



Management Sciences for Health
1925 North Lynn Street
Suite 400
Arlington, Virginia 22209

PN # 885

**A STATUS REVIEW LEADING
TO THE DEVELOPMENT OF A
USAID STRATEGY FOR WAR
WOUNDED IN EL SALVADOR**

**A Report Prepared by PRITECH Consultant(s):
DANIEL B. EDWARDS**

**During The Period:
JUNE 1993**

**TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT
Supported By The:**

**U.S. Agency for International Development
CONTRACT NO: AID/DPE-5969-Z-00-7064-00
PROJECT NO: 936-5969**

**AUTHORIZATION:
AID/S&T/HEA: 09/03/93
ASSGN NO: HSS 155-EL**

This Field Report is produced under sub-contract to PRITECH by Training Resources Group for the Office of Health, Population and Nutrition of the USAID Mission to El Salvador.

For purposes of this review, War-Wounded are defined to include all ex-combatants as well as all civilians physically, sensorially, or mentally impacted by the war. A Comprehensive Strategy for War-Wounded, as defined by USAID, refers to the assistance that will concentrate exclusively in the following areas: (1) completion of required medical interventions for the FMLN ex-combatants, (2) a comprehensive physical rehabilitation program, and (3) a Post Traumatic Stress Disorder health campaign.

Contents

Chapter	Page
1. ASSISTANCE REQUESTED AND TASKS PERFORMED	1
1.1 Background and Terms of Reference	1
2. FINDINGS	6
2.1 Brief Summary of AMED Project Status	6
2.2 Factors Affecting the Implementation of the AMED Project to Consider in a Comprehensive War-wounded Strategy	7
2.2.1 Project Design	7
2.2.2 Project Structure	8
2.2.3 Communication and Trust	9
2.2.4 Roles	9
2.2.5 Definition and Dimension of the Client Population	10
2.3 Dimensions for a Comprehensive War-Wounded Strategy Emerging from the Current Experience	11
2.3.1 Need for a Comprehensive Approach to the Problems	11
2.3.2 Needs for a Strong Community-field Orientation and Decentralization	12
2.3.3 Need for Dealing with a Range of Mental Health Problems	12
3. RECOMMENDATIONS	13
3.1 For the AMED Project	13
3.2 Key Elements to Include in a Comprehensive Strategy	14
3.3 Structural Recommendation for Any Future Project	16
3.4 Conclusion: Steps to Complete the Strategy	16

Chapter 1

ASSISTANCE REQUESTED AND TASKS PERFORMED

1.1 Background and Terms of Reference

The Office of Health, Population and Nutrition (HPN) of the USAID Mission to El Salvador requested the contractor to perform a brief review of its current project that provides medical assistance to the war-wounded in El Salvador (AMED project, 519-0394/ESF-91). One major objective of the review was to include the major organizations now working with the war incapacitated in collaborative strategy development for 1994 and beyond when the AMED project has been completed in October 1993. The AMED project was designed for a one-year life and directed at emergency assistance to war-wounded for the *Frente Farabundo Marti Para La Liberación Nacional* (FMLN). The HPN has been working on research leading to a draft strategy but this effort is still in the preliminary stages and has not yet included major involvement by others working in the sector.

The AMED project works with and through a number of governmental and non-governmental organizations (NGOs) to accomplish its mission (explained below in 1.2). While the objectives of the AMED project are restricted to physically maimed FMLN ex-combatants needing medical attention, the project collaborates with organizations which work with the broader spectrum of war-disabled and those that are severely war-affected, displaced, mentally and physically damaged and dysfunctional.

In the statement of work for the contractor, the HPN office anticipated a two-part consultancy in which activities of the first phase were limited to data gathering through interviews on current efforts, blockages, and needs while also considering input into a future strategy. At the same time, the HPN wanted to assess the potential for a second-phase activity, in which the major actors would be brought together in a workshop forum to discuss a longer range strategy and their respective roles in it with either A.I.D.-supported efforts or other donor support. The recommendations in Chapter 3 detail those steps required if a second-phase workshop would be a useful activity for continued strategy development. This sub-contract is limited to only the first phase of these efforts.

