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FACTORS THAT MITIGATE WAR-INDUCED ANXIETY AND MENTAL DISTRESS

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Summary. The effects of war-induced anxiety and mental distress on individuals and groups can either be mitigated or exacerbated by 'humanitarian action'. This paper focuses on two key factors that protect the mental well-being of war-affected populations: organized displacement or assisted relocation; and coordinated humanitarian aid operations that are responsive to local needs. Qualitative data from two internally displaced person (IDP) camps in Eritrea are presented. Analysis of these data serves to substantiate and refine a working hypothesis: that social support of the right type, provided at the right time and *level*, can mitigate the worst effects of war and displacement on victims/survivors. An integrated model of *psychosocial transition* is suggested. The implications of this approach for humanitarian policy and practice are discussed in the wider context of current debates and lamentations of the 'humanitarian idea'.

Introduction

The 'humanitarian idea', or at least Western conceptualizations of it, have been the subject of lament, apologetic discourse and heated debate among practitioner–scholars and observer–analysts (Slim, 2000; Vaux, 2001; Terry, 2002; Rieff, 2002). Humanitarian ideas translated into humanitarian action or inaction in settings of war and conflict continue to entail moral misdemeanors (Ignatieff, 1997; Slim, 1998). Contemporary history of humanitarianism is replete with contradictions between action and rhetoric and betrayals of the humanitarian principle, with little evidence on the ground that 'lessons learned' actually translate into change in policy and/or practice (Terry, 2002; Minear, 2002). The influence of mass media, both print and audio-visual channels, continues to increase, often distorting the nature and magnitude of disasters. Humanitarian action and inaction continue to reflect the uneasy symbiotic relationship between the media and aid agencies: donor funds and enhanced visibility through sensational reporting being at stake, sometimes with positive results (Christie & Hanlon, 2001). There is a glimmer of hope in peace reporting and applications of mass media in health and development education (Adam & Harford,

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1998, 1999; DFID, 2000; Gumicio Dagron, 2001). This is the global context in which this paper seeks to engage in the humanitarian discourse with the aim of distinguishing positive from negative types and consequences of humanitarian action.

Anthropologists and others have already communicated eloquently in descriptive, analytical and explanatory terms what humanitarian intervention entails, why it matters, to whom, and how it can do more good than harm (Summerfield, 1998; Anderson, 1999; Last, 2000). However, in practice, the more humanitarian action is said to have reformed and changed, the more it remains the same, for both the not-necessarily telegenic humanitarian worker who constantly has to learn new skills in order to survive (Slim, 1995) and the victim/survivor of war and other disasters whose 'vulnerability' is accentuated, rendering her/him powerless as a result. The dominance of emotion-focused culture, and demoralization of humanitarianism continues to be a cause for concern (Slim, 1998; Pupavac, 2004, this volume). At the core, international humanitarian action seems to be motivated by Western paternalistic, enlightened self-interest (Vaux, 2001; Terry, 2002), and continues to be at odds with itself (Rieff, 2002).

International humanitarian agencies' involvement in psychosocial interventions inspired by undue pathologization of survivor responses to war and displacement continues to generate debate (Bracken *et al*., 1995, 1997; Bracken, 1998; de Vries, 1998; Pupavac, 2002a and b; Summerfield, 2001; de Jong, 2002). Effects of war-induced anxiety and mental distress may be exacerbated by imported 'debriefing' and 'talk therapy' programmes which tend to keep survivors 'locked up' in the victim position on shaky grounds, and without their informed consent (Summerfield, 1999). The clinical gaze, with the power and value systems it represents, is itself subject to interrogation (Foucault, 1994; Summerfield, 2002). Moreover, even in Western settings, individual 'debriefing' is considered less helpful than peer support among those with shared experience, such as combatants returning home to the United States (Shay, 2002). However, arguments in favour of mental health and psychosocial programmes in non-Western settings have highlighted the plight of the seriously mentally ill, using a 'rights-based' approach (Silove *et al*., 2000): hence the need to distinguish between severe mental illness requiring medical attention and the more contested assumptions of 'mass trauma'.

This paper examines factors that mitigate the effects of war-induced anxiety and mental distress, from a salutogenic (health-centred), as opposed to a pathogenic (disease-centred) point of departure. The theory of salutogenesis, developed and refined by Antonovsky (1987), is least known and/or recognized in the humanitarian sector. In his seminal work introducing the idea of production and maintenance of health through intrinsic and acquired 'sense of coherence' (SOC), Antonovsky postulated that individual resources, context and culture determine a person's ability to find purpose and meaning in life and to manage adversity. This theory has found resonance with non-medical researchers and practitioners in health promotion who have applied the SOC scale in a wide range of settings across cultures. It has also been central to the professions of nursing and health visiting where understanding individual context and available 'resources for health', also described as 'social capital', is central to promoting health (Cowley, 1995; Cowley & Billings, 1999). This paper proposes that a serious consideration of individual sense of coherence in

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settings of war and other disasters is warranted and long overdue. However, the first step should be to examine the context in which individual sense of coherence and 'resources for health' operate.

