Possibilities for Working with Cultural Knowledge in the Rehabilitation of Mine Victims in Luena, Angola

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Introduction

Following the signing of a peace treaty by the parties fighting the civil war in November, 1994 in Lusaka, there arose justifiable hope that the civil war in Angola was finally over. The war had lasted for over twenty years and had cost thousands of human lives. Tens of thousands were left injured and mutilated. Above all, the land mines used by both sides had cost countless people their limbs or their eyesight. This was true for soldiers but even more for the civilian population. In order to relieve the suffering of the victims of the war and mine injuries, at the end of 1995 Medico International, the Frankfurt-based aid organization for social medicine, began building a center for community-oriented rehabilitation. Together with my colleague Ralf Syring, I organized the setting up of the center and headed it during the first two years of its operation. During this time, I was confronted with a wide range of problems that are frequently too trivial in nature to talk about in detail. Taken as a whole, however, they constitute a part of the culturally specific information that determines the greatest portion of our practical work on a day to day basis. Perhaps these things should not even be mentioned in this article. But who would suspect that such simple things as the qualities of water, light, fuel, the wood used for building houses, or a few nails would make up a substantial part of the project activities of the rehabilitation center? *Culturally specific information* is commonly understood in a different way. Nevertheless, the greater part of Angola, and with it also the majority of the people who live there, is characterized by the culture of a post-war society. This post-war Angolan society is marked more by a culture of scarcity than by traditional, independent, cultural elements.

When describing *Disability in Different Cultures* we should not forget that many of the countries of the Third World, and especially Africa, are still in a state of war or in a post-war condition. An additional fact is that

not only the disabilities of the people in these countries, but also the problems that arise in the course of their treatment and rehabilitation, have their origins in the typical features of a post-war society. Thus, it seems legitimate to me to use the concept of *culturally specific information* in my account differently than it is normally used.

Medico in Angola

For several years Medico International has been involved in the treatment of disabled people in a number of countries of the Third World. Having started with support for a workshop manufacturing artificial limbs in El Salvador and a rehabilitation center in Cambodia, in 1995 Medico intensified its work in Angola. We chose Luena, the capitol of Moxico, the most eastern province of Angola, as the location for a center for community-oriented rehabilitation. Luena is a city with approximately 80,000 inhabitants. In former times the economic life of the city was centered around the Benguela Railroad, which connected the copper producing region of Zambia and the former Zaire with the Angolan port of Lobito. During the last years of the civil war, which raged most fiercely between the first Peace Agreement of 1992 and the last in 1994, an additional 80,000 people fled to Luena from throughout the entire province. The countryside surrounding the city was mined several times, partly to prevent attacking armies from entering the city, partly to prevent the city's inhabitants from leaving. The mine belt was so dense that, for years, the city could only be supplied from the air and the first truck convoy only reached the city in October 1996, after Luena had been cut off from the outside world for over four years.

Proceeding on the basis of experience in other countries, where we had been confronted in various ways with the rehabilitation of mine victims, we developed an exemplary plan to provide comprehensive assistance for these people in all areas of life. This plan was also reflected later in the guidelines of the anti-mine program of the German Action Group for the Banning of Land Mines. It had been clear to us for a long time that the people who had lost a leg through a mine explosion were not helped by only being fitted with an artificial limb. We knew, for example, that efforts to help the victims of land mines would only be credible if, at the same time, the mine fields were cleared, since accidents were constantly occurring. Part of our project, as a result, involved close co-operation with the British Mines Advisory Group, which was engaged in land mine