Fourteen organizations were interviewed during the two weeks of the consultancy. An interview format was structured to determine current activities, problems, successes and lessons learned that should be carried into any future strategy. Interviews were conducted with each major group represented in the current AMED project and also with organizations playing major roles in current or past efforts to assist the target population. Interviews were conducted by the consultant with the support and in the presence of HPN project coordinator, Mr. Hector Casanova. On occasion Mr. Casanova excused himself to allow the interviewee to speak alone with the consultant. In one interview (with the F-16

health coordinator) Mr. Hartenberger (Director of the HPN Office) was present and an additional interview was conducted with the F-16 without Mr. Hartenberger.

Part of the interview information solicited was "what roles have been carried out by the group involved and what roles might be desirable in a future strategy." A list of those organizations interviewed and a synopsis of their roles are presented by category of involvement/proximity to the AMED project. Categories include a) direct project participation, b) closely affiliated by working with direct referrals from AMED, c) NGOs working with the same client population in other or related capacities, d) the government military ex-combatant program for war-wounded, and e) multilateral programs working in similar, overlapping or affiliated programs.

Organization

Relationship to AMED

Direct Project Actors

The National Reconstruction Secretariat (SRN)

The official GOES umbrella organization set up to coordinate and channel development assistance for reconstruction after the civil war. One section of the SRN has oversight for the AMED project. As set up in project agreements, their role is primary project management, financial, and technical monitoring of the AMED project.

Ministry of Health (MOH)

Manages AMED project with a project management unit set up under its planning and projects division. Provides surgical or other medical attention and interventions primarily in its San Rafael Hospital and refers cases to private hospitals when necessary. Channels AMED funds to cooperating organizations.

Organization

Fundación 16

Asociación Salvadoreña Lisiados y Discapacitados de Guerra, 23 de Febrero (ASALDIG)

Closely Affiliated and Referral Receiving Organizations

Instituto Salvadoreña de Rehabilitación de Inválidos (ISRI)

Telethon Foundation Pro-Rehabilitation (FUNTER)

Relationship to AMED

The principal FMLN NGO that is the major contact and advocate for all assistance to the FMLN ex-combatants. Provides advocacy services, referrals, surgical monitoring of AMED doctors, and manages the guest houses of the patients as they enter and leave surgery. Has 20 field promoters under the project to provide counseling and medical monitoring follow-up to patients.

Advocates, refers and works closely with F-16 to monitor and represent the interests of (ASALDIG) the FMLN disabled ex-combatants.

GOES national agency for handicapped, blind, deaf, (ISRI) neurologically disabled population. For the war-wounded population, they are working primarily with the blind FMLN ex-combatants.

NGO. Provides training and manufacturing of prosthetic and orthotic devices; rehabilitation and follow-up to amputees with prosthetic devices; sets up service centers and turns them over to the MOH for continued management. Funded by a separate A.I.D. project and through private fund raising.

Organization

NGOs with a Role in the Ex-combatant Community

Fundación Antidrogas Salvadoreña (FUNDASALVA)

Promotora de la Organización de Discapacitados de El Salvador (PODES)

Sociedad Salvadoreña de Psicología (SSP)

Government Military

Center for Professional Rehabilitation of the Armed Forces (CERPROFA)

Multilateral Organizations

Programa de Desplazados, Refugiados y Repatriados (PRODERE)

Organization

Relationship to AMED

Drug prevention and education funded by A.I.D. and private donations. Conducting training programs for teachers and local groups in war zone in how to recognize clinical manifestations of the Post Traumatic Stress Disorder (PTSD).

Provides prosthetic devices; conducts training for the manufacture of prosthetic devices by setting up small enterprises run by ex-combatants. Funded by US-based PVO "Medical Aid for El Salvador" and Medico Internacional from Germany.

Professional association of psychologists. Founded in 1966, has a total of 200 members between psychologists and social workers. Currently training the professional community through workshops in mental health.

Provides full range of rehabilitation services for the GOES military ex-combatants through a one-year readjustment and vocational rehabilitation training program. Funded by the GOES.

United Nations' Development Program (UNDP). Broad-based integrated development in the former combat zones: micro-enterprises, health centers, water, schools, agriculture credit, development centers.

Relationship to AMED

Organization

Pan American Health Organization
(PAHO)

European Economic Community:
Programa de Reinserción Productiva de
Lisiados de Guerra

United Nations El Salvador Mission
(ONUSAL)

Relationship to AMED

Coordinated the first emergency post war medical attention to war-wounded, civilians and ex-combatants, during the year after the peace accords. Set up field health centers for diagnosis, preliminary treatment and prevention, and dental attention, and equipped and set up an emergency operating facility at Rosales Hospital of the MOH in San Salvador, where it provided surgeries to the FMLN and civilians at the end of the war. No current direct project role.

