



UNICEF Indonesia

**PSYCHOSOCIAL INTERVENTIONS
EVALUATION OF UNICEF SUPPORTED
PROJECTS
(1999- 2001)**

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Executive Summary

This evaluation assessed the design, implementation and impact of the two major psychosocial projects sponsored by UNICEF Indonesia from October 1999 until the end of 2001. The first, the 'Psychosocial Help Training Project' aimed to support teachers and counsellors to provide basic psychosocial assistance to children, first in West Timor and then throughout the conflict zones in Indonesia. The second was the EMDR project, which trained professionals and paraprofessionals in the use of Eye Movement and Desensitisation Reprocessing. The project aimed to treat the effects of trauma, and as such, was a treatment intervention.

Psychosocial Help Training Project

Design and Implementation

Overall, the design of the Psychosocial Help project was logical and effective, particularly the design of the first phase in West Timor. The project consisted of a series of psychosocial trainings for teachers, counsellors and youth volunteers in West Timor, with substantial follow-up to support the activities in the East Timorese refugee camps. The second phase was a psychosocial training workshop in Jakarta for counsellors and children's workers from throughout the conflict zones in Indonesia, which was followed by 3 district level trainings for caretakers of separated children. The main beneficiaries were children and parents experiencing psychosocial difficulties as result of armed conflict but not those with clinical psychological problems - that is, the project did not provide psychological or psychiatric treatment.

The strengths of this design were that in West Timor, it was a comprehensive, multilevel intervention – that is, the first level of intervention was by parents, teachers and youth volunteers and for those needing more specialised assistance, they could be referred to the second level of intervention conducted by counsellors. In West Timor, a comprehensive field-based assessment was conducted, and the projects included strong follow-up and support to activity implementation. Due to the continual presence of UNICEF staff in the field, the project was flexible to the changing circumstances and needs, and emerging problems were effectively overcome. In West Timor the activities were integrated with UNICEF educational and health projects, while the district-level trainings in other parts of Indonesia were integrated within UNICEF's Children in Need of Special Protection Section. In both West Timor and the project for other conflict areas, the activities focused on strengthening children's support networks, and emphasised child resiliency, which are ethical, effective and efficient ways to promote children's healing. Activities included recreational and expressional activities, and in other conflict zones also included skills building (such as relaxation) and vocational training. These activities were mostly conducted in groups which was culturally appropriate and an efficient way to reach large numbers of affected children. The trainers were very knowledgeable, experienced and used an effective training style – that is, they were elicitive, participatory, flexible and culturally sensitive. All activities were conducted in close collaboration with relevant organisations, and build local capacity. Finally, the project was timely given the constraints, particularly of working in the emergency situation in West Timor.

Some areas to improve for future projects would be to involve children in the project design and implementation, to incorporate clear protocol from beginning of project, and to implement activities by members of the community (such as youth volunteers and teachers) first so as to build confidence

with the community and children, and after this implement activities by counselors. Overall, the training topics were good, but there needed to be a better balance between knowledge/attitude change and skills building, and there was a need for more specific group counseling techniques for children. There may be a need to supplement group activities with some specific individual interventions - for instance, individual follow-up for vulnerable children. There was also a tendency to overestimate the skill level of trainees – for instance, it was also clear that 5 days is not enough to train ‘counselors’. Selection of participants for these trainings need to be done very carefully, and should not be left entirely to counterparts. While it is important to coordinate and involve many different organizations in the project as beneficiaries or advisors, the number of partners responsible for implementation should be limited. For the Jakarta training there was little follow-up and this was a major short-coming of this training. This appeared to be at least partly due to the initiation of EMDR and the subsequent lack of funds to continue with psychosocial interventions.

This project was largely consistent with UNICEF policies and practices regarding psychosocial interventions. This project effectively implemented the following principles: the provision of psychosocial support as a child’s right, especially in emergency situations; that programme decisions and priorities must derive from a situation analysis on the ground; that psychosocial projects should be holistic and integrated/coordinated with other interventions; that the focus of such programmes should be on normalising children’s lives; that projects should promote community-based support networks for children; and that children’s resilience should be valued. Future programmes should also pay attention to the following principles, which were not effectively implemented in this project: that children should have an active role in designing and implementing programmes; that projects should focus on healing, as many of the activities in this project were limited to activities that help them enjoy themselves or express their problems, and did not take children through a ‘healing process’ to help build their skills to *deal with* their problems.

Impact

This project had a substantial impact on a large number of primary beneficiaries – that is, children and their parents. In West Timor approximately 9,000 children participated in recreational and/or expressional activities, 1,000 children received counseling, and 500 parents participated in community meeting or support groups. 20,000 children in other conflict areas (primarily Madura, Central Kalimantan, Maluku and East Java) benefited from recreational and/or expressional activities. It is estimated that 19% of the targeted beneficiaries were reached by this project, which is very substantial proportion in the Indonesian context. It was found that children who participated in psychosocial activities had a lasting (at least one year) significantly better psychosocial outcome than those who did not have any psychosocial assistance. Benefits included: children were happier, more animated, developed their social skills, had better family relationships, were more able to make up their mind, were less scared, hyperactive, and regressive and had fewer psychosomatic problems¹; the refugee camps were more animated, and care-takers were empowered to improve the situation of children in these camps; This was also an efficient project, as it cost approximately \$9 per beneficiary.

¹ One worrying finding was that for adolescents, participation in psychosocial programmes appeared to make them more likely to engage in risk-taking behaviour, such as drinking or going to dangerous places. This finding needs to be confirmed in other research but certainly raises questions about the relationship between healing and protection of adolescents in armed conflicts. Another concern is that levels of PTSD remain high in some areas, despite significant drops in levels of anxiety and depression as a result of the psychosocial programmes.

Beneficiaries were primarily children under 12 years old, particularly in West Timor, so future projects need to focus more on the adolescent age group.

For professionals and para-professionals, the impact was also important. A total of 60 counselors were trained, 160 teachers/care-takers and 60 youth volunteers were trained, and key changes in the trainees included: greater self-confidence and motivation to work with children in armed conflict, understanding of children as active learners, recognition of the importance of self-knowledge and expression, and skills to help children express/play. Finally this project served as 'framework' for much of the psychosocial work conducted in Indonesia –for instance, the training manual and approach has heavily influenced the psychosocial work of two key Universities in Indonesia.

