

Reflections on HIDEP - Evaluation and Strengthening

Introduction

HIDEP as a concept is sound. Relating to the human, social and economic needs of displaced persons does require more than immediate survival support. Health - including education and prevention as well as primary treatment - is a major component of the more.

But the conceptualisation remains seriously incomplete. The operational definition of displaced virtually as anybody who has recently moved certainly has the virtue of avoiding artificial exclusions, but may be too inclusive. The meaning of displaced person community apparently has not been explored coherently and has been conflated with the issues of displaced persons/original resident community and displaced persons/local government relations. The follow-up for displaced persons who wish and become able to go home and need help to re-establish themselves has not been incorporated - perhaps inevitably in area based component projects? (In the Mozambique case over the 18 months of operation almost all the initial displaced persons have gone home - albeit many within the district - while a much larger number of home comers have entered and seem to be viewed as displaced by HIDEP, which is indeed true as to need for health support but not in other respects.) Health is an entry point but neither the only nor the broadest one. Livelihood (economic opportunity), nutrition, water/sanitation and primary plus adult education are also needed (whether within HIDEP or in a coordinated approach with other institutions).

HIDEP's articulation is context related and flexible. But it is at risk of becoming formless and anarchic. No general guidelines or parameters - beyond doing more than enabling survival - appear to exist in any operational sense. It is very difficult to see how the Mozambique, Croatia and Sri Lanka projects are related parts of a larger whole in more than an umbrella slogan and a human concern sense. That may be an unduly critical perception which would be altered by closer observation.

WHO has avoided a long lag between idea and initial action - partly because HIDEP came from an Italian Central American focused approach which was already operational there. But it is hard not to receive the impression that "Don't just sit and think about it; do something now!" has been acted on rather more than would have been optimal. At the least more built-in monitoring and ongoing review of HIDEP - as a whole as well as of country components - would have been and remain desirable.

Displaced - Who Are They?

The existing projects have very different groups of displaced persons/part communities:

- a. fleeing war (all three);
- b. returning after war (Mozambique);
- c. victims of urban renewal (Sri Lanka);
- d. urban entrants seeking to escape rural poverty and lack of opportunity.

In addition one project (Mozambique) is basically rural while the other two are metropolitan in terms of area of operation and to a substantial extent in the places of origin of the displaced persons.

Either by implicit (or explicit) division of labour with UNHCR or by chance, no project involves transfrontier displacement (refugees in international law status), albeit in the Croatian case that may be a legal fiction as the prospects for restoring the Republic of Croatia's governance over the Krajina are at best problematic.

There is a good deal to be said for including diverse groups of people who are displaced and have substantial common concerns. However it needs in that case to be recognised that their concerns, aspirations and final destinations (literally and socio-economically) may diverge substantially with consequential implications for project design.

One relatively problematic inclusion is urban newcomers who came to escape grinding rural poverty and lack of economic opportunity - one of the three groups in Sri Lanka. Clearly these persons are poor and need access to health. But their different motivations mean that they are usually individuals/nuclear families seeking to relate to general urban opportunities and into existing urban communities with no desire to return home. For them general strengthening of health services in low income peri urban areas may be a more appropriate response than 'targeting' as a special group.

Two groups - beyond transborder refugees - which do not now feature may be appropriate candidates for future projects. The first are communities (often indigenous minority communities) displaced by major rural based projects (especially hydro and irrigation) or by resettlement/migration schemes promoted to afford land access to households/communities from overcrowded and ecologically imploding areas. In these cases health, education and water facilities are crucial because the diseases prevalent in their new homes are likely to be different from those in their old ones so that the incomers have little resistance to them nor knowledge of what practices would reduce incidence.

A final category are displaced persons who never moved but have been pauperised in place (usually by war) and huddle in fear around the ruins of homes and hamlets, venturing out by day to scabble on bits of half overgrown fields. So long as the war lasts they are often inaccessible, but after peace their needs are very similar to those of the returning home displaced persons who fled to places of greater safety. (Theoretically HIDEP does not include this group; in practice the Mozambican project almost certainly does.)

Community - What Do We Mean?

HIDEP lays great stress on community participation. Presumably this initially (and in Central America) related primarily to the displaced person communities. But it now means local government. In the cases of Metropolitan Colombo and Split (and to a lesser extent Malenje District), it is difficult to see the local government apparatus as a community in any normal, person related sense. It may represent, be responsive to and serve communities, but that is not the same thing.

