



# Taking Darfur to Asia? True or false?

Vivien Margaret Walden

**Did aid workers, used to working in very poor countries, have inappropriate expectations when they helped with the *tsunami* relief efforts in middle-income countries? Or should the same levels of assistance be provided everywhere? This article asks the opinions of the aid workers involved.**

During the recent *tsunami* response, some aid workers remarked that 'we took Darfur to Asia' or that 'we entered the arena wearing Africa glasses'. There is some anecdotal evidence that the humanitarian response in water, sanitation and hygiene promotion in middle-income countries is often coloured by an organization's experience in low-income countries. This article sets out to explore these issues further and to determine how the phenomenon, if it is true, can be rectified.

## Methodology

A literature search was carried out for published papers on the subject. Pre-tested questionnaires were sent out to 27 Oxfam-employed public health engineers and public health promotion advisers. These people were not randomly selected, but were chosen for having worked in at least two categories of country, including low-income and lower-middle-income (countries were classified using the World Bank Atlas method of gross national income per capita expressed in US dollars).<sup>1</sup> Questions were for the most part open-ended in order to use qualitative data methods for coding and analysing according to accepted methodologies.<sup>2</sup>

Although confidentiality is virtually impossible with email replies, responses were printed (without names) before being read and analysed so that some anonymity was maintained.

## Results

The response was poor – only 11 out of 27 replied (41%). In total, 13 low-

income countries were named as places of working experience and six middle-income, out of which two were *tsunami*-response countries. Respondents were asked to state what they thought were the basic principles for an Oxfam Watsan/hygiene promotion approach. Answers were as follows:

- An appropriate and creative response.
- Community consultation, ownership and management with a focus on the household level.
- Intervention based on good baseline information on context, culture, practice and risks.
- Adapted to religious, educational and economic differences.
- Underpinned by a good monitoring system enabling activities to be adjusted to reflect the changing humanitarian environment.
- Adherence to Sphere standards.
- Needs-based approach with emphasis on where the community was before the disaster (infrastructure, hygiene knowledge and practices).
- An enabling environment for people to continue health practices or adopt new ones.

## Expectations of the field workers

Four people agreed with the statement 'NGOs have been accused of taking Darfur to the *tsunami* and wearing Africa glasses'. Two people disagreed, three were undecided whilst two felt that they both agreed and disagreed giving examples for and against.

Over half the respondents felt that there was a difference in approach according to the type of country, and

examples were given where inappropriate methods had been used. The main reason seemed to be a lack of knowledge about the cultural and societal norms of the people, or not understanding the implications of middle-income communities forced to live 'in very different circumstances to their normal habitats'.

People resorted to unhygienic behaviours in these countries because they lacked the access due to having no facilities as a result of massive destructions, as opposed . . . to limitations in experience with use.

One person thought the whole standard approach for public health promotion was a 'typical Darfur model' and not appropriate for middle-income countries. This resulted in what another person called 'patronizing and ineffective' messages and 'inappropriate and culturally unacceptable' facilities (see Box 1).

### Box 1. Inappropriate solutions

One example of culturally unacceptable facilities was the use of pit latrines in urban areas where people had been used to pour-flush latrines. This has also been a problem in non-*tsunami* countries such as Palestine. Pit latrines are seen as being only for the poor.

An example of inappropriate hygiene promotion in a *tsunami* country was holding sessions with children who should have been in school but who lacked transport to the functioning neighbourhood school. The children needed to return to a normal way of life, but the NGO had not recognized this and continued with their rather didactic sessions that only reinforced the children's abnormal camp situation.



After the *tsunami*, there was more money so more technology: this emergency town water supply was supported by Oxfam. Credit: Jim Holmes/Oxfam

However, there was also a feeling that programmes should not be tailored to the economic and literacy status of the country as some families ‘have high income, but their literacy level and hygiene practice might be lower than poorer families who practised better sanitation’. One person felt that the ‘Africa glasses’ were needed during the emergency phase as a ‘precautionary principle’, but that they ‘outlived their usefulness past the second month’.

### Higher expectations of local people

Communities in middle-income countries had higher expectations of services and ‘struggled when water was not available to maintain standards in ways previously expected’. People who had indoor plumbing had ‘different perceptions’ than poorer households used to well water. These higher expectations also meant that a different type of hygiene kit was given out in the *tsunami* response:

The items or rather the qualities were different from what was being used in developing countries. The justification was that these (were) what they were used to given their income level. People know what they want and ask for them, whereas in developing countries there is a need to create demand.