In conclusion, the psychosocial training project is an easily implementable, practical project that has proven psychosocial benefits for children and their communities. It is cost efficient, and generally consistent with UNICEF policies and guidelines. It is an approach that should be continued and strengthened, particularly based on the West Timor model with minor adjustments to integrate the lessons learnt that are highlighted in this evaluation.

EMDR Project

Design

The EMDR project consisted of a series of 5 trainings and 1 week field supervision to train mental health professionals and para-professionals in the use of EMDR for children and families 'traumatised by violence'. As such, it aimed to treat clinical psychological problems resulting from exposure to sudden, life-threatening events. It mainly focused on Aceh and the Malukus.

The strengths of the design and implementation of this project were that: it build local capacity (through training) and was a collaboration with local organisations; the design was logical as it included step-based training with practical assignments and supervision; it did contribute to the individual aspect of healing process; it helped some beneficiaries to overcome their problems, particularly uncontrollable fear of the perpetrators of violence; and did provide a psychological technique to deal with the effects of trauma to some paraprofessionals who previously had none. The project was more effective in Maluku than Aceh, primarily because in Maluku a core group of the trainees had experience and opportunity working with children, and had basic counseling skills (see below). Generally, EMDR was implemented along with other activities, such as play groups, or cognitive, behavioural or relaxation therapies.

None-the-less there were some serious problems. First, the project focused exclusively on problems resulting from exposure to trauma, but many beneficiaries stated that psychosocial problems resulting from other issues, such as dislocation, family problems, loss of loved one etc. were a higher priority for them. It did not help to 'normalise' beneficiaries' lives and was not a holistic approach to their problems. Resilience was not core concept, it did not focus on strengthening children's support networks and it utilised a medical model, which can be disempowering for the beneficiaries. There was no children involvement in the design, and the needs assessment was biased and not sufficiently field-based. The training topics did not contextualise EMDR in the Indonesian context – for instance it did not address signs of trauma in Indonesia. Despite substantial experience, the first set of trainers used a didactic and inflexible training approach. EMDR is a treatment methodology which is not the

usual focus of UNICEF's programming, and as described above, this approach was not consistent with any of UNICEF's policies, except building local capacity. Many beneficiaries, and some trainees, found the process difficult, strange, and time-consuming which calls into question the cultural appropriateness of this technique within Indonesia. The individual nature of EMDR for adults was inefficient for dealing with large numbers of affected people. Finally, and perhaps most importantly, the field based paraprofessionals often did not have basic counseling skills to use EMDR effectively or ethically. This raised the danger of unsupervised and unsupported paraprofessionals raising the beneficiaries traumatic memories and not being able to effectively process them (this occurred in a least a few cases).

Impact

There were a limited number of beneficiaries of this project, and there was little impact of these activities that could be demonstrated. Beneficiaries were estimated at 500-600, of which an estimated 175-250 were children. It is estimated that less than 1% of the targeted population benefited from EMDR services. The cost per beneficiary was \$430-500 or \$860-1000 per UNICEF targeted beneficiary (children or parents). The majority of beneficiaries were from Maluku, and a more limited number from Aceh and Madura/Surabaya. There was no difference found between the overall psychosocial outcomes for children who participated in EMDR activities, and those that did not participate in any psychosocial activities². This may have been partly due to the fact that the quality of EMDR interventions varied widely. A recent metaanalysis concludes that EMDR does have an impact, but that it is similar to certain other types of treatment, and that the bi-lateral stimulation which is the supposed core of the treatment is not crucial to its effectiveness. In this project, the impact on the trainees was mixed, with some trainees who had basic counselling skills happy and effectively able to add EMDR to their range of intervention techniques and other paraprofessionals without basic skills very happy to have at least one technique to deal with traumatised children/adults. Other trainees were frustrated because they found EMDR so difficult to implement.

In conclusion, EMDR is difficult to implement and generally inappropriate for the Indonesian context, particularly given the limited basic counseling skills of child workers in conflict zones but also because of the questionable cultural appropriateness of the technique. In this project, EMDR had limited, if any, lasting positive effects on children that could be demonstrated, and it does not appear to be more effective or efficient than other therapies which may be more easily implemented in Indonesia. It is inconsistent with UNICEF policies and guidelines, and not cost effective. At this stage, EMDR is not appropriate for helping children deal with the psychological and social effects of armed conflict in Indonesia.

² The specific differences found were erratic, and on half the items, the non-EMDR group had a better outcome than the EMDR group.

Background and Evaluation Methodology

General Context as it Affects the Psychosocial Status of Children and their Families

During 1999-2001, Indonesia was experiencing a surge of internal armed conflict. Aceh, West Papua and East Timor were all engaged in separatist conflicts, which had become even more intense since the fall of Suharto in 1998. Inter-religious/ethnic conflict also turned violent in the Malukus, Sulawesi and Kalimantan in the post-Suharto era. Regions such as Madura, West Timor and northern Sumatra were reeling from a large influx of IDPs from the various conflict zones. According to the World Food Program, over 1.3 million people were displaced in of March 2002. Many more than that were affected in other ways.

Children growing up in the midst of this conflict are vulnerable to life-long effects from its many implications: malnutrition or untreated sickness in crucial developmental stages could permanently stunt their capacities; disruption of their families' livelihood could mean the end of their educations; destruction of community structures can alter irreversibly social values and traditions, leaving children isolated and confused; witnessing or participating in violence can cause long-lasting psychological problems.

During this period, UNICEF launched two projects to promote psychosocial well-being and recovery of children who have experienced armed conflict in their communities. These projects aimed to protect children from the potential social and psychological problems and to improve their ability to deal with future events. They focused on helping children and their families heal from the difficult events which they have experienced, and rebuilt their lives.

Summary of Available Information about the Psychosocial Situation of Conflict-Affected Indonesian Children

The consultant was only able to locate two documents containing information about the psychosocial situation of conflict-affected Indonesian children during the course of this evaluation, primarily due to time limitations. As this is certainly not exhaustive, the results of these documents will not be reported here as they would not be comprehensive, and could be misleading. Rather a more exhaustive document review could be conducted as part of a comprehensive assessment following this evaluation.