Displaced persons - at least until they seek to integrate individually or as family units into broader communities which is primarily an urban and/or a second generation pattern - do tend to have or to recreate communities of their own. These, necessarily, perceive reality from quite different vantage points than local government (in which they are inevitably under or non-represented politically as well as in administrative and operational staff).

Indeed it is also a contextual question whether local government will perceive the key displaced persons'/original residents' interactions and stresses in the same way as do the original residents' own communities.

The case is not one for abandoning local government links. These are vital for legitimacy and 'domestic ownership' of projects. It is to argue that local government as usually constituted is not enough. Some mechanism for direct involvement (from project design and policy decisions all the way through to monitoring, evaluation, adjustment and ultimate phasing out) of displaced persons' and original residents' community representatives is needed. Who these are will vary as will how (a special local government committee - or in Mozambique a sub-committee of the Provincial Calamities Commission - may often be suitable), but the principle of direct incomer/original resident community involvement is of general importance.

From Displacement To What?

Displacement is an event (or a series of events for multiple move displaced people). Return and/or reintegration are processes. Envisaged return/reintegration destinations vary over time and also in realism (e.g. most of the Mozambican displaced persons have gone or are now going home while only an arrant Panglossian optimist, or a refugee desperately longing for his lost ancestral home, would hold out similar prospects for those who have fled ethnic cleansing in the Krajina).

Clearly what needs to be done now does depend in part on what present displaced persons will be doing in five years time and where. Historically those displaced to urban areas rarely go home though the Batticloa internal refugees could be an exception if peace can be regained in Sri Lanka. Rural ones, however, often do and even more often hope to do so (however unrealistically) in their initial years of displacement. This is a sensitive area - encouraging integration into new communities for displaced persons/communities with little chance of return is hard to achieve so long as they do not see their chances in the same way.

The clear issues relate to follow up when displaced persons go home (and also when returnees from outside enter project areas initially focusing programmes on persons displaced from outside them). Returnees to rural homes need working capital - food to last out clearing, rebuilding, planting, tilling, harvesting for 9 to 18 months as well as tools, seeds, basic household gear (a bucket as opposed to a large can can save up to 4 hours a day in water collection with evident economic as well as sanitation, health and gender implications) and core livestock for pastoralists. They also need health services in their areas of return. HIDEP has, apparently, not addressed this issue, albeit in Malenje it now caters primarily to homecomers while its initial users are now elsewhere and outside its scope.

Health As Sole Entry Point?

Beyond survival to re-establishment is a sound goal in relating to displaced persons' needs and aspirations. Health is one of those needs. But it is not the only one and, by itself, has obvious limitations as an entry point.

Other - complementary - entry points are livelihood (access to economic opportunities), water and sanitation, primary and adult education, nutrition. All relate to and, if successful, support the health vector. Experience suggests persons are usually very keen to regain at least partial livelihoods (part of the case against massive segregated camps whose heads talk and act as if they were penal or correctional camps speaking of "absconding" and "illicit trade in rations!"). Self respect, escape from destitution, keeping ready for the hoped for time of return home all

play parts. It should be, but rarely is, a major part of the task for those serving displaced persons to identify and facilitate access to even partial livelihoods. HIDEP may have done so *en passant* at project level but there is no evidence it has thought this issue through systematically (as its Central American precursor may have done).

Nutrition and community initiatives may be an entry point to livelihood opportunity improvement (especially for women) at least in rural areas. Certainly, the record of the 'Iringa model' child nutrition and community participation programme (now operative in most Tanzanian Districts) suggests that. The Mozambique project would be the best of the present trio to test the approach for rural areas while the Colombo Batticloa community might be an appropriate urban pilot.

Coordination: WHO and who?

Clearly WHO has not the expertise nor the finance to cover all aspects of multi entry point strategies. But it can - and arguably should - seek to catalyse them and to bring partners on board.

The evident ones are UNICEF, IFAD, ILO and domestic social sector bodies (e.g. churches, mosques, women's groups, Red Cross chapters, and co-operatives at village-district-provincial-national levels). Foreign NGOs are more problematic as they resist coordination, are frequently syndico anarchist in philosophical approach to government and often prefer isolated, short term projects to coordinated - as long as it takes - capacity building. But there are exceptions, e.g. Action Aid has three multi sector programmes closely integrated with local and provincial government in Lower Zambesia Province and might be an optimal partner in Malenje (in Upper Zambesia).

Political Sensitivity For Apoliticism?

WHO by definition cannot have any political agenda except backing better health and those who seek to ensure access to it. But it would be naive to suppose its local partners and communities served were apolitical.