New program in 1993 under development to provide surgical interventions, follow-up, environmental health, professional training and vocational placement, and micro-enterprise development for three years (\$4,500,000) to war-affected populations and war-wounded.

Provides mediation, human rights observation, on-going round table discussion of problems relating to maintenance of the peace accord. Meets regularly with AMED project and F-16 and ASALDIG groups in discussions related to conflict resolution. Provides conflict management forum between GOES and FMLN on agreements related to peace accord.

Chapter 2

FINDINGS

2.1 Brief Summary of AMED Project Status

The AMED project started officially in October 1992 and has a PACD of October 1, 1993. The first funding reimbursement was December 23, 1992. The October through January timeframe was spent in setting up administrative systems, hiring staff, making agreements, and arranging for logistical support. AMED worked with ASALDIG during the start-up period to promote the availability of services and ASALDIG provided the first wave of patient referrals. The first patients provided by the F-16 were to be 50 priority cases that needed immediate attention. AMED believes that ASALDIG did not have the logistical capacity to mobilize patients and there were a number of delays when patients were promised then not delivered for various reasons. AMED provided transportation and sent vehicles to bring in patients on two arranged dates but patients did not show up. Meanwhile, physicians had been retained and were waiting to operate and work. After these two delays 26 patients finally arrived in January, many of whom were not considered to be in need of immediate/emergency medical attention by the AMED staff. These early start-up problems began a spiral of frustration and distrust among all parties that continue to this day in the project.

The history of project activities have been characterized by intense infighting between the F-16/ASALDIG and the AMED project director over all details including the status of the hospital facility and its equipment, the doctors allowed to be used, the data gathered on patients and the use of the data, the number of promoters that F-16 could hire and what they would do, how a disability is defined, how patients are treated, the amount of money doctors should be allowed to charge or how charges are determined. ASALDIG stopped project work and referrals on January 16 because they believed that the AMED staff were not properly attending the patients and the hospital was not properly equipped.

The January through May 1993 time frame produced a very low number of patients attended:

	Planned	Achieved
1. Surgical Interventions	90	30
2. Medical Consultations	505	365
3. Physical therapy	432	115
4. Laboratory exams	534	220

In the month of May, however, progress in surgical attentions leaped to 60 (twice the number for the previous five months). It seemed that a flow of patients was on the way to normalizing. However, during the two weeks of this consultancy (last week of May, first week of June), it was reported by the F-16 and confirmed by the AMED project that approximately 19 percent of patients receiving surgery at the San Rafael Hospital have experienced infections. A study is currently underway to determine the cause(s) of these complications. The F-16 initially threatened to suspended project activities again because of these complications and a charge that AMED could not handle the increased numbers but under negotiations supervised by the UN observer group, the AMED project agreed to dismiss two doctors, undertake a study to determine causes, to conduct refresher training for staff on sterile procedures and to correct any problems.

2.2 Factors Affecting the Implementation of the AMED Project to Consider in A Comprehensive War-Wounded Strategy

There are number of factors that affect the current performance of the AMED project that provide lessons learned for a comprehensive war-wounded strategy.

2.2.1 Project Design

It is unclear to the consultant exactly how the project scope was determined or developed but there are a number of design flaws that have created implementation problems. They are:

- Unclear scope of work
- Duplicated elements
- Unclear roles in implementation
- Several undefined and elusive terms
- Failure of continuity of prior efforts by PAHO

It appears that many of the elements added to the original project design included an expanded set of activities that were not defined; nor did they correspond to current project capacity to implement.

Some of the undefined items and phrases added to the action plan were **integrated rehabilitation, developing necessary hospital infrastructure, community-based rehabilitation programs and follow-up, formulating a long-term action plan, equipping service centers for patient care**, and also language was added that refers to an undefined second and third phase to be developed during the first phase (presumably the 1992 - 1993 time period).

The current project action plan also specifies language requiring that AMED provide medical attention in the San Rafael Hospital (a MOH hospital not previously used).