Definitions

Psychosocial Development. "Children's psychosocial development is defined as: changes in cognition, emotion, spirituality and social relations mediated by socialization processes."³

Psychosocial Programming. "Psychosocial programming consists of structured activities designed to advance children's psychological and social development and to strengthen protective factors that limit the effects of adverse influence."⁴

³ Technical Notes: Special Considerations for Programming in Unstable Situations. Chapter 14: Protecting Psychosocial Development, p. 1.

⁴ Ibid.

Resilience. “a universal capacity which allows a person, group or community to prevent, minimize or overcome the damaging effects of adversity”⁵

EMDR. Eye Movement Desensitisation and Reprocessing. A protocol for treatment of the symptoms of PTSD.

PTSD. Post Traumatic Stress Disorder (PTSD).

Conflict Zones. Areas where there has been widespread, repeated violent conflict affecting significant numbers of children.

Sustainability. The degree to which the benefit of the project extends beyond the project itself. Sustainability can mean that

Community-based intervention. An intervention which strengthens the community mechanisms available to support children’s psychosocial development. Primary actors include parents, peers or other role models (e.g. youth volunteers), educators, health and social workers, and community (religious, political etc.) leaders.

3 LEVELS OF INTERVENTION

- *Promotion* – recreational and expressional activities, play groups, community meetings with parents, training for teachers, health workers, youth workers
- *Prevention* – group or individual counseling, play and art counseling
- *Treatment* – psychiatry and clinical psychological services

Summary of Two Psychosocial Projects

From the period October 1999 until the end of 2001, UNICEF sponsored two major psychosocial projects. The first, the ‘Psychosocial Help Training Project’ aimed to support teachers and counsellors to provide basic psychosocial assistance to children in conflict zones. It was initiated in West Timor, and then generalized to other conflict zones. This project aimed to both promote psychosocial wellbeing and prevent serious psychosocial distress.

The second was the EMDR project, which trained professionals and paraprofessionals in the use of EMDR. The project aimed to treat the effects of trauma, and as such, was a treatment intervention.

Psychosocial Help Project

Project Aim:

- Build individual resilience and community capacity in WT IDP community to “protect displaced children and facilitate their recovery from trauma” by
- “Initiat[ing] the provision of psychosocial services to displaced children” and
- “Capacity building for Indonesian personnel who were dealing with areas of unrest in other areas of Indonesia”⁶

Training Topics/Approach

- Child rights focus (what does this mean?)
- Child and family focus
- Self-learning i.e. understand one’s own reaction to the situation as a way to understand how children react and how to help children recover

⁵ Basic Training on Psychosocial Help for Children in Situations of Armed Conflict. Training 1. A trainers manual (2000). CFSI, UP/CIDS, p.40.

⁶ Promoting Child Protection and Recovery through Training in Psychosocial Rehabilitation, Report and Evaluation, CSFI, p.13.

Project Phases/Activities:

1. West Timor psychosocial interventions with refugees
 - a. Initial 3-day teacher training for 30 teachers in 10 camp schools
 - b. Counsellor training for 23 community members such as nuns, teachers, child welfare workers
 - c. Evaluation of first training
 - d. Conducting 5-day training sessions for 50 teachers in WT of refugees
 - e. Training of Play facilitators* - conducted by West Timor trainers, in cooperation with local NGO, Tapemmasu
 - f. Training of NGO volunteers* - conducted by West Timor trainers, in cooperation with local NGO, Xayasan Cemara
2. Advanced training in Psychosocial Help in Jakarta for 30 counsellors working throughout the conflict-affected zones
3. Follow-up projects throughout Indonesia

Name of Project	Location	Trainers	Partner
a. Training for community workers	Northern Sumatra	TOT trainers	Child Protection Body
b. Training for CPB workers	Central Java	TOT trainers	CPB

Note: Participants were from many conflict-affected areas, including Central Java, West Java, East Java, South Sulawesi, West Kalimantan

c. Training for teachers	East Java	TOT trainers	CPB, UA, US
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Time-frame: September 1999 – Mid 2001

Total Cost: \$271,600

(\$46,000 West Timor project costs, \$14,000 Jakarta training costs, \$15,000 follow-up project costs, \$116,000 trainer fees, \$80,000 support costs)

Number of beneficiaries: Approximately 34,800 of which an estimated 1000 received counselling. All were children or parents.

Cost/beneficiary: \$7.80

*These projects were conducted after the advanced training in Jakarta

Eye Movement Desensitisation and Reprocessing (EMDR)

Project Aim:

Assist children and their families heal from trauma.

Project Activities:

- Assessment
- Level 1 EMDR training in both Maluku and Aceh (5 days with 29 and 28 participants respectively) in
- Level 2 training in Jakarta, Maluku and Aceh
- 1 Week supervision of trainees

Training topics/approaches:

- Principles of EMDR
- EMDR techniques

Follow-up Activities:

- None sponsored by UNICEF.

Time-frame:

Dec 2000 – December 2001

Total Cost: Approximately \$258,000

(\$145,000 to trainers, \$23,000 for workshop costs, \$90,000 project support)

Number of beneficiaries: Estimated 500, of which an estimated 200 are children
Cost/beneficiary: \$516 or \$860 per UNICEF targeted beneficiary (children or parents)

Methodology

This evaluation was conducted utilizing three different sources of information:

a. Desk study of relevant documents

The consultant reviewed all available relevant documents in order to first design the evaluation framework (see section below), and secondly, to gain information relevant to the evaluation. The documents reviewed are listed in Appendix 3.

b. Interviews with the project staff (including UNICEF staff and project consultants) and the trainees

Project staff were asked the questions presented in the evaluation framework and trainees were asked the questions listed in Appendix 2 and were asked to complete the questionnaire presented in Appendix 5. When interviews were conducted face-to-face the consultant conducted the interview, with translation by the project assistant, Ms. Faye Scarlet. When conducted over the phone with trainees who did not speak English the project assistant conducted the interviews. The list of interviews with project staff and trainees is presented in Appendix 3.

c. Focus groups, interviews and questionnaires with beneficiaries

Wherever possible, focus groups, individual interviews and questionnaires were conducted/distributed to the beneficiaries in order to assess the impact of the project on the beneficiaries and to determine if the project met the priority needs of the beneficiaries. [See Appendix 3 for list of beneficiaries who were interviewed and who completed the questionnaire.] The questionnaire was designed to assess the current psychosocial situation of the beneficiaries and was developed especially for this evaluation. Very few questionnaires to assess children's psychological status have been standardized and adapted to the Indonesian context. In addition, those that are available, such as the Child Behaviour Checklist, do not adequately address the diverse psychosocial effects of violent conflict on children (such as changes in values), nor did they include items specifically to assess the symptoms of trauma (such as strong, invasive memories). The questionnaire utilized in this evaluation was designed to address: standard psychological/behavioural problems; additional problems especially common in violent conflict (including changes in values, problematic relationship with community); and symptoms of trauma. Two versions were utilized in this evaluation – the first, for children 12-18, and the second for adults (see Appendix 6). While questionnaires for parents of children aged 0-5, 6-12 and 12-18 were developed, these questionnaires were not utilized due to time limitations.

