with several organizations which operate in other regions. Over the next few months, I plan to contact more individuals from the Ministry of Health, local NGOs, and other development organizations with family planning activities. If possible, I would like to contact more pharmacists, clinic staff, and people working in the informal sector.

Based on these interviews and program documents, I plan to establish common themes and challenges in the lives of IDPs living near Luanda. I hope to use the data collected from the larger survey to further research the relationship between women's migratory experiences, vulnerability, and their RH outcomes and intentions, including fertility, unwanted pregnancy and abortion, and contraceptive use. By placing RH issues in the wider political and economic context of recent Angolan history, the findings will help to better target populations needing assistance, guide policymakers and programs in the

development of appropriate interventions, and increase the awareness of underlying structural factors for risk.

Selected Bibliography

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