Primary qualitative data from internally displaced person (IDP) camps in war-afflicted parts of Eritrea are presented. The analysis sets out to test the hypothesis that humanitarian action (local/national and/or international) can either mitigate or exacerbate the effects of war-induced anxiety and mental distress among those at the receiving end. The mental health of aid workers is not a concern of this study. Humanitarian action refers to aid/material assistance, a form of 'social support'. An analytical model of *psychosocial transition* is proposed outlining a number of possible pathways from crisis to either positive or negative aftermath, taking account of the interplay between types, timing and *levels* of social support. Particular emphasis is placed on the need to engage war-affected and/or displaced groups in the investigation and analysis of their own situation. Lessons learned from the active participation of men and women survivors of war and displacement in describing and interpreting their own collective realities are discussed with a view to directing follow-up research aiming to inform and guide effective humanitarian and public health policy and practice.

Background

Eritrea is the newest state in Africa, having emerged intact from 30 years of armed struggle for independence in 1991. Several factors have contributed to the unique image of resourcefulness and self-reliance with which Eritrea has been marked (Firebrace & Holland, 1984; Kinnock, 1988; Iyob, 1995; National Union of Eritrean Women, 1998), all of which make it an ideal site for research into collective and individual resilience.

In brief, the Eritrean People's Liberation Front (EPLF) had succeeded in implementing its policy of 'Unity in Diversity' through popular participation, mobilization and ongoing education/persuasion of 'the masses', embracing nine ethnic groups with distinct but often related languages and cultural traditions. During the war, the EPLF functioned as the Government Apparent of Eritrea from its base in Nakfa, Sahel, the 'Liberated Zone'. Highly motivated, resourceful, responsive, efficient and accountable departments of health, education and humanitarian emergency relief and development aid augmented the liberation army/department of defence (Duffield & Prendergast, 1994; Iyob, 1995; Connell, 1997; Gottesman, 1998). Men and women with military training (*Tegadelti* or fighters) in the EPLF and their civilian (*gebbar*) constituents built shared identity and nationhood while living under constant threat of Ethiopian aerial bombardment and successive ground military offensives. Women constituted a third of the liberation army, instigating and achieving significant social reforms in Eritrea, including the right to own land, and emancipation in marriage (Wilson, 1991; Wolde-Sellassie, 1992).

Eritrean primary health care (PHC) developed in the early 1970s in response to the felt and expressed needs of war-affected and poverty-stricken rural, predominantly pastoralist communities in the Liberated Zone; independently of, and yet in the true spirit of 'health for all' as advocated by the World Health Organization with

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'community participation' at the heart of it (see WHO, 1946; Mahler, 1981; Black & Fassil, 1986; Fassil & Silkin, 1988) from the bottom up, rather than top-down (Rifkin, 1996). This was a unique achievement of the liberation movements of both Eritrea and Tigray (northern Ethiopia) born out of necessity: the real and pressing needs of ordinary people who had supported, sheltered and nurtured the liberation fronts, and with whom the latter reciprocated by demonstrating good governance and accountability through efficient primary health care provision (Sabo & Kibirige, 1989; Kloos, 1998).

The EPLF served as a mentor and ally of the TPLF, sharing skills and resources. Inter-governmental cooperation continued after the fall of the Menghistu regime and the TPLF's ascendance to power as the provisional government of Ethiopia. Eritrea's independence was formalized by a UN-supervised referendum in 1993. The Mereb River, a tributary of the Blue Nile, is a natural boundary between the two countries; however, the land part of the border between Ethiopia and Eritrea had been established by agreements made between the Italian and Ethiopian governments during 1900–1903. Demarcation of the border with Ethiopia had not been agreed at the time of Eritrea's independence. A few years later, Ethio-Eritrean relations began to deteriorate amidst growing internal instability in Ethiopia and in the wake of Eritrea's launch of a new currency, the *nakfa.* In May 1998, fighting broke out over a border dispute which flared up almost instantly into a major and costly war resulting in loss of lives and displacement: internal displacement, flights of refugees across international borders from both Eritrea and Ethiopia into the Sudan, and the inhumane mass deportations of Eritreans and Ethiopian citizens of Eritrean descent (Legesse, 1999, 2000). The United Nations Mission in Eritrea and Ethiopia (UNMEE) supervised border demarcation and a peace agreement was eventually signed in the Hague, the Netherlands, on 13th April 2002. However, the final decision of the UN over demarcation of the border, signed by both governments, has not been implemented on account of the Ethiopian government's decision to retract and thereby prolong the period of displacement for the IDP.