It was discovered during this review that another MOH hospital, Rosales, had been completely equipped by the United National emergency program carried out in 1992 and implemented by PAHO (and funded indirectly by A.I.D. and by other donors). Part of the equipping process included rehabilitation of a complete wing of the hospital for the purpose of serving the war-wounded. It may have been possible that these major efforts, structures, physical equipment, staff, and project learning established by PAHO with an excellent record of performance might have been used or carried forward to the AMED project in its design phase and incorporated into the current project. While PAHO reported that considerable advice was passed on, the AMED project appears to have started from scratch. However, during the first week of this consultancy, the new equipment for the emergency room of the San Rafael Hospital had its public donation ceremony.

2.2.2 Project Structure

Closely related to project design is the project structure, which brings no end of opportunity for conflict. The project is structured so that all implementation project resources, management and control are channeled through the MOH. Yet the project recipients (and particularly their representatives) have just spent the past twelve years in armed combat with this government, were wounded by the military of this government, and consider agencies like the MOH and the elite medical community the enemy. The stage has been set by this structure for charge and countercharge, and control and resistance to control.

The consequence of this arrangement is politicization of the implementation rather than attention to technical and professional matters that meet the needs of the war-wounded. For example, that the AMED project director must approve any expenditure incurred by the F-16 and ASALDIG for field staff, transportation, per-diem and lodging of patients should ensure that project funds are properly used by them, yet they will not allow access to these matters by him. On the other side, by agreement and subsequent protest and settlement, F-16 has rights for medical observers (and employ a number of doctors for this purpose) at all stages of treatment, approval of which doctors are selected for operations, review of patient records and procedures, and approval of the status of operating and hospital facilities used. Each party has the potential to expend vast amounts of energy blocking the progress of the others (and have done so). This process quickly has become politicized; both sides accuse the other of making political points. With the next year dedicated to an election campaign, suspicion runs high that everything will be done to use the war-wounded as bargaining chips by everyone. For example, the F-16 recently requested a total of 50 field promoters (approval was given for 20). They were immediately suspected of wanting to have field organizers paid for by the project to organize the votes for the electoral campaign among patients. The F-16 contends the reason that patient referrals for surgery have dramatically increased is the added presence of promoters and the cumulative field work of several months of start-up.

2.2.3 Communication and Trust

Communication is ineffective among project implementation groups and in the larger community working on similar problems. Most of those interviewed believed that there was a lack of clear, positive and experienced project leadership in AMED. SRN believes it has done the best job possible in searching for fresh, unbiased and honest project management, and they believe they expended considerable effort to find a project leader who had not been contaminated by negative past experience and had not been politically involved.

In general, those interviewed stated that there is an atmosphere among the NGOs and governmental and international agencies working with the post-war effort of competition with each other for recognition and for resources.

Mechanisms for building and sustaining communication (apart from mediated round table discussions managed by ONUSAL) were not in existence. Steps to build trust have not been set up; these could include project initiation workshops, team building, regular staff meetings with implementation parties, exchanges and definition of criteria in technical matters. This issue is linked to the difficulties encountered in coordinating project activities.

2.2.4 Roles

The following role confusions were encountered:

- The MOH project director feels he has several bosses all requesting reports and attention - the SRN section dealing with war-wounded and displaced, the MOH division of planning that has organizational oversight for AMED, the head of the SRN, A.I.D. office of HPN and A.I.D. office of IRD.
- There are role conflicts between the AMED project director and the director of the health department of the F-16; each believes they have the right to make project decisions related to patient care policies, project management and definition of eligibility.
- It is unclear if the AMED project director has any technical supervisory authority over the field promoters provided by ASALDIG and F-16.
- It is unclear why pre- and post-operative care that takes place in the guest houses for patients attended at the San Rafael facility has been assigned to F-16 and that F-16 manages the payments to the guest houses and the per-diem to patients rather than the AMED project directly. During the year of emergency activities, Rosales Hospital maintained the guest houses and used the opportunity to provide counseling services.