It was also acknowledged that often ‘better equipment is sent’ to middle-income countries’ and there is ‘more

public sympathy, and therefore more money’.

There was a problem of cleaning and maintaining facilities as ‘some members of the community expect lower cadres . . . to maintain/clean communal facilities for them’. Sharing latrines appears to be a problem encountered in middle-income countries even if there are paid workers to clean them. This was not only an issue in the *tsunami*-affected countries but has also been experienced

elsewhere, such as in Palestine and some Central American countries, where people used to indoor plumbing and piped water are suddenly faced with basic and unfamiliar amenities.

Another aspect highlighted was that of working with local authorities. In developing countries NGOs often set up parallel services. However, in middle-income countries it could usually be assumed there would be ‘good functioning health services and central government’. This meant that local protocols and functioning systems were usually adhered to. It also meant that the sustainability of services was less of an issue in a middle-income country since, once the emergency was over, there were established methods for service continuation.

Sphere is generally used as the minimum standard. Respondents felt that this decision was not always unproblematic:

Using Sphere standards in developing countries may often mean that the people outside the camps/humanitarian response are living below the minimum standards . . . In middle-income countries it is often the host community that is used to higher standards . . . so there is always a problem of fitting the response to the local situation.

However, in middle-income countries there was always the possibility of upgrading to local wishes at the development stage. In the *tsunami* response,



In Darfur less costly technology was used. Adrian McIntyre/Oxfam



Higher literacy rates mean posters and written messages are possible, such as this one on malaria prevention. Credit: Jim Holmes/Oxfam

this was possible due to the unprecedented amounts of funding available.

## Induction

There was a general feeling among respondents that more in-depth information about a country (standard of living, culture, religion) was needed before individuals were deployed, as all respondents had strong Africa backgrounds. One person felt that they had been ‘lucky’ to fly out with two people who had over 20 years’ experience in the region, but this was purely coincidental.

A couple of respondents felt that there was a lack of middle-income country literature available:

Most of the (Oxfam) protocols used are still biased to developing country response strategies. Since people are using these books, they tend to tailor their strategies towards the book.

## Discussion

There was no literature relevant to this subject, making it difficult to compare the results of this survey with other organizations or situations. Moreover, the number of respondents was small, even for a qualitative study; nevertheless, some interesting issues have arisen.

Respondents admitted to having inaccurate assumptions about countries before they went out. These were fairly

stereotyped: levels of literacy, use of sanitary facilities, hygiene practices and the ability of the local authorities to engage. Several respondents cited examples where these assumptions had led them to make decisions that later proved to be incorrect and needed to be rectified:

I assumed all people are the same, given that they are in the same country.

In the *tsunami* countries, although these wrongly informed decisions did not jeopardize people’s health (there were no major outbreaks of disease),<sup>3</sup> it did mean that the principle of a needs-based approach was not always followed. Despite the fact that most respondents felt that the approach needed in middle-income countries was to assist people to adjust to their present situation with a return to normalcy as soon as possible, there were also examples of ‘socially unacceptable solutions’ and ‘clumsy’ attempts at hygiene promotion (see Box 1).

Knowing the principles behind an approach does not, on its own, equip a field worker to function in a programme. Almost all the respondents felt that they needed a better induction, preferably from someone who knew the culture. However, another suggestion was that workers should not make assumptions, but should ask more questions and assess the situation for themselves.

There seemed to be a feeling that people’s needs in middle-income countries are usually met but that this is not always the case in developing countries. There is insufficient evidence to show if this disparity is because of better funding or whether middle-income people ‘expect and demand more’. This is an area that needs more investigation, especially if developing country beneficiaries receive less because they are less vocal.

## Conclusions

There are differences in approaches used in low-income and middle-income countries and these should be acknowledged. An important influencing factor appears to be the public interest and amount of funding available. Better inductions for relief workers, with emphasis on the standards of living, literacy rates, culture, religion and other aspects, should be the pre-departure norm.

The principle of ‘starting where people are at’ should always apply, but it is important that all staff are aware of the pre-emergency situation of people in the particular country rather than making assumptions. Finally, does the difference in approaches mean that developing countries are being short-changed through NGO complacency? Should we view Africa through ‘*tsunami* glasses?’

## About the author

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## References

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