removal in this region of Angola. We also knew that the victims of mine-related accidents needed immediate medical treatment to reduce their risks of dying from loss of blood or as the result of infected wounds. And we had to think about the provision of temporary aids to mobility, such as crutches and wheel chairs, that would enable the injured persons to get around until they actually received their new leg and were able to walk with it. As a result, support for the local hospital and the distribution of crutches or wheel chairs was one of our first activities. In co-operation with the Vietnam Veterans of America Foundation, we were able to set up a workshop that started producing the first lower leg prostheses in October, 1997. This workshop for the production of artificial limbs has an attached physiotherapy department. Residential accommodation for patients who come from distant rural areas completes this facility. Even this was not enough. A former patient in Cambodia, whom we encountered begging on the side of the road, answered our question of why he was not wearing his new prosthesis very clearly. "Your new leg doesn't feed my stomach!" This answer reveals, in its precision, a central problem of *cultural knowledge* in relation to work with disabled people in developing countries. The restoration of the physical form and function of the disabled person was not an adequate goal for the project. More basic and ongoing measures were necessary to improve the lot of the disabled in a society so torn by war and the expulsion of people from their local areas.

1. Disabled persons must have the possibility of earning a living and of supporting themselves and their families.
2. The network of social ties within the family and the community, which allows for reciprocal help and support for the disabled, must be regenerated.
3. Communication among the members of the village community disrupted (or destroyed) by the effects of war and forced population movements must be stabilized and contact among members improved before community-oriented rehabilitation measures can even be attempted.

This is where our understanding of psycho-social work with the disabled comes into play: the attempt to revive the self confidence of the disabled person, along with that of the village community, also strengthens the sense of personal initiative and willingness to accept responsibility among the people.

The Situation of Disabled People in Angola and the Role of the Organizations Acting on Their Behalf

According to the official statement of the Angolan Ministry for Health, there are approximately 100,000 disabled people in the country today. According to an independent study in 1989, 73 percent of physically disabled persons in Angola had had one or more limbs amputated. Moxico was named as being among the provinces of Angola with the highest concentrations of amputees. However, there is no official estimate of the total number of physically disabled people in the province at the present time. Approximately 3,300 people are currently registered as physically disabled in Luena. Reliable estimates assume that about 1,500 of these have suffered leg amputations.

As early as Summer 1995, Medico was in contact with ANDA. ANDA is the national organization for disabled people which was established as an NGO by military and civilian disabled people to represent their interests. The organization's regional representative in Luena particularly impressed us with his detailed knowledge. He expressed a great deal of interest in our integrated approach and especially emphasized the large numbers of disabled. In the meantime it has become apparent that the role of ANDA, and particularly that of its provincial staff members, can be best described as that of *professional beggar*. Their relations over the years with NGOs and United Nations organizations had made the group so pliant in their rhetoric that, after a few sentences, you noticed which approach to aid was being advocated by whichever national or international organizations that they were dealing with at the time. They were able to adapt to any discussion partner in a chameleon-like way. One of ANDA's few accomplishments was the keeping of an indexed file of their clients. This list served as a source of data for practically all of the national and international aid organizations and thus served, in an essential way, to enable the distributers of food rations to organize their operations. Because disabled persons, like orphans and refugees, belong to the especially needy groups, the people on this list receive an extra ration of free food. Therefore, it is not surprising that places on this list were openly bought and sold. This too is a culturally specific problem of a special kind.

On the other hand, it was entirely possible to co-operate effectively with some individual members of this organization. However, they had to first learn how to approach their own clientele again, step by step. They had become much too accustomed to operating according to a bureaucratic administrator mentality, and evaluated their work in terms

of an impressive office and a swollen organizational structure. The core of our own file of physically disabled persons in Luena and its hinterland was compiled by a few members of ANDA. In the process, it was revealed that often the functionaries of the organization were visiting other disabled people at home for the first time and finally witnessing the terrible suffering of their clients face to face. This was an extremely helpful experience for people who, for years, had been accustomed to graphically describing the terrible suffering of their members to foreign aid workers. Today, the file contains information about approximately 900 physically disabled persons, including 518 mine victims.