In Eritrea, social support had played a significant role in terms of psychosocial responses to crises. During the first year of liberation, 1991–92, the country had undergone a period of collective grieving and social healing. The homecoming of *Tegadelti* had brought with it joy and unexpressed grief. The latter was processed through the official release of information about the war martyrs, followed by a period of national mourning in mid-1992. Social healing began with a torch-lit silent procession on the streets of Asmara, the capital, and all other urban and rural centres on the evening of June 21st, Martyr's Day, following the distribution of an official 'Certificate of Honour' to the family/relatives of each and every war martyr bearing her/his hand-written name and printed details of the circumstances of death: location of battle/injury and date. These were issued ceremonially, by religious leaders who convened simultaneous parish meetings at every church and mosque in the country. The fact that the EPLF had kept detailed records of over 50,000 of its members who had fallen in battle was highly remarkable. The official period of national mourning allowed everyone to grieve together. It was followed by the first National Festival in Asmara in August 1992. The Asmara Expo, one of the deadliest prisons of the Menghistu era, was purposely restored to its original state as an art and cultural

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exhibition centre in time for the festival. It was said then that the martyrs had not died in vain and the price of independence was paid for: the phrase used repeatedly was *Qeyahti kefilna,* 'we paid in red', referring to the sacrifices made (Almedom, 1992a, b). Government policies in social welfare and primary health care prioritized the needs of 'the masses': those who had paid the most, particularly in rural and peripheral regions.

With regards to policy concerning mental health and psychosocial well-being, the departments of health, social affairs, education and employment had traditionally promoted social support and 'work therapy' with little or no medical component. There is only one psychiatric hospital in Asmara inherited from the Ethiopian era, and the government policy guidelines emphasize community-based health services for mental health (Ministry of Health, 1998); paying special attention to the internally displaced (Ministry of Health, 2000).

Methods

Contextual data relating to a total of seven study sites involving displaced and non-displaced participants have been communicated elsewhere (Almedom *et al.*, 2003). This paper confines itself to the data obtained from the IDP camps of Adi Qeshi, located in *Zoba* Gash Barka, and Hamboka, in *Zoba* Debub. The two provinces of *Zoba* Debub and *Zoba* Gash Barka were worst hit by the 1998–2000 war, due to their proximity to the Ethiopian border: the battleground. Fieldwork in these two locations was carried out during December 2001 and January 2002.

A total of 112 participants, 48 women and 64 men, were included. Activity-oriented, facilitated group discussions were held separately for women and men in both camps. Trained, qualified and experienced facilitators moderated the discussions using the participants' first language, Tigrinya. Trained note-takers accompanied the facilitators who also took their own notes while listening to responses to intermittent questioning and probing, picking up cues from the discussion participants. Group activities included drawing and discussing contents of the 'community map' of the camp showing the location of significant places such as water points, latrines, administration offices, schools, churches and/or mosques, health services, and market places/shops; discussion of the history of displacement using a 'historyline'; and discussion of a 'seasonal calendar' of common diseases and/or illnesses in the camp by month/season encompassing the previous twelve months. The study was designed and conducted in collaboration with the PHC Division of the Eritrean Ministry of Health. The methods and tools of participatory investigation and on-site analysis employed in this study were developed, pre-tested and widely used in previous studies conducted in Eritrea, among other countries in Africa and Asia (Almedom *et al.,* 1997). A local multi-disciplinary and inter-sectoral advisory group was established at the outset and the study was carried out in accordance with established methodological and ethical protocols, including Tufts University's Institutional Review Body (IRB) guidelines for research involving human subjects.

Group discussions of local history prior to and after displacement, community maps and seasonal calendars were effective in engaging study participants in investigation and analysis relatively quickly. Data analysis comprised an iterative

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process of questioning local knowledge, cross-checking and double-checking information during the course of group discussions and feedback sessions. It was particularly important for the study team to make oral presentations of the study findings in summary for local people, including those who provided the data in the first place, to comment and offer correction of errors, and/or additional information where necessary.

Findings

Adi Qeshi and Hamboka IDP camps differ significantly in altitude, climate and the duration of the residents' stay. The ethnic composition of the inhabitants of both camps is the same – predominantly Tigrinya – and certainly all Tigrinya as far as representation in the group discussions is concerned.