Methodological Constraints

There were a number of methodological constraints. The primarily one was that as the projects were dealing with highly mobile populations, especially in West Timor, and were conducted quite some time ago, it was difficult to access beneficiaries. In some cases we were unable to contact trainees. This assessment contacted beneficiaries and trainees where this was practical and not too time-consuming.

In addition, no base-line data was collected, so it is more difficult to assess the impact of the projects. For the West Timor project, this was inevitable as, due to the urgent need to begin activities, there was

no time to do so. In the psychosocial project and EMDR a base-line assessment could have been valuable.

In this evaluation, we attempted to overcome this problem by doing a cross-sample comparison – that is, comparing beneficiaries who participated in the EMDR or psychosocial projects with those who did not. For psychosocial projects, this worked well as it was possible to compare children from the same school, in these two different conditions. For EMDR, it was more difficult, for two reasons. First, the EMDR participants often came from diverse contexts, and therefore it was impossible to find a precisely matched control sample. Rather we had to try to match the control group as closely as possible to the sample group, to reduce the likelihood of confounding variables. We did this by including as many EMDR children as possible in the sample, and then finding groups of children that matched the EMDR subgroups as closely as possible. For instance, in Aceh the EMDR group included children from high conflict zones who had been dislocated, and in some cases, separated from their parents – the control group also had these characteristics and came from similar geographical region. The second problem was more fundamental and less easily overcome. In most cases, EMDR was conducted along with other interventions, such as play groups, or cognitive, behavioural or relaxation therapy. As a result, if any differences were found between the EMDR and control groups, it would be difficult to know whether it was the other activities, or the EMDR, or the combination that led to the improvement in psychosocial status.

Another problem was that the author was unable to locate any appropriate psychosocial tests that have been tested and normed in the Indonesian context. While some were identified⁷, they were not sufficiently broad for the purposes of this evaluation. Given the sensitive and private nature of the issues being addressed in this evaluation (for instance, children's feelings about themselves), it was decided that a confidential method of assessing the psychosocial status of children would be necessary, and individual interviews would be too time-consuming. Therefore, an individual questionnaire was necessary to supplement the information gained through focus groups with the beneficiaries.

A final constraint was a number of unavoidable delays. Most importantly, the permit to Ambon was not available until 2 months after the consultant began the evaluation. As a result of this delay, the consultant had to begin work on other projects before completing the evaluation, which again further delayed the completion of the evaluation. The consultant also was not familiar with the Indonesian context. The uncertainty regarding the security situation leading up to and after the Iraqi war began made planning at the end of the evaluation more difficult and prevented conducting focus groups with children who had participated in psychosocial or EMDR activities in Ambon.

⁷ The author asked various psychosocial and psychiatric experts from Indonesia and abroad for their advice in this issue. Although no appropriate instruments were identified in this process, we cannot rule out the possibility that appropriate instruments exist that were not identified in this process due to the time limitations.

Project #1 – Psychosocial Help Evaluation DESIGN

Overall, the design of the Psychosocial Help project was logical and effective, particularly the design of the first phase in West Timor.

a. Who were the beneficiaries?

The West Timor project was designed to address the psychosocial needs of IDP children fleeing from East Timor to West Timor. The project initially focused on the Belu district of West Timor, as this was where the largest number of IDPs were concentrated. As the project was initially situated in the IDP camp schools, the majority of beneficiaries were students at these schools. However, other IDP children did benefit indirectly through the assistance given to their parents. In addition, later through the training of play facilitators and NGO workers, the beneficiaries were expanded to include IDP children throughout the TTU and TTS districts of West Timor. The beneficiaries were mostly primary school age children, although later in the project some attempts were made to conduct activities for adolescents⁸. Overall this beneficiary profile appeared to be logical, although more efforts could have been made to address adolescent beneficiaries in the programmes.

The Jakarta and follow-up trainings were designed to provide psychosocial assistance to children and their families affected by armed conflict. The project focused primarily on IDP children and their families, but did aim to provide limited assistance to other communities that had been affected by armed conflict (such as the remaining population in West Kalimantan). The follow-up trainings focused on IDP children who had been separated from their families in East and Central Java, as well as north Sumatra.

While frequent references were made to dealing with ‘traumatised children’ in project documents, there appeared to be a lack of clarity about whether the project should deal with all IDP children, or only those who experienced ‘traumatic events’ or children who are ‘traumatised’ (that is, seriously distressed). However, in practice, the projects aimed to provide basic psychosocial assistance to the entire population of school-aged IDP children in the targeted camps, and prevention activities (i.e. counselling) to children experiencing more problems. Clinical treatment was not provided for seriously distressed children – however, these children may have been provided counselling as it was the only available form of specialized assistance. While this level of conceptual clarity appeared to be sufficient for this project, particularly given the limited psychosocial capacities of the trainees, future projects should attempt to more clearly define the level of distress of their beneficiaries.

b. Where the objectives of the projects relevant to the needs of the beneficiaries?