For example, in Mozambique the government genuinely wished to restore health (and education and water and demining) services to all its people including those in Renamo occupied areas. But it also saw such action as a vote winner and a Renamo local governance destabiliser. So did Renamo and therefore not only direct government but often government

personnel via NGOs were rejected. In Malenje the local Renamo leadership wanted the services for the people in its controlled areas so long as this did not involve naked handover of the substance of local government services and was prepared to break with central Renamo directives on this issue. Thus Malenje (a sensible choice on pure need grounds as well) for HIDEP was a political choice of the Government of Mozambique made possible by a mixed political/humanitarian decision of the local Renamo leadership.

The point is not that WHO should become practising local politicians. Rather it is that political analysis is needed to understand any context and how to relate to it. In the case cited both the Government of Mozambique and Renamo's district leader are 'using' WHO, but as long as they use it to enhance access to health for displaced (and other seriously war impacted) persons, WHO can accept that. But not all uses will be so benign. To sort and to choose requires understanding who wants what, why, and to which ends in the actual political context.

Other Issues

The reflections above are on themes clearly integral to HIDEP. Evidently evaluation must cover other issues which are more general: achieved coverage, relevance and priority of activities, lags in relation to target levels and dates (if these have been pre-set), gender sensitivity, cost/benefit ratio in the broadest sense using whatever 'output' proxies are available and not irrelevant.

Personal Concern/Relevance

I have been working with post-war livelihood rehabilitation and survival through rehabilitation to renewed development for the past eight years. My initial entry point was a main author of UNICEF's *Children On The Front Line*. Since then I have been operationally involved in Mozambique where I am (part time) Senior Social Policy Advisor to the National Directorate of Planning and especially its Poverty Alleviation unit. Of Mozambique's perhaps 9,000,000 absolutely poor people about 7,000,000 were (perhaps 4,500,00 to 5,000,000 have now gone home) war displaced or pauperised in place. I have done additional analytical work on this area in respect to the Horn and am now doing a short consultancy on the short and long run costs to Tanzania of the Ngara (Bonaco) Rwanda refugee concentration and how these could be met, offset or alleviated..

My survival-rehabilitation-development concerns began in the war/complex emergency process. However, they have also included work with SADC on natural calamity-linked food security in 1984 and 1992/93. More generally IDS has a research focus on this topic.

I am not in any sense a medical professional. However I have applied experience in social science/general development interface with health strategy and praxis in Tanzania and in Mozambique going back to the 1970s. In addition I have published in *Social Science and Medicine* and *Health Policy and Planning*.

My experience is largely, but not exclusively, African. I have however an ongoing interest in Sri Lanka whose export sector was one of three covered in my 1961 Harvard doctoral thesis and I have been there several times and kept roughly up to date on changes.

IDS Relevance

IDS has a focus on survival-rehabilitation-development which will, as a first coordinated output, shortly publish the proceedings of an international workshop as an issue of our *Bulletin*. It has an inter-disciplinary staff with experience in Mozambique (e.g. Simon Maxwell, Martin Greeley and Malcolm Segall, as well as myself) and Sri Lanka (Mick Moore, and, peripherally, myself). The disciplines include medicine - Malcolm Segall is a medical doctor with governmental and consultancy as well as research experience.

IDS would deploy one lead researcher/project manager plus inputs from other professionals as needed. It has research assistant, library, secretarial and reproduction/communication back-up. As a result and because IDS consultancy/sponsored research must cover full cost (including staff time) since we no longer have any relevant core (block grant) funding, we are not, I fear, low cost.

The draft budget appended, assumes 90 person days of professional time, limited local consultant inputs (if practicable), back-up and travel costs. It is of course subject to your and IDS' Finance Officer's approval. A smaller budget might be feasible, but would involve less input. I doubt that a wholly Geneva/Falmer desk study without project trips would meet your needs.

Budget Draft

90 days professional time plus back-up personnel, overheads, etc.	\$50,000
* 4 Field trips. (Estimated external travel cost)	10,000
* Local travel. (Presumably largely Mozambique)	1,000
* 48 Field day subsistence at average of \$175.	8,400
* 3 Trips to Geneva (travel and per diem while discussing)	3,000
* Local Associate Consultants	<u>5,000</u>
Subtotal	<u>77,400</u>
* Contingency (6% rounded down)	<u>4,600</u>
	<u>\$82,000</u>

- R. H. Green
 Nairobi
 24 August, 1994