It was reported that all residents of Adi Qeshi camp had arrived at about the same time: in February 1999, following evacuation of their home villages, prompted and assisted by their local administration upon imminent danger of Ethiopian raids. Government-provided lorries, buses and smaller vehicles facilitated the people's flight to safety, giving pregnant and nursing women, children, the sick and the elderly had priority of space in the vehicles; while others walked or ran away from their home villages. Village administrators/leaders accompanied and kept track of their constituents. On arrival at the camp, the (displaced) men and women were already known to their administrators. They did not have to 'prove' their identity, family size and other vital details to unfamiliar administrative camp officials and/or foreign aid workers. Village/camp administrators worked with members of the Eritrean Relief and Refugee Commission (ERREC) in order to expedite distribution of food, blankets and other supplies. Children's immunization and nutritional surveillance systems were set up, and the Water Resources Department and local Ministry of Health whose nearest offices were located in the town of Barentu provided water points and ventilated-improved pit (VIP) latrines, one for every five tents. Inspection of the camp facilities confirmed that these facilities were still functional and that the Adi Qeshi community map was trustworthy.

On the whole, men and women were equally prepared to discuss psychosocial well-being in general terms. However, in one instance – a women's discussion group in Adi Qeshi camp – participants explained that they had already been asked too many questions about violence and trauma by other researchers/visitors to the camp, and they had grown weary and sceptical as a result. They stated that while they did not consider themselves to be victims of physical violence, prolonged displacement and uncertainty about the future had robbed them of their *Qisanet* (ease, serenity), and some had indeed succumbed to *Aemro mitfa* (Tigrinya, lost their memory and/or minds). However, most women had coped well 'thanks to *Qidisti Mariam*' (Saint Mary) who 'helps women', particularly during the critical periods of pregnancy and childbirth. Many believed that a sense of staying together with their home village communities, and keeping track of the news by listening to *Dimtsi Hafash* ('Voice of the Masses'), the popular national radio station, had protected them from *Chinquet* (mental oppression), *Hasab* (too much thinking, worry) and *Ihihta* (sighing). Nevertheless, some expressed weariness about the length of time they had lived in the

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camp. The women explained that even if the peace agreement and border demarcation went smoothly during the forthcoming month of '*Yekatit'* (February 2002), as was then anticipated, they may not be able to return to their homes until their villages were cleared of landmines. This group of women preferred not to discuss the topic any further and their wish was respected.

Men in Adi Qeshi camp readily discussed the topic of mental well-being. Many talked about their inability to come to terms with the loss of lives and assets, including livestock. They described overwhelming feelings of anger and desire to take revenge. Nonetheless, they believed that their displacement had purpose and meaning, because 'defence of national territory' had necessitated the war. They expressed appreciation of *Dimtsi Hafash* broadcasts and regular meetings convened by their administrators.

In contast, Hamboka IDP camp, on the main road between Sen'afe and Zalambessa, sheltered people who had fled from the villages of Ambesetegeleba (lit., *Lions' Ranch*, Tigrinya) near Zalambessa, a southern town on the Ethiopian border. Unlike those in Adi Qeshi camp, Hamboka residents had experienced serial displacement. They had first been sheltered in Mai Habar, a lowland safe haven farther north from Sen'afe. Their experiences of assisted evacuation/relocation varied although they also benefited respectively from familiar/sympathetic and coordinated administration and relief efforts of both governmental and non-governmental organizations in both Mai Habar and Hamboka. The men's discussion of mental well-being in Hamboka focused on their worry about their reputation. They expressed concern that they may have been tarnished with the label 'war-mongers' as they believed they were blamed for 'starting the war' by failing to resolve their localized quarrels with their neighbours on the other side of the border.

The women's discussion group in Hamboka was less reserved on the general topic of maternal health as well as specific questions of mental well-being. Availability of health care in general, and maternal health services in particular, was limited or non-existent. Compared with Mai Habar, where water supplies and mobile health services were more readily accessible, Hamboka camp lay on the outskirts of Sen'afe, a town that had sustained serious bombardment (the big hospital building had been destroyed and all that remained was a make-shift hospital made up of large tents labelled 'Médecins Sans Frontières (MSF)', left behind after MSF's brief intervention during the 'emergency period' when bombing and shelling was ongoing). The women reported that Mai Habar, a lowland location, was hot and heavily malarial, while Sen'afe was the opposite, lying over 2500 m above sea-level and being very cold at night. Their worn-out tents and blankets provided inadequate shelter: below the Sphere Project's 'minimum standards' (2004).