For West Timor, it was difficult to assess whether the objectives of the project met the primary needs of the beneficiaries, as it was not possible to interview the beneficiaries (as noted above). However, the project documents do provide some indications. It is clear that the parents and adolescents were focused on material needs, and the larger question of whether they would return to East Timor. The

⁸ See Emergency Education and Psychosocial Support Programmes for Children of Internally Displaced People in West Timor, Field Trip Report, March 5-9, Jiyono Education Officer, UNICEF and Monthly Report, Reporting Period 1-31 March 2000, Ali Aulia Ramly, UNICEF Consultant.

counsellors thus reported difficulties in getting adults and adolescents to participate in counselling. As stated by one of the trainees a common attitude was “What good does talking do? It doesn’t bring me food”⁹. There was also a general tendency to want to avoid remembering or talking about the difficult events they experienced in East Timor. However, parents were concerned about the lack of structure for their children, and most were therefore happy to have their children involved and occupied in either psychosocial activities or education. They were also concerned about the changes in behaviour they noticed in their children, although this appeared to be a lower priority than other issues (health, food, shelter, uncertainty over their future). Certainly linking the psychosocial activities to the schools helped to overcome the perception among some parents that psychosocial activities weren’t a priority for their children’s wellbeing. In contrast, the school-age children themselves did appear very involved and interested in the psychosocial play activities. It should be noted that it was impossible to assess whether the other needs of children identified above were adequately taken care of, although UNICEF documents state that they were.

Similar conclusions can be drawn about the Jakarta training and the follow-up trainings. In Madura, psychosocial concerns, such as how to adapt to their new environment, overcoming grief and other such issues were obviously a high priority for the adolescent’s we interviewed there. In interviews with trainees, many indicate that psychosocial concerns were important among the beneficiaries – for instance, they noted that care-givers for separated children needed to know how to get the children to open-up and express their concerns, hopes etc. Other trainers noted that because parents were so exhausted, they needed to find other community volunteers (often youth) who could play with the children and help them express themselves, and that the children clearly ‘needed and wanted’ this.

c. Was the approach utilized appropriate to the context?

In West Timor, the project was a comprehensive community-focused project, which worked to strengthen the capacity of the key support mechanisms of the children to provide psychosocial assistance to the children. In different phases, the project provided training to teachers, counsellors and play facilitators. The teachers and play facilitators were to provide the first level of intervention (promotion) to ensure that a large number of children received basic psychosocial assistance. They would also identify children in need of additional assistance. The counsellors then provided a more in-depth intervention (prevention), including individual and group counselling, for the children experiencing more extensive psychosocial problems. This was an appropriate design as it provided for both basic psychosocial intervention for a large number of children, and more intensive assistance for the more limited number of children needing it. In addition, as all the activities were situated at the school, it was easy to ensure an appropriate referral system between these two mechanisms. Having different actors providing psychosocial support also increases the likelihood that all children received some type of assistance. For those children who received multiple forms of assistance (e.g. a session with their teacher, and participation in a play-group session) having multiple actors providing psychosocial assistance increased the likelihood of that the activities will have a positive impact on the child’s psychosocial wellbeing.

Another advantage of this design is that it aimed to strengthening the children’s support network, through training of teachers already working in the camps, most of whom were IDPs themselves. The training of play facilitators can also be seen as helping to strengthen the community support

⁹ Interview with participant of youth volunteer project.

networks for children, as these facilitators were living and working in the host communities where the IDPs settled¹⁰. This approach was appropriate in this situation for a number of reasons. First, it was an effective way to provide large numbers of children with basic psychosocial support. Secondly, a strong support system is one of the most important factors predicting children's resilience in times of violent conflict – that is, children who have strong support networks are more likely to be able to overcome adversity. Third, challenging psychosocial support through existing community mechanisms helps to 'normalise' children's life – that is, if children are getting psychosocial assistance as part of their everyday activities such as school or play by people they know and trust, these activities will not be seen as another 'strange' or new thing in their life. Ensuring that children have routines and stable relationships is an important goal in psychosocial programming, particularly with IDPs. Fourth, this approach strengthens community solidarity and self-reliance, and builds the capacity of the community appropriately care for their children. In turn this creates an environment that is more conducive for children's psychosocial healing and development.

One strength of the design of this project was that it addressed parents and other care-givers. Given the emotional importance of parents to children, and the more individual attention that parents give to their children, it is essential that they are involved in any community-based psychosocial programme. As was to be expected, parents were having many problems, and that this was affecting their children's academic and psychosocial status¹¹. In this project, posters were designed for care-givers to help them deal with their own difficulties and to help them understand their children's reactions and how to deal with them. Counsellors conducted some support groups for women and community meetings for parents to help them to be able to care for their children's psychosocial needs more effectively. Parents were involved and invited to the recreational psychosocial activities for their children.

This project also focused on the concept of child resiliency. It was stressed that children and helpers were resilient – that is, most are able to find ways to deal with and overcome difficult circumstances. The role of psychosocial helpers is to support this process, and give additional assistance to those children and families who are having particular difficulties to cope with their situation. The trainees stressed that this was a very empowering approach for them, as it helped them to see themselves as strong and resourceful in the face of adversity. It also helped them to see and treat the children as active and capable of developing solutions to their problems.¹² Thus, framing this project in terms of strengthening children's resiliency was important, as it built the self-esteem and moral of the helpers, and helped "children to be active agents in rebuilding communities and a positive future"¹³.

A further strength of the design of this project was that the post-training activities were incorporated in the initial design. In the trainings, the participants designed their activities in cooperation with the trainers and UNICEF, so that it was clear what they would actually do. In addition, on-going meetings with the teachers and counsellors were included in the design for the purposes of further professional development for the trainees, and monitoring activity implementation. Supplies were also included

¹⁰ The counsellors were not living in the IDP camps, and generally they were not living in the host communities close to the camps. Therefore they were not part of the existing support network for the children.

¹¹ See for instance, Promoting Child Protection and Recovery through Training in Psychosocial Rehabilitation, Mission Report, Dr. Alleza and Ms. Lourdes, February 2000, p.10.

¹² Ibid.

¹³ Technical Notes: Special Considerations for Programming in Unstable Situations. Chapter 14: Protecting Psychosocial Development, p. 1.

and distributed to allow the counsellors and teachers to effectively implement the activities. While there were some problems in the implementation of the designed activities, the follow-up meetings with the trainees allowed the psychosocial activities to be adjusted as necessary. The fact that UNICEF staff were constantly in the field, monitoring and following up activities was an extremely important factor in the successful implementation of field activities. From the reports, it is clear that this presence was *essential* to help overcome the many problems and obstacles that the trainees faced in implementing the psychosocial activities, and that without this field presence by UNICEF few activities in the field could have been accomplished.