2.2.5 Definition and Dimension of the Client Population

All parties involved believed that the task of defining the client population (the project recipients) was very inexactly accomplished in the start-up and project design phase. Trying to arrive at a fair estimation of who should and should not be served by the AMED project is difficult as recent efforts by the HPN/IRD office to clearly identify the target population indicate. Even more complicated is the task for a comprehensive war-wounded strategy. The following history provides some of the reasons:

- At the end of the conflict, ONUSAL attempted to register all the ex-combatants of the FMLN by giving them an identity card. In this process those registered were asked if they had war-related disabilities and they were also observed visually and classified. This was not always carried out with medical assistance but by UN military staff. Those classified as disabled were given a special identity card.
- During that time period, many FMLN combatants were not in El Salvador but were in Nicaragua, Cuba, Switzerland, and other places. Some of these had war-related disabilities and wounds. These did not received an identification card.
- Many civilians were also wounded; they had stepped on land mines, were sensorially damaged, raped, witnessed atrocities in their families and with others, were displaced, widowed, and maimed. Estimates by FUNTER are approximately 3,000 physically maimed. At a mental health workshop assisted by two U.S. military specialists on PTSD, those attending estimated informally that 15 percent of the civilian population in combat zones suffer some form of PTSD. Many of these may claim they were FMLN if this will allow them to receive help. This population does not have identification cards.
- Many individuals were distrustful of being registered by anyone and avoided the process or gave false names.
- The UN medical effort led by PAHO treated anyone who asked for help during the one-year immediate post-war program period without requiring identification.

Currently, many in the NGO community find that some of the same patients return for services two and three times and give a different name each time.

Each organization interviewed had a different data base of numbers, none of them agreed. Some were attempting to build and refine existing data bases including the F-16, AMED, and FUNTER. The European Community has commissioned a new census for the

geographic areas of the conflict to try to redetermine war disabled in a number of categories. These data will be available in mid-July. There was a general population census completed for all of El Salvador recently and these data may be useful; the results will be available in September 1993. One of the groups interviewed gave an estimate that as much as 72 percent of the population living in the former conflict zones are women, many without husbands and single parents. Should this prove even remotely close, it has implications for any future strategy and implications for all development assistance efforts in these areas.

Another problem is defining what constitutes a war disability. Those having a physical disability can be easily measured, whatever their past affiliation or non-affiliation, if access to them is possible. However, there is increasing evidence that large segments of all war zone populations are experiencing post-war traumatic stress (episodic flashbacks, nightmares and inability to sleep, depression), psychosis, acute and severe depression. However, no group has any data on the real dimensions of this problem aside from data on populations currently being treated for physical problems. Even in the case of verifiable medical problems, complications in definition have occurred. One case was a woman with an amputation who was subsequently pregnant and experiencing difficulties with the pregnancy due to spinal stress related to both the amputation and the pregnancy. The project has not defined criteria for situations such as these and this leaves matters open to judgement. In a politicized atmosphere, judgement calls can be (or suspected of being) interpreted politically.

2.3 Dimensions for a Comprehensive War-Wounded Strategy Emerging from the Current Experience

One of the questions asked of all of those interviewed was "what should be taken into account for a longer range strategy based upon what you have learned from experience to-date?" This question was in relation to the larger needs of the war-wounded and the severely war-affected populations and included civilians, currently unattended FMLN and GOES and ex-military personnel. In part, the question was intended to begin a dialogue that would continue into the strategy development that the HPN could help establish over the next three months. Most of the responses were a mixture of information and recommendations and should be considered in conjunction with the recommendations in Chapter 3. The trends in suggestions are discussed.

2.3.1 Need for a Comprehensive Approach to the Problems

Most of those interviewed believed that the objective should be the integration into normal life and productive society of those populations severely affected either physically, mentally and emotionally, and/or displaced economically by war actions by losing contributors to family income and subsistence. They believed that past attempts had tried to define target populations too narrowly as war maimed (*lisiados*) or wounded. And, that programs should not end with an operation and a prosthesis but carry forward through reestablishment of a

normal, productive life. Additionally, severely mentally disturbed and traumatized and victimized families were left out of the equation.

Another aspect of the need for comprehensiveness was the problem that disabilities ramify into many other problems for families. Consequently, treatment should include post operative follow-up counseling, job rehabilitation, placement or training, and economic development activities (small businesses). Training for family members in how disabilities affect them should be provided.

2.3.2 Needs for a Strong Community-field Orientation and Decentralization

Those NGOs experiencing success, and the prior post-war emergency-year program of PAHO, managed to set up programs with strong field presence and linkages from the community to appropriate levels of specialized service. One of the weaknesses of the current AMED project is that it primarily depends on one organization to provide the linkage to the community. Many of those interviewed advised A.I.D. to structure a future program in an "open access" format and to include elements of community work (such as rehabilitation follow-up and community and peer group counseling) and to structure needed elements of specialization at regional levels when possible. Bringing patients to San Salvador should be only for very specialized care.