Pregnancy and childbirth were reported to be associated with anxiety and mental distress in women, even in 'normal' times. During this 'critical' period, women are ideally protected from undue mental/emotional burdens that are likely to have negative health consequences. Women in Hamboka camp explained that traditional observances of postpartum seclusion and rest for newly delivered mothers had been compromised due to the lack of resources, including space; and so mothers and infants in the camps were subject to early 'exposure' and subsequent infections and disease. Traditional birth attendants provide much valued support to expectant

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and nursing mothers who often considered them their friends and confidantes as well as skilled health practitioners. This was said also in Adi Qeshi camp. However, the Hamboka women's group discussed candidly the case of a woman known to them who had suffered severe mental illness. This woman had been ill during her pregnancy and got worse after delivery. The women distinguished mental illness from other types of illness based on the mother's inability to relate to her newborn. The mother in question had become withdrawn, not talking even to her baby, and was unable to breast-feed. This mother was taken to her own mother to be cared for in a village north of Sen'afe while her baby was looked after by her relations and friends in the camp and fed goat's milk.

Both camps had schools and churches. Adi Qeshi had two elementary schools and Hamboka had one. The struggle to ensure that children's formal education is not interrupted dates back to pre-independence years and both men and women's groups reported the need for more school supplies. In Hamboka, mothers talked about the way school materials were rationed causing disappointment among some children because there were not enough notebooks and sandals to go round. The significance of churches in the camps was also discussed: they helped to maintain the observance of Saints' Days, which are numerous in the Orthodox calendar and of high social significance. However, the most important function of the churches was reported to be the provision of necessary services involving christening and burial rites and rituals. No weddings were mentioned.

Discussion

Displacement 'ruptures' the emotional connections of a person with familiar places to which the person belongs and from where her/his identity derives (Fullilove, 1996). Leaving home under life-threatening conditions would thus entail disorientation, nostalgia and alienation, three psychological processes believed to affect mental health. In her socially oriented analysis of the psychology of place, Fullilove discussed how lack of familiarity with the immediate environment can evoke 'fight or flight' responses (particularly heightened awareness of danger and attention to detail in the new surroundings) and how attachment with and sense of belonging to a place can result in nostalgia and alienation from loss of identity with a locality. Drawing from anthropological perspectives, Fullilove, a psychiatrist, concluded 'While treating displaced persons is imperative, an ounce of prevention is still worth a pound of cure' (Fullilove, 1996, p. 1521). Preserving social connections, reconstruction of order in a new place and affirmation of each person's sense of belonging in that place, constitute restorative steps. Fullilove's indicators of success include (a) people live in a 'good enough' place; and (b) people know their neighbours and interact with them to solve communal problems.

In the case of Adi Qeshi camp, assisted relocation to a 'safe enough' place with basic provisions of shelter, food and health care would be expected to have mitigated the worst effects of anxiety and mental distress caused by the loss of lives and assets including homes and livestock. Moreover, the findings indicate a complex web of support mechanisms that may have prevented the worst psychological effects of displacement. The social fabric of both Adi Qeshi and Hamboka camps may have

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been worn, but had not ruptured. Adi Qeshi camp was a particularly vibrant community with small shops selling basic supplies; a row of tailors offering colourful fabrics for men and women's everyday wear and traditional hand-woven materials for special occasions. There was order and an atmosphere of safety. When the study team first visited the camp, a weekly market was in full swing. The residents carried themselves with dignity. They demonstrated resilience and resourcefulness, not helplessness and despair. However, the group discussions revealed that prolonged displacement was stretching the people's resources to their limit. The women expressed more realistic and pragmatic expectations concerning return to their home villages, pointing out that even after the peace agreement was signed it would take time for their home villages to be cleared of landmines.

The majority of the men who participated in this study were outside the productive age groups, otherwise they would still have been away in national service. It was said that one of the most burdensome aspects of living in the camp was the inability to use the land for farming. Camp residents were only 'guests' of the administrative sub-Zoba of Lalai Gash, with their own (Adi Qeshi) administrators. They were not entitled to own and farm the land, but they were permitted to have burial grounds for their dead. Many considered the camp burial grounds 'temporary', because they expected to take the remains of their loved ones home to their final rest – for *Kalai Qebri*, second (permanent) burial – eventually. Such traditional practices can involve huge expenditures, beyond the capacity and/or mandate of humanitarian agencies to support, although the need for bereavement assistance has long been advocated for (Harrell-Bond & Wilson, 1990).