The training of the youth volunteers and NGO community workers was not originally part of this project. This appears to be because when the project was designed UNICEF was not aware that these organizations existed, or they did not think about utilizing youth volunteers. Given that this was the first emergency psychosocial project conducted by UNICEF, it was inevitable that new possibilities for psychosocial interventions develop through the course of the project. Including the training of youth and community workers in the psychosocial programme as this opportunity arose was an excellent example of flexible and responsive psychosocial programming.

However, it does appear that there were some problems in the distribution of responsibilities among the trainees. As described below, teachers had some difficulties to identify cases to be referred to counsellors, and were not very active in conducting activities after school, and the teachers had some difficulties to have children accept to talk, particularly in individual sessions and to access the beneficiaries. In hindsight, it may have been useful to design the psychosocial interventions as follows:

- a. Teachers conduct basic psychosocial activities during school hours
- b. Youth facilitators conduct basic psychosocial activities after school hours
- c. Counsellors support and advise teachers and youth facilitators, and conduct community meetings with parents, and support groups with children.

In terms of timing, it would have been more logical to focus first on teachers and youth facilitators, after which the counsellors could have been trained and intervened (rather than leaving the training of the youth facilitators to last).

Another weakness of the design of this project was that there was only limited involvement of children apart from as beneficiaries. Adolescent children were utilized to conduct some of the play activities, but children were not involved in the assessment for this project, nor in any aspect of the design or management of the project. It does require time and expertise to be able to provide children with the skills and opportunity to make a meaningful contribution as providers or designers of psychosocial activities. As such, given the very limited capacities in psychosocial programming in West Timor, it is understandable that children's role in this project was limited. However, key UNICEF staff felt that this was one area of the project that they should have given more attention to. In addition, this is a key principle of UNICEF programming when working with children in especially difficult circumstances¹⁴ and as such must be given due attention in future psychosocial programming.

¹⁴ United Nations Economic and Social Council (1995) 'A Review of UNICEF Policies and Strategies on Child Protection', UNICEF Executive Board Annual Session June 1996 Item E/ICRF/1995/13. See also Technical Notes: Special Considerations for Programming in Unstable Situations. Chapter 14: Protecting Psychosocial Development.

It is unclear the degree to which an evaluation protocol was clearly articulated within the design of this project. Certainly, there is a significant amount of documentation relating to project evaluation. The high field presence by UNICEF staff, and the trainers, and associated reports did provide strong project monitoring and evaluation. The trainers did conduct an impact assessment, which focused primarily on the impact of the training on the teachers and counsellors. However, there appeared to be a lack of systematic evaluation, so some important issues are not addressed in these evaluation reports – for instance, how many children actually benefited from these activities? What was the actual impact of these activities on the children? It is understandable that such a protocol was not developed given the highly volatile context, and the urgency to implement the activities. However, future psychosocial projects should more clearly articulate their evaluation framework/protocol as part of the project design and where possible include an assessment of the impact of the project on the primary beneficiaries – that is, the children.

The design of this project did not aim for long-term sustainability. Rather the aim was to provide short-term emergency psychosocial support to a displaced population. However, by working to strengthen the resilience of children and to build the skills of the community to provide psychosocial support to children, the project did aim to provide the beneficiaries with skills that they can use throughout their life to deal with difficult situations. The project did aim to have camp members conduct recreational activities for the children largely independently of UNICEF after some time¹⁵. While there was some capacity building for local organizations later in the project, such as the church and local NGOs, this was not a *primary* focus of the project. This level of sustainability was appropriate given the transient nature of the IDPs in West Timor.

The design of the Jakarta training, and subsequent trainings in East and Central Java and North Sumatra, were not as comprehensive in the West Timor project. There was not the model of two levels of intervention – teachers, parents, youth providing initial basic psychosocial assistance, and then counsellors providing the more advanced ‘counselling’ for children and families requiring it. Rather, most interventions conducted after the training focused on one of these two levels, more commonly the first.

This part of the project did adopt the same general orientation, which is to focus on building social support for children, and strengthening their resilience through play activities. This was the main positive aspect of the design of this stage of the project. Again, the designs did not involve children, and evaluation was a core part of the design, but was lacking a clear framework.

In the Jakarta training there was no follow-up activities, or support for implementation of activities. The lack of material support for activity implementation could be considered a positive element of this project, since if it was deliberately designed in this to encourage the organisations to support activity implementation themselves, hence making the project more sustainable. While it appears that this was the logic behind this decision, in some cases it was difficult for trainees to implement without material support. In addition, there was certainly a need for follow-up monitoring and professional support to the trainees when they were implementing the project. For the follow-up psychosocial trainings the original design included structured follow-up and support for activity implementation and evaluation. It should be noted that all of these trainings were remarkably sustainable, as many of the trainees still

¹⁵ See Psychosocial Activities, Progress Report, Ali Aulia, UNICEF Consultant, July 2000.

used the skills they learnt in these trainings, and many psychosocial activities using these skills without support from UNICEF for activity implementation.

d. Did the activities that were conducted meet the objectives of the projects?

Overall, the process of assessing the needs of the beneficiaries and the subsequent designing of the project appeared to be good, primarily because the assessment was in-depth and field-based. The joint education-psychosocial project was proposed in response to an initial assessment of the needs of the IDP children by UNICEF. A feasibility study was conducted involving field visits and consultations with relevant local government institutions in NTT and local church organizations in Belu District¹⁶. A detailed training needs assessment was also conducted by the training team (2 trainers from Philippines and 2 from Jakarta) for two weeks. For the second batch of teacher training, logistical problems prevented a comprehensive training needs assessment. As noted above, one main problem in the design process and needs assessment was that children and parents were not consulted. According to the CFSI final report, this was because of language problems (i.e. translators could not speak the language of the children). Given that this was the case, more attention could have been paid to assessing the needs of the children before the second round of teacher trainings. Another problem was that more attention should have been given in the assessment to the capacities of the available service providers, including the skill level of the trainees and their coverage of the beneficiaries. The assessment should also have addressed the resources and coping mechanisms of the community more fully¹⁷. However, it should be noted that in general such oversights are to be expected given the innovative nature of such work in West Timor and when working in such a volatile environment. They are best considered lessons to be incorporated into future programming.