The Target Group

With the first attempts to develop a program of assistance for the core of our target group, the disabled victims of war and land mines, it soon became apparent that the European-oriented approach to the social reintegration of the disabled in many cases was not suitable for the actual situation. This was because, when we observed the condition of the *non*-disabled more carefully, in many ways it was not essentially very different from the situation of the disabled. As refugees, the members of both groups have no opportunity to support themselves economically and they are, temporarily at least, dependent on outside assistance. As settled residents of the city, both groups are forced to earn a meager income though petty trade at the marketplace or through the illegal distillation of liquor. Both groups have little opportunity to receive adequate health care or schooling. This is a phenomenon that is readily overlooked in investigations into the condition of disabled people when interest is too exclusively focused on the disabled themselves (Ingstad 1997: 20). We sometimes observed exactly the opposite. Often the disabled appeared to be essentially more demanding than the rest of the poor population, although they were already the beneficiaries of free food rations. Above all, former soldiers are very skillful, often playing the moralistic card very aggressively, at putting the representatives of aid organizations in uncomfortable situations when they stop the foreigners' cars on the street to beg or to demand a lift. Along with this, we observe over and over in daily life that the people of the city hardly make a distinction between the injured and the non-injured. The woman on crutches with a baby on her back, carrying a basket of dried fish on her head to the marketplace, hardly evokes any extra sympathy in Luena.

The customers haggle over her prices just as vigorously as over those of the other fish sellers at the market. We also could not establish that any special consideration was being extended to disabled people, at least to those who were among the less severely disabled. Even the driver employed in our project, from whom one might expect a certain degree of sensitivity, would honk the horn loudly if someone was crossing the street too slowly. It did not matter if the pedestrian was walking with crutches or on two legs.

Cultural Knowledge, How Can We Obtain It?

Besides this culturally specific information, which can be observed to arise directly from the culture of poverty and the results of war, there are still other aspects which play a role. These additional aspects result from traditional ideas, reservations based on experience or other cultural elements, and other information that is possible to obtain and which could certainly influence the work of the project. Thus, the obligatory question arises of how can we gain this information. Cultural knowledge can only be applied to some aspect of the project's work if it is available. In the initial phase of its community-oriented rehabilitation project in eastern Angola, Medico International made the attempt to learn something about the situation of those people whose needs were supposed to constitute the focus of the project. In order to do this, we applied the classic method for gathering data. We selected a group of eight women and men from the region to work with. All of these eight people had attended school for a minimum eight years and some had as much as twelve years of education. In personal interviews all of the eight had fulfilled our expectations of people who do not want to teach other people something but, rather, were open to learning something through contact with others. They also had to pass a written test. This written test was so structured as to indicate to us which persons were sufficiently prepared to listen carefully to informants' statements and to record these statements. The test indicated if the candidate was capable of listening in a nonjudgemental way to the expression of attitudes that might contradict their own. In addition, an important criterion was knowledge of the major languages spoken in the region.

Classic Data Collection in a Culture of Poverty

In co-operation with an experienced Angolan social worker from Luanda, we carried out an introductory course in our desired methods of gathering information with the eight people that we had chosen. Already at this stage, we were taking numerous steps that had to with culturally specific factors although we had very little cultural information available to work with at this point. From those people chosen to carry out the data collection, we encountered no disagreement. They all wanted to work for a foreign NGO, even if it was only for a short period of time, and hoped to improve their income as a result. Most of them had taken leave from their jobs with the government to be able to work for us. In their regular employment they received very low pay and were paid, at the most, every few months. This wish to improve, through us, their material circumstances overlay everything that we did from that point on. The extent of the influence of this specific aspect of a culture of poverty only became clear to us in the course of our work.