In a comprehensive review of the anthropological and sociological literature on theories of stress and social support, Jacobson (1986), a social anthropologist, identified three types of support that mitigate the effects of crisis: *emotional support* – behaviour that fosters feelings of comfort leading the person to believe that s/he is loved, respected and/or cared for by others; *cognitive support* – information, knowledge and/or advice that enables the person to understand the crisis and adjust to the change(s) that have occurred; and *material support* – goods and services that help to solve practical problems. With particular reference to 'griefwork', the process of adjustment following a loss (involving a sequence of '*numbing, yearning, and searching* for that which is lost'; '*disorganization and despair*, giving up hope of regaining what was lost'; and then '*reorganization,* adjusting to change and relating to the world and/or people around oneself in a new way'), Jacobson outlined how people's responses to stressors can vary and one type of support given at the 'wrong' time may do more harm than good. To illustrate, Jacobson cited work done with cancer patients and their carers: emotional support may be most critical and helpful to the patient in the early stages, at the point of diagnosis and thereafter, allowing him/her to express feelings of fear, anxiety and emotional distress. Similarly, the bereaved struggle at first to manage feelings provoked by their loss, and gradually accept the loss and proceed to deal with material changes, and the types of support appropriate to the process are *emotional* support, *cognitive* support and *material* support, usually in that order. However, Jacobson observed that emotional support may be needed at all stages of psychosocial transition while cognitive support requires fine-tuned timing to be helpful. For example, it can be unhelpful, even harmful to

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provide information about why a cancer patient or a bereaved person finds her/himself in the situation he/she is in in the early stages of his/her struggle to absorb shock and to manage feelings of anger, anxiety and mental distress, when emotional support may be all that is required. Only when the person is ready and asks for it does cognitive support help.

Jacobson's analysis is useful and applicable to the data from Adi Qeshi camp where emotional support was derived from concerned/caring administrators and existing social networks of family, friends and community. Social cohesion was preserved by keeping village units together. This is very important because people who have shared the same experiences and suffered together tend to form strong support groups and provide safe space for expressions of pain, anger and grief. Moreover, cognitive support, information and advice on impending danger and the provision of organized relocation and shelter/refuge was, reportedly, well timed and appreciated. Material support should help at any time, as long as it meets felt and/or expressed need. It was observed that the residents of Adi Qeshi and Hamboka could have done with more material support. However, political factors may have limited the amount of humanitarian aid Eritrea was receiving. The country has followed a policy of asking for and receiving international aid on the basis of local needs and priorities, and not those of donor countries and agencies with unrelated agenda. As summarized by 'Rosso', one of the most qualified and experienced veteran humanitarian workers and researchers in Eritrea:

> [International] Aid is not given based on demonstrated necessity, or even the capacity of using it properly. It is usually guided by donor priorities, whatever they may be. The approach of the government of Eritrea has been determined by independent national priorities and emphasizes upgrading domestic capacities … External [humanitarian] actors were expected to fill the gaps created by the lack of national resources and capabilities during the short transitional period. Their role was seen as limited to providing funds and technical support in specific areas. However, if such assistance undermined or replaced domestic capacities and initiatives, it was considered undesirable. Thus the role of external actors was not an unrestricted one and was seen by them to unduly inhibit their actions … This experience has thrown new light on aid mechanisms and relationships that prevailed elsewhere during the last three to four decades. Some regard the Eritrean approach as a source of inspiration and a model for other countries. Others consider it too rigid, and attribute the low level of external assistance to the restrictive attitude of the Eritrean government. (Wolde-Giorgis, 1999, pp. 94–95)

It is evident that divergent agenda and priorities of action drive humanitarian action. The interplay between the most dominant forces – donor funds and agency ethos/culture – can often result in inappropriate humanitarian action, or inaction and neglect of local needs and priorities. For instance, over ten years ago, an evaluation report to Oxfam (UK) had highlighted recommendations for the agency to support documentation of individual and collective histories of the war years. This need had been identified by local humanitarian institutions (the Eritrean Relief Association (ERA) and the then newly affirmed National Union of Eritrean Women) to promote pyschosocial well-being by accentuating and rewarding resilience (Almedom, 1992a, b). However, psychosocial enquiry was a new area of consideration, and Oxfam's focus was on social programming (although the agency had commissioned D. Summerfield to prepare an illuminating and timely report in 1990; cited in Almedom, 1992a). A follow-up report to Oxfam detailing the process of national mourning and

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subsequent deceleration of 'work' (Almedom, 1992b) did not arouse enthusiastic action-planning by the agency at the time because provision of psychosocial support was not in the list of priorities for funding.