In discussions with several groups it was learned that most are planning to set up some kind of "center" at the regional level. Any future strategy should attempt to coordinate these efforts so that there is not a proliferation of centers, many trying to do the same thing.

2.3.3 Need for Dealing with a Range of Mental Health Problems

As previously indicated there are a range of mental health problems. Some directly relate to war injuries (i.e., counseling the amputee on accepting the disability and moving ahead), and some are related to war atrocities (rapes, loss, displacement, hopelessness). Many of the ex-combatants were very young and had not developed any skills or direction in life before entering the war (on either side); many of these are now lost in a no mans land of nothing to do, lack of purpose, lack of skills, lack of education, few opportunities and low self image. Some of these continue to have weapons and are committing crimes. Many believe that the consequences of war will not be ameliorated until something is done in the area of mental health, and also in the economic development and educational arenas (perhaps part of the basis for the conflict in the first place).

Chapter 3

RECOMMENDATIONS

3.1 For the AMED Project

For a number of reasons it is important that the AMED project be accelerated to accomplish its primary task of dealing with the population needing surgical interventions. Surgical interventions should be taken care of and this population served before more complications develop over time in patients. Additionally, the politicization should not be allowed to continue into the election period of 1994; this can only be detrimental to the welfare of the patients. AMED should be considered a "crash" program that is providing a bridge to a longer term strategy. It should not be viewed as an institution building program for the MOH or any other group. The objective is to serve the war-wounded population requiring medical attention. The following recommendations are suggested:

- In general, every possible step should be taken to facilitate quick response mechanisms and to provide expedited services to this population. A reasonable target of December 1, 1993 should be set to complete all work. At this time, the AMED project should be completed and any additional surgical work should be referred to other programs managed by the multilateral donors or be managed as one small part of an expanded, long range strategy.
- The opening of surgical attentions at the Rosales Hospital should be negotiated and this capability added. There is no reason to limit attentions to one MOH hospital when Rosales has already been fully equipped and has an excellent record of attentions.
- If more field promoters are required by F-16 to speed up the process, they should be added and a distribution plan for the workload be planned, discussed, and justified for their use. It is suggested that promoters also be considered for cooperating organizations such as FUNTER, FUNDASALVA, and PODES so that the transition to other organizations that will be working on a future strategy in areas of employment, counseling, and prosthetic renewal can begin during the next six months. There is no reason why only one organization should be referring patients to AMED with field promoters.
- It is counterproductive to put too fine a point on whether the patient is an ex-combatant from the FMLN group or not. If they are a non-affiliated war-wounded person, they still have a disability and need attention. The game of data base registration and endless forms to fill out is very time consuming

and serves a dubious purpose that can be used by all for political purposes. Records beyond those needed for medical follow-up, which should be client confidential, should not be a part of AMED. The objective is to take care of the medical needs of the patients. One of the reasons that PAHO believes it was able to attend to so many in a short time was that they simply "weren't asking and nobody was telling."

- Current administrative bottlenecks should be removed. AMED should be given authority for expedited processes in procurement of supplies and equipment needed for direct patient care. Arrangements with hostels should be set up directly by the project for flat rates for full use and the potential game of amounts per head and piece services should be dispensed with. Direct payments of incidental travel expenses should be given directly to patients by AMED. There is no need for F-16 to act as middle man.

3.2 Key Elements to Include in the Comprehensive War-Wounded Strategy

There are a number of elements that will enhance the likelihood of success in any future strategy based upon the lessons learned. While many of these have already been pointed out in Chapter 2, they are summarized here:

Neutrality

Any future strategy should not set up a structure that provides an opportunity for politicization. It should be set up to put the best professional and technical resources available at the disposal of the population at risk. Funds should not be directly channeled through the GOES or any group considered to have a political stake in the outcome. A.I.D. should retain direct control of the project's technical and administrative matters. An effort should be made to convince the GOES that under the bi-lateral agreement with A.I.D., it is in their best interest to allow this particular population to be served from a strictly humanitarian service perspective.