The Attempt to Construct an Open-Ended Instrument of Data Collection

We wanted to prepare our eight new employees to administer a data collection instrument which consisted of several components. Firstly, there was a standardized part: a questionnaire that was intended to gather some personal data and also data about the type of disability. We especially needed, for the production of artificial limbs, information about possible amputations, about crutches and wheelchairs already in use, the wearing or not of shoes etc. Next came a semi-standardized section: using an outline, at least two persons would gather information by means of an interview. During the interview, notes were not to be taken. As much as possible, the details of the interview should be retained in the memories of the interviewers and, immediately afterwards, be recorded as exactly as possible. In this way, we tried to insure that as little as possible interpretation and summarizing occurred. What this was supposed to achieve, we attempted to explain with the following example, among others. An ill person arrives at a medical station and tells the nurse, "I have a cat in my belly." The nurse translates for the doctor, "She says she has stomach pains." Thus, the doctor cannot know what the expression "cat in my belly" reveals about the quality of the pain. Our

original intention to develop the outline for the interview together with the Angolans was not successful. Over and over, they asked us to state our questions and then they agreed to these questions. We wanted to know what it means for a person to be disabled in every zone of the eastern part of Angola, what the non-disabled inhabitants of a village or residential district in the city think about the disabled, and how disabled people are dealt with and treated. While doing this, it was very clear to us that our own views of the disabled, and their position in society, would be reflected in the data collection process. However, we believed that this bias would be reduced and modified if people from the region, speaking the same language as the villagers, were collecting the information.

Disability and Its Causes

Eventually, the protocols of interviews with two hundred disabled persons and seventy five family members lay before us. The final evaluation has, up to now, proved to be more work than we anticipated and still remains to be done. However, I would like to point out some aspects of our research where information was collected that we consider to be culturally specific, and other points where we are not sure if our data really reflects the reality. Exactly half of the disabilities of our basic sample of 200 people were caused by mine accidents. A little over a quarter of the disabilities (24.5 %) are the result of illness. Significant here, above all, is poliomyelitis. Of the illnesses, 39 percent were attributed to *feitico*, and thus to a deliberate attack, in the form of a curse by another person. In addition, in five cases such attacks were named as the direct cause of a disability. Notably, in none of the cases was a mine accident attributed to *feitico*. In relation to this question, the interview protocols do not fully correspond with information obtained from other sources which do connect mine accidents with *feitico*. This cause, however, is indicated far less frequently in this situation than for cases of illness. At the present, we have no secure basis for interpreting this phenomenon. It could possibly be due to the fact that the local culture has no explanations for the effects of modern warfare. Ideas about disability caused by a land mine accident might be similar to the word for mine in Chokwe, the regional language. The word does not exist in Chokwe though and the Portuguese word *mina* has been adopted into local speech from the official language.

Subjective Perceptions of Disabled People and the Role of the Family

The family played an important role in gathering data. This was reflected in some of the questions but also in the fact that only a few interviews were carried out only in the presence of the person being interviewed. Members of the family were almost always there too. One hundred and fifty disabled informants answered the question of what was the most serious problem resulting from their disability. The fact that they could not adequately care for their family, especially their children, was indicated by 29 (19 %) of them. When we count those who answer that they are not able to work as before, for example as a person is supposed to work (*devidamente*), we now have 102 answers. This means that 68 percent see their biggest problem as not being able to fulfill their obligations to their family or their community. This corresponds to a high percentage of the responses of non-disabled family members. Included in the interview outline was a question about recurring dreams. This question was actually asked only fifty eight times. We received no convincing explanation from our interviewers for why they so often forgot to ask this question, which was not true for any other question. Thirty six times (62 %) the answer was given that the disabled person repeatedly had the same dream. These respondents dreamed that they were not disabled and that they could walk with both legs, in the case of amputations, or, in the case of blindness, that they were watching a movie.