The criteria for selection of the teachers was that they should have training in active learning and be available to participate in the training. These are appropriate basic requirements given the limited capacity of the teachers. The selection criteria for counsellors and the participants in the Jakarta training were not clear from the project documents. However, the documents do indicate that the selection criteria for the Jakarta training participants was perhaps too high. One criteria that could have been given more weight in both the counsellor and Jakarta training was the ability to implement psychosocial work with children – this includes both appropriate individual skills and experience working with children (which appeared to be a criteria utilized in this project), but also an institutional commitment and capacity to implement psychosocial programmes (which did not appear to be a criteria in this project).

Overall, the training topics appeared to be very appropriate in this project. As noted above, all the trainings addressed: psychosocial needs of children, the effects of stress and trauma on children including children's resilience, how to identify children with psychosocial problems, and how to help children with psychosocial problems through play. Each training ended with the participants developing an outline of their plan of action to implement psychosocial activities. The style of training was very good as it was participatory and elicitive, drawing first on participants own experiences, then identifying common lessons learnt from these experiences, and concluding with a small lecture about general principles on the issue. The trainers used Structured Learning Exercises,

¹⁶ See Emergency Education and Psychosocial Support Programmes for Children of Internally Displaced People in West Timor, Field Trip Report, March 5-9, Jiyono Education Officer, UNICEF

¹⁷ See Monthly Report, Ali Aulia, UNICEF Consultant, 1-31 March 2000.

lecturette, group discussion and role-playing. Participants were guided to reflect on their own experiences, and learn from these and the experience of the trainers. There was an appropriate balance between positive and negative aspects of their experience and knowledge. The main problem was that the trainings were largely focused on changing the trainees' attitudes and knowledge, and not enough attention was given to skills development and practical techniques to use with children. While the level of the training was at times, too advanced for the trainees, the trainers were very flexible in adjusting the content and style of the training to be more appropriate.

The initial 3-day training for teachers focused on the following topics:

- a. Processing of the teachers own difficult experiences, and lessons learnt; stress and coping;
- b. Understanding own childhood and decision to become a helper; children's needs; camp children's reactions and problems; effects of stress on children, and children's coping
- c. How to identify signs of stress in children; normalizing children's reactions (i.e. normal reactions to abnormal situation); referral; use of activities for children's expression.

Given the difficult experiences that these teachers were experiencing, starting with processing of the teachers experiences was extremely important. As noted above, in this training more attention could have been given to how the teachers can deal with particular behavioural problems and techniques to support children, and less on self-reflection.

The second training for teachers (over 5 days) addressed the above issues, and added the following topics: self-awareness; psychosocial issues among unaccompanied children; grieving process in children; interviewing children; stages of Disaster and Crisis. While these topics are important, it is not possible to know whether the additional 2 days had a significant impact on the teachers' abilities to provide psychosocial assistance to the children. A number of follow-up meetings were conducted for the teachers, but these were not very well attended, and field visits to the field were regularly conducted by UNICEF staff. These were important opportunities to monitor progress on activities.

Training for counsellors focused on the following issues:

- a. Day 1- introductions and expectations
- b. Day 2 - reflection on own experiences working with children (positive and negative); basics of psychosocial help, including importance of knowing oneself, stress and coping; understanding self as caregiver;
- c. Day 3 - Participants' experience of childhood; developmental tasks; participants understanding of childhood; CRC, resiliency and children's needs;
- d. Day 4 - emotional reactions of children in camp; effects of stress on children and families; counselling process and basic counselling techniques; practicing counselling process;
- e. Day 5 - communication, grief, techniques for intervening with children; participants' skills in coping with stress; planning field activities.

Overall, these topics are all appropriate and necessary, and they formed a logical, coherent sequence. The only change would be to have spent less time on general issues, especially introductions and knowing oneself, and more on intervening skills.

The training of the play facilitators was only 1 day, and was therefore too short to allow them to do more than conduct recreational activities with the children. The trainers were participants in the Jakarta training from West Timor.

The trainers appeared to be very well qualified, judging by the quality of the training provided. The design was very good and consistent with UNICEF's policies and approach (see below), and they were flexible in response to the needs and capabilities of the participants. In retrospect, it would have been better to have a translator who spoke Bahasa Tetun as well as Bahasa Indonesia, as many of the participants could not speak Bahasa Indonesia, particularly the colloquial version used by the translators.

For the counsellors, there were regular follow-up meetings every 2 weeks with UNICEF staff. This was an extremely important opportunity to provide additional guidance to the counsellors, adjust activities as necessary and monitor the progress of the activity implementation. Thus, the project provided good opportunities for practice of the skills, with appropriate professional support. This was one of the most important strengths of this project. The only suggestion for improvement would be to have included an additional 5-day training, focusing primarily on play counselling skills practice. This seemed necessary given the limited skills of the trainees, and the fact that they were meant to provide counselling¹⁸. The counsellors suggested a number of different topics that could be included in the training¹⁹, the most important of which included processing of children's activities; and helping children to express their feelings/problems.

The activities to be conducted after the training were designed partly in the training and partly afterward. While in the West Timor trainings, there was good follow-up to ensure that the activities were appropriate to the needs of the beneficiaries, the main problem in the Jakarta training was that there was no such follow-up. Originally, in West Timor teachers were to conduct play activities, and identify and refer children needing additional assistance to counsellors to conduct individual counselling. When this did not work, as the teachers were unable to identify children to be referred, and individual counselling was found to be inappropriate, the activities were redesigned. Teachers continued to conduct recreational and expressional activities in the schools, while counsellors conducted these activities after school, and after some time (and experience) moved to more typical 'counselling activities', such as support groups and community meetings. Posters were also developed with appropriate content for parents (how to identify psychosocial problems, how to help children and how to deal with own stress)²⁰.

For Phase II, the participants were to be drawn from academe, technocrats and their field. The selection criteria was designed by the trainers, CFSI/UP-CIDS and sent to KOMNASPA as the implementing partners. The initial criteria for participant selection was experience working with children, access to children affected by conflict, and basic counselling skills. The major problem with this was that there was no discussion with the Indonesian partners about whether these criteria were relevant or not (as noted before, they were perhaps unrealistic). KOMNASPA then selected the participants, and for needs assessment, sent them a questionnaire. This questionnaire was designed by the trainers to assess the training needs of the participants, and allow them to design the project. The needs assessment was conducted in this way as the trainees were from various conflict zones

¹⁸ In contradiction to the assessment of UNICEF staff at that time, the less experience the 'counsellors' had in conducting psychosocial activities, the more important it was to provide them with additional training - See Promoting Child Protection and Recovery through Training in Psychosocial Rehabilitation, Report and Evaluation, CSFI, p.14.