A time limited mandate with sustainability as needed

The future strategy should not be envisioned as setting up a post-civil war industry dedicated to perpetual service to the conflict. The strategy should define a carefully crafted vision dedicated to reintegration of the population at risk and consider ways to "graduate" that population to independence rather than creating structures that will maintain them in dependence (and the NGO or GOES organization) for life. When on-going needs are required, these should become institutionalized within the ex-combatant community and made self-sufficient.

A better definition of the target population

While it may be difficult to be precise about who exactly will be the beneficiaries of the future strategy, an estimate should be made to serve the purposes of planning. The current census conducted by EEC should be considered, along with the estimates of the service groups. Criteria for who this population is should be established and specified in the strategy document.

An expansion to the larger community and an expansion of needs

The population at risk should not "belong" as the particular children of any one group but be considered as the conflict-affected community. This should include civilians or non-affiliated and past-affiliated populations on all sides.

Address the whole problem

The area of need most neglected to-date is mental health. It is perhaps the least understood and the most difficult to measure, as well. A special effort should be made during the next three months to conduct a needs assessment using some sample populations and some field investigation techniques to, at least, get a better idea of what types of problems need to be treated and how many people this problem might involve. The strategy should include this aspect of the problem. There is expertise available and a number of very effective projective techniques have been used within therapeutic group settings with ex-Vietnam populations. Efforts should be made to bring in this expertise to assist with strategy design.

Beginning efforts are underway to provide self sufficiency for the population through job placement, job training and small business development. These efforts should be supported and enhanced in a future strategy.

Should female populations that have been severely affected by the war prove to be significant as a percentage of the risk group, consideration of strategies to address this need should be given. It could be important to ensure that female promoters in higher numbers be included as well as special counseling approaches for rape victims. Employment and enterprise strategies for single mothers may also be needed.

Variable response mechanisms and capacity for sub-grants

The strategy should have the flexibility to learn from experience and continue to define emerging needs. Efforts should be made to build in review mechanisms, such as monitoring workshops, technical training and special studies. Mechanisms for flexible responses that will allow for creative initiatives for new responses to problems should be built in. The comprehensive war-wounded strategy should be

able to quickly and easily fund sub-grants to NGOs and others working on the problems on the basis of proposals.

Technical assistance and training

Many of those interviewed said that they are learning how to deal with this client population. There is a need to bring together a group of professionals with experience and dedication to assist the entire community that is attempting to work with the ex-combatants and their families and communities. The future strategy should include attention to training, periodic workshops to discuss strategy and lessons learned, and opportunities for learning.

3.3 Structural Recommendation for Any Future Project

As discussed in Chapter 2, the current structure for the AMED project has limitations. The principles discussed above should be applied within a professional and technically oriented environment. It is recommended that A.I.D. retain an institutional contractor to guide the implementation and the coordination of the strategy. The contractor should bring together professionals from the international community with experience who can advise and train others in the local community and administer sub-grants to meet the needs.

This should serve as a conduit for the needs described above. The advantage of this structure is that accountability and managerial control will be more direct and responsive, and a neutral actor will be able to provide the services now muddled by politics. Specific design of this structure should become a priority for the HPN over the next several months (along with strategy development) so that this is in place by January 1994 to provide continuity to current efforts.

3.4 Conclusion: Steps to Complete the Strategy

During the brief process of this consultancy a dialogue has begun with many of those involved in the post conflict service community. All those interviewed were told that the dialogue would continue and that as USAID began to develop draft language for a strategy, their input and advice would be solicited. This is, essentially, the major next step required. Over the next three months, a series of mini-conference sessions should be conducted with different groupings (for example, the mental health community, the bi-laterals, all those involved with prosthetic devices, all those involved with job placement, etc). Each meeting should be facilitated and should propose and develop strategy. The HPN may wish to assign more internal or consultant resources to this process, given the high work demands now being placed on Mr. Casanova to manage projects and the amount of time the current AMED project requires and will require if it is accelerated.

By mid-September every group should have had considerable input into a future draft strategy. By that time, as well, the AMED program should have served a substantial

portion of its target population and major conflicts between them and the F-16 group should have been ironed out.

If the above scenario has been successfully completed, a future strategy workshop would be a very useful vehicle for bringing the community together to compare and comment on the different parts of the strategy, to define criteria and to agree upon roles where unneeded duplications exist. Ideally, the last two weeks of September 1993 would be a timeframe to target for this activity.

Following this strategic review, a project paper should be developed using the strategy framework as its basis and a project approved with a January, 1994 target start-up date.