With or without humanitarian assistance, war-affected groups and individuals strive to live 'normal' lives. There is now a growing collection of locally supported publications, mostly in Tigrinya and Arabic, with one of the most profound and engaging accounts having been translated into English by its own highly accomplished author (Tesfai, 2003). Readings of such insightful, deep and original accounts of the social history of the war, broadcast on the radio and disseminated through print media, were observed to be important sources of comfort and motivation for ordinary people in the study sites. The next phase of this study aims to assess in quantifiable terms levels of resilience (derived from intrinsic attributes as well as available social support of the right type, timing and level) and the possible pathways to positive aftermath following crisis and subsequent *psychosocial transition*. It is hypothesized that those directly affected by the recent war remain focused on the lives lived and poised for social recovery (Summerfield, 2002), unaware of and uninterested in the currents that seem to fuel inter-group tensions and prolonged conflict in distant places, including the 'war in cyberspace', which has attracted the interest of some researchers (Guazzini, 2001).

The study findings justify a focus on social support (Fig. 1) when looking for factors that mitigate the effects of war-induced anxiety and mental distress. At the core is *emotional* support, and the relative importance of *cognitive* and *material* support may be expected to vary according to study site and population, if not individual characteristics and resources. An integrated model of psychosocial transition is suggested (Fig. 2). This extends Jacobson's analysis of types and timing of social support further, bringing in a new dimension – *level of support* – and applies it to settings of complex emergency, which was not Jacobson's area of study. This model makes three assumptions. First, the circumstances of mass displacement and duration of stay in the camps are important inter-connected determinants of psychosocial well-being. This allows for the possibility that people may remain unscathed or undergo a period of *psychosocial transition*. Second, the type, timing and level of social support may be critical determinants of outcome: whether or not *cognitive* and/or *emotional* and/or *material* support bring about positive aftermath ('recovery' or 'new start') following *psychosocial transition*, and *how*. Third, macro- and micro-level support systems may or may not operate in synergy, and this may ultimately predict positive aftermath; while deficit in one or more of these may result in negative aftermath – perhaps chronic 'trauma'. Not only is it important to ask, '*who* gives *what* to *whom*, concerning *which* problems and *when*?' but one should also add 'at *what* level is social support operating – *macro* or *micro?*' This approach and set of hypotheses are in-keeping with developments in current thinking on the links between social ties and mental health in non-emergency settings where egocentric social networks are nested within broader structures of social ties mediated by 'social capital' (Kawachi & Berkman, 2001). This study contributes to the literature on social support and resilience such as those included in the global mental health review with particular reference to low-income countries (Desjarlais *et al.*, 1995).

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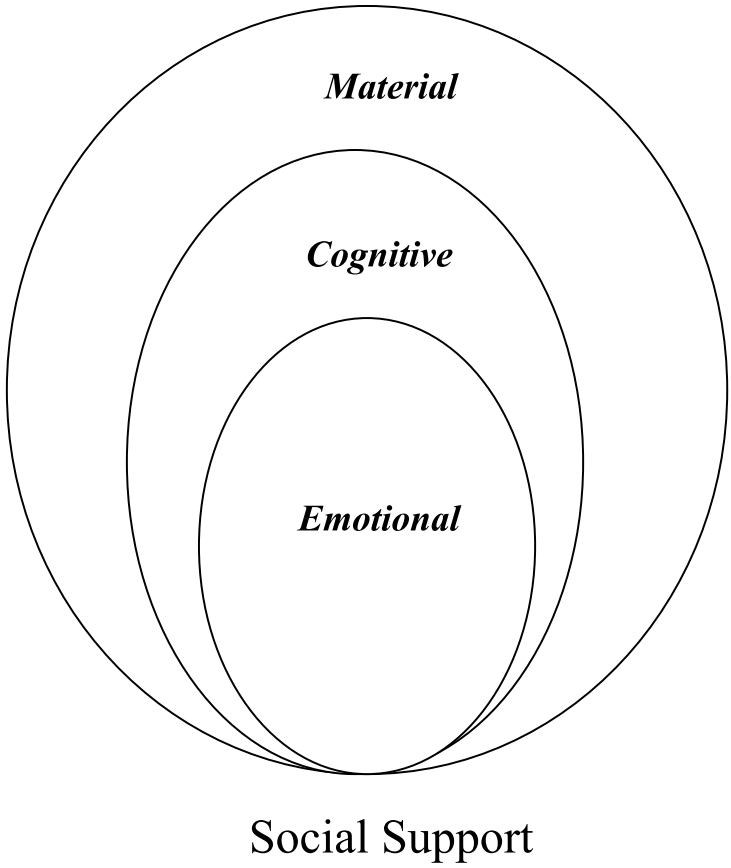


Fig. 1. Types of social support.