The Disabled and Traditional Healers

Disabled people were asked for their opinion of *Kimbandas*. In this area, the *Kimbanda* is synonymous with *Curandiero* – healer – and therefore not, as for example in some areas of Brazil, a mainly negative concept. Nevertheless, we received only eleven clearly positive answers (8 %). Ninety two percent of the responses indicate a lack of trust in, and rejection of, the traditional healers. Some respondents stated that they preferred the supposedly more scientific Western medicine, others answered that they never went to healers. This last response was given forty eight times (36 %). Thirty three respondents (24 %) answered that these healers were only able to cure traditional illnesses, such as sickness caused by *feitico*, and that for other diseases they were of no help, especially in the case of a disability caused by a mine. Ten respondents

considered the traditional healers to be too expensive, eight (less than 6 %) simply stated that they do not like the *Kimbandas* and one respondent said that all they do is cause conflicts. These are four examples of statements containing culturally specific data. However, these statements indicate to us that the results of our data collection cannot simply be understood as culturally specific information in itself. We only recognize the problem when we take into consideration, in our evaluation of the results of the research, other kinds of experience gained through the work of the project. On the basis of this experience we know that people's attitude toward the *Kimbandas* differs from what our results seem to indicate. It seemed to us highly unlikely that 36 percent of the disabled people interviewed never went to a traditional healer. As a result of their direct experience, the workers in our project know that the local people, in situations of serious illness, see the *Kimbanda*, at least in addition to their treatment by a medical doctor. In this case the explanation for why the people who were interviewed answered in this way is very simple. Our interviewers, without exception, were from the same region and spoke the same language as the people that they interviewed. They came, however, as employees of a foreign NGO with the name Medico International. In Portuguese, this name conveys the impression that the organization has something to do with medical doctors (medico means doctor). The appearance of such an organization awakens the expectation of the availability of medical facilities. In order to profit as much as possible from these services, it is necessary from the start to establish a relationship with the organization that is as good as possible. Thus, their answers reflect whatever it is they imagine their listener wishes to hear.

How the Research Method Influences the Results

This interpretation was frequently confirmed when we asked people about it. In retrospect, it seems so simple that we should have anticipated the problem. Thus, we made a mistake that could have been avoided. Possibly our information could have more accurately reflected reality if we had contracted with an Angolan institution, for example the School of Social Work in Luanda, to conduct the data collection. Also, the danger of this type of research has already been noted. Ingstad and Whyte mention numerous studies that were carried out during the International Year of the Disabled. "The very act of interviewing people about their infirmities raised hopes that something was going to be done

for them. A consciousness about disability was created without any follow-through" (1995: 24).

Other Sources of Cultural Knowledge

An understanding of the other examples only becomes possible when we include culturally specific information from additional sources as part of the interpretation. Thus, we can use information taken from the literature about the belief systems of Bantu cultures in general, and that of the East Angolan Chokwe culture in particular (Altuna 1985/1993; Redinha 1974). From the literature, we learn that, according to the view of reality held by the people that we are working with, a close connection exists between the visible and an invisible world and both are equally real. Every visible phenomenon corresponds to an invisible reality (Altuna 1985/1993: 64). What the Western person would consider a cause, is for him (the Bantu) the instrument of a hidden power. This does not mean that he denies causality. Just the opposite is true. The idea of causality is so natural to him that he applies it constantly, sometimes even obsessively (Altuna 1985/1993: 65). Even when he understands the effects of viruses and bacteria, or that of climate and anemia, he would never consider these as ultimate causes. In cases of misfortune, an invisible force is at work. The ill person goes to the hospital but, at the same time, he requires the help of the traditional healer who, by using his power, counteracts the malevolent magical cause of the illness. This behavior, which is logical according to cultural principles, paralyses these societies and leads to a certain fatalism, asserts the Angolan author Altuna in his book about Bantu cultures (p. 66). In the practical daily work of the project, this assumption led to one of our workers taking his seriously ill wife to a *Kimbanda*, after she had been unsuccessfully treated at the local hospital. He in no way justified this to us Europeans as being a complementary, alternative or even more natural form of treatment. Rather, he responded to the hopeful but worried questions about his wife's condition during this treatment, that this was a *different*, a *traditional*, method of healing, unknown to Europeans, and therefore he saw no possibility of letting me know anything about the success of the cure. He was supported in this by our entire group of co-workers who, at this moment, abandoned all the European-style logical thinking that they usually employed in their health education efforts in the village.