¹⁹ Promoting Child Protection and Recovery through Training in Psychosocial Rehabilitation, Mission Report, Dr. Alleza and Ms. Lourdes, February 2000, p. 11.

²⁰ Monthly report, Ali Aulia, UNICEF consultant, March 31, 2000.

throughout Indonesia. This method of needs assessment seemed sufficient given that this was the second phase of the project. One question that remains unclear is whether there was a need for more information about the specific needs of regions other than West Timor – in the final evaluation, some of the participants mentioned that they felt that too much attention was paid to the problems in West Timor.

The training was conducted over 10 days, and addressed the following 7 topics:

- Getting Started
- Understanding the self
- Understanding the context of children in Indonesia
- Understanding children
- Understanding psychosocial help
- Back home application and evaluation

The approach was similar to the West Timor trainings, focusing on resilience, building community support for children, and using play to address psychosocial needs. It was elicitive and participatory. As with the West Timor trainings, these topics were logical, and generally appropriate for the participants needs. As this was a longer training, more attention was paid to skills building, particularly in the section, ‘understanding psychosocial help’. The only recommendation was that, as this was the first psychosocial training for helpers in conflict zones, more attention should have been given to basic topics²¹, although what topics this would include was not specified. Perhaps more attention could have been given to the effects of armed conflict on children and their families, reactions to stress, the difference between stress and trauma, sources of resilience etc.

The trainers for the Jakarta training were the same as those for the West Timor training, and therefore were very good. The follow-up trainings were conducted by trainers who had all participated in the Jakarta training. These trainers were rated overall as very good, as they used participatory, elicitive approaches. However, some of the trainers were better than others, and some participants stated that there needed to be more participation from trainees.

e. Was the approach utilized consistent with UNICEF policies and practices?

The main UNICEF policies and practices and their relation to this project are outlined below.

a. Provision of psychosocial support as a child’s right, especially in emergency situations. UNICEF considers psychosocial support as a core element of its responses to emergencies.

b. Programme decisions and priorities must derive from a situation analysis on the ground²². This policy was clearly fulfilled, as described above.

c. Children should have an active role in designing and implementing programmes. As noted above, the lack of involvement of children in the design of this project, and their limited role in its implementation was one of the main problems of this project.

d. Children’s resilience should be valued. This project had as its major focus the strengthening of children’s resilience.

²¹ Promoting Child Protection and Recovery through Training in Psychosocial Rehabilitation, A Report and Evaluation on the collaboration between UNICEF, CFSI and UP/CIDS-PST.

²² United Nations Economic and Security Council (1995), A Review of UNICEF Policies and Strategies on Child Protection, UNICEF Executive Board Annual Session June 1996 Item E/ICRF/1995/13, item (b)

e. **Promoting community-based support networks for children.** As noted above, this project did strengthen community support networks for children, particularly their educational support networks. Attempts were made to strengthen familiar support, but more work could have been done in this respect.

f. **Focus on healing, including normalizing life.** This project, and the associated educational project did work to normalize children's life by providing educational and recreational structure in their life. However, much of the activities were limited to expressional activities, and did not take children through a 'healing process' to help build their skills to overcome their problems.

IMPACT

a. What beneficiaries were reached by this project?

In West Timor, it is estimated that between 2400 - 5000 children in 30 camp schools benefited from the activities conducted by the teachers. Approximately 1000 children benefited from the more in-depth psychosocial activities conducted by the counsellors and approximately 4000 – 6000 participated in recreational activities conducted by youth facilitators. Approximately 4000-8000 parents benefited from the posters, and approximately 500 participated in community psychosocial meetings or support groups. The total number of beneficiaries was therefore between 11,900-20,500 and the project primarily benefited children under 13, but some adolescents also benefited, particularly later in the project.

Approximately 22,930 children in other conflict areas benefited from recreational and/or expressional activities through Phase II. Approximately 10,000 were from East Java, 6000 from Madura, 3000 from Central Kalimantan, 3500 from Maluku, 350 from Aceh/North Sumatra and 80 from Sulawesi. It should be noted that because there was only 2 participants from Aceh, and two from North Maluku very few activities were conducted there. Future projects should attempt to involve more trainees from these two regions, and to try to ensure more activities are conducted in Sulawesi.

The majority of beneficiaries were from 9-17 years old. 130 were street (not IDP) children, while the rest were IDP or conflict affected children. An estimated 1000 parents benefited from activities in East Java.

In total, it is estimated that 19% of the targeted beneficiaries were reached by this project. At this time there were 1.3 million IDPs, of which 520,000 are children, of which estimated 30% in need of psychosocial activities, which means 156,000 targeted beneficiaries. This project reached approximately 30,000 children.

b. What was the impact on the trainees?

In West Timor, 33 teachers received 5 days training and 50 received 5 days training. 23 counsellors received 5 days training. The teachers and counsellors were very active in the training²³. These trainings affected the teachers and counsellors knowledge and attitudes, and gave them a limited number of skills in dealing with children's psychosocial problems. The effect of the training on teachers included that they: were more confident in dealing with children and parents, and more

²³ Promoting Children Protection and Recovery Through Training in Psychosocial Rehabilitation, Mission Report, CFSI, December 1999.

motivated and positive about their contribution; enjoyed their work more; understood the children more and felt closer to them; more able to deal with stress; see the children as active learners and able to cope with the situation. Effect on counsellors included: see children as capable and able to overcome their problems; self-esteem of the counsellors improved; awareness of children's rights and motivation to work for them. As stated in the final report "the counsellors indicated that the training helped them a lot in understanding their own stress and their manner of coping with it, the fun and joy they experienced in doing their work with the children, and the liberating discovery of their courage, bravery and confidence in [spite of] the odds that they were encountering with their work"²⁴. Teachers and counsellors generally very satisfied with the training, and the topics addressed, broadly speaking, met their expectations.

The main problem was that many of the teachers and counsellors had difficulties to absorb and understand the training, as they lacked the