The study findings highlight the need for international humanitarian agencies to support local capacity for disaster preparedness and mitigation (Anderson, 1999; Minear, 2002), rather than continue with literally far-fetched interventions in the form of Western style 'talk therapy' with possible negative ethical and political consequences (Summerfield, 2001; Pupavac, 2002a, b). At a practical level, there are positive developments in re-framing interventions to focus on victim–survivors' ability to function 'normally' during their psychosocial transition (Bolton & Tang, 2002; Bolton *et al.*, 2002). It is not clear, however, whether these will extend to recommending that humanitarian action should be guided by the needs and priorities of survivors. If the ultimate goal is to justify humanitarian action to intervene in order to enable people to function at a basic level, with the help of foreign medical and non-medical intervention, questions will continue to arise as to what humanitarian actors can actually do to restore profound dysfunction. For example what can be done to help those who 'can look after themselves and their families' in terms of daily task accomplishment such as for example, getting dressed and walking long distances every morning to fetch water for household use, but remain unable to

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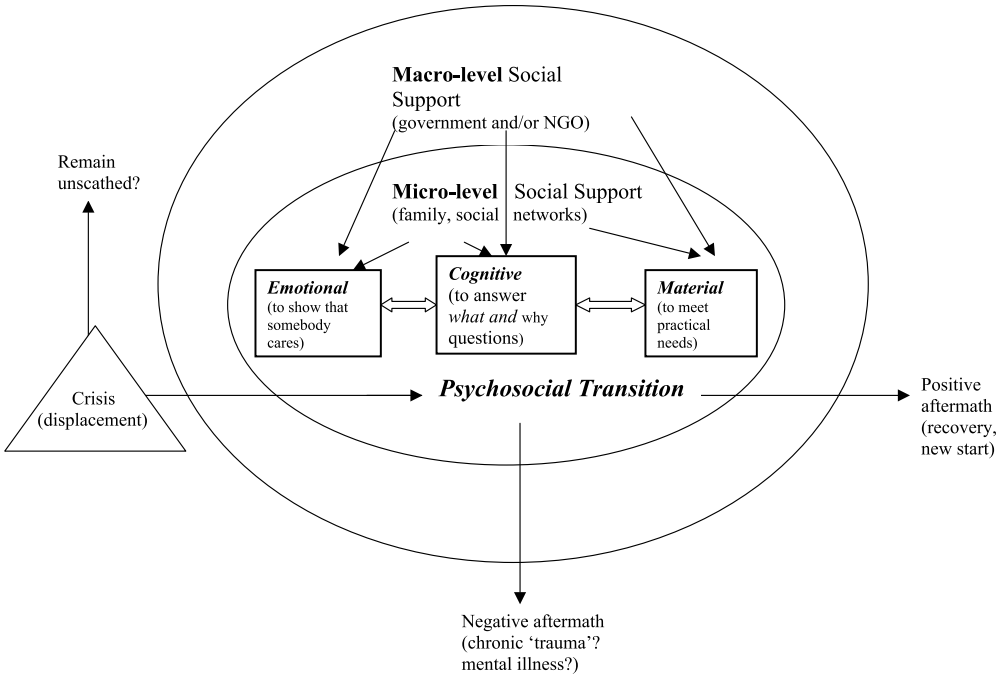


Fig. 2. Psychological transition: an integrated model.

function socially and make economic recovery/transition from war-induced destitution and chronic poverty by attending and achieving at school to qualify for employment? Would these (most women) be missed by function measurement scales and thus be deemed not in need of humanitarian/material support? What about children, especially girls, who may be considered able to accomplish basic tasks to 'look after themselves' as well as other members of their families and communities: will mental health experts' focus on function detract attention from children's profound deprivation and low morale? Is there not danger in researchers' focus on methods and psychometric scales without a clear understanding of the context – social history and political economy – of any given 'complex emergency'?

Clearly, there are ways in which humanitarian action can continue to do good in the Eritrean context, particularly where international players are willing to support local priorities and operate under the coordination of the ERREC. As Last (2000) observed, the Eritrean government's refusal of help in the form of the 'acceptable or dominant form of healing' displeases international donors. Local humanitarian actors may remain puzzled by Western donors' reluctance to help even when aid is used effectively and accounted for meticulously (Wolde-Giorgis, 1999). As long as humanitarian action remains driven by external interests and priorities, far removed from expressed needs on the ground, it will remain limited in mitigating the negative psychosocial consequences of war. Attention to individual sense of coherence and collective resilience in response to collective stressors such as war and

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displacement may facilitate a redeeming process whereby the humanitarian idea, conceptualized cross-culturally, may achieve 'unity of truth' within itself.

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