In the ethnological and anthropological literature, we find an abundance of indications of this kind which are also often contradictory. We accept them to the degree that they offer explanations for phenomena which we encounter through working with people as part of our project. This means that the study of the literature is necessary but not sufficient for a project carried out in an alien cultural context. Such information only has meaning for those people who, in the actual situation, have sufficient sensitivity and powers of observation to perceive the foreign. Along with this goes the ability to relativize one's own ideas about disability and the awareness that the concept of disability, in the Western sense, is not necessarily to be found in other cultures.

What Significance Does Cultural Knowledge Have for the Ongoing Work of Our Project?

When cultural knowledge is available – and I hope that I have made clear how difficult it is to obtain – what meaning does it have for the ongoing work of our projects? Through what we now know about the social and cultural conditions in Moxico Province in the eastern part of Angola, we see ourselves confirmed in our community oriented approach. Among other things, this involves more than just helping people who have lost a leg through a mine accident by providing them with an artificial limb. It also means, for example, making it possible for them to receive vocational training in small workshops together with non-disabled people and, thus, to be able to support themselves. We help them to rediscover agricultural methods and farming practices that were forgotten during the period of war and population displacement. We initiate and support cultural and sporting activities that allow the participation of disabled people. We create, in general, the conditions to contradict through experience the assumption that a person with a physical impairment has lost the ability to fulfill his or her social and familial obligations. In so doing, we experience over and over that we are not dealing with an intact culture, handed down from one generation to the next, but instead with something that is the result of a lengthy and thorough process of social and cultural destruction, and as a result, that poverty, competition between individuals and hopelessness have become fundamental sociocultural elements. On the other hand, we see the persistence with which the people interpret reality according to their centuries-old system of concepts and beliefs. For example, they consult the *Kimbanda* when they

are sick or when their children undergo initiation. Even if they laugh when they tell us about doing so, we can see what power, despite all the attempts to destroy them, these traditional beliefs still hold. The constant presence of an invisible aspect of reality, the spirits of the ancestors, sometimes seems to us to be a barrier to the application of the efficiency criteria of our funding agency and to our own success-oriented project work. If we are sometimes hindered by these beliefs we can also see these barriers as reassuring evidence that the destructive force of our own culture, which is considered to be and presented as globally dominant, is amazingly limited.

Dealing Honestly with the Contradictions

Therefore, we have to be careful that the use of cultural knowledge in the work of our projects does not become a tricky process of so-called participant observation, in which our target groups can see their wishes and interpretations of reality expressed in a way that they can understand. The use of culturally specific information must become a basic part of our communication with every person that we work with in our projects. It is not our task, and is no way expected of us by the victims of war in eastern Angola, to act as if we are culturally neutral and only wish to serve their culture. We can, indeed, be very helpful in this by supporting a medical station in a village. If we, who rush to take aspirin in the event of the slightest headache, explain to the rural people in a village that they really should go to see the *Kimbanda*, we make ourselves ridiculous and are not taking those people seriously who do it anyway, if they consider it necessary. It comes down to offering to do what we can do. This involves showing them that what we can do is not more valuable than what their concepts represent. In the post-war situation in Angola, what we call psycho-social work has especially to do with making clear that, we too, have no solution for the manifold disability that the decade-long war has produced. Through this, we show that we all need to work together to overcome the problems. The experience of the people of Moxico will cause them not to believe us. We will, against our will and despite our own social and political origins, be associated with those who have ruled wherever they have appeared and have attempted to make dominant their own view of the world. Much patience is required if we want to get the message across that we want to do things differently. We will only succeed in this if we really want to be different, meaning that

we abandon cultural dominance as an essential element of our own culture. It is debatable whether this is possible at all. It should be made clear, however, that the ongoing work of projects not only requires the consideration of cultural knowledge relevant to the alien culture. It also requires a culturally specific and critical consciousness of our culture, along with a willingness to take steps to modify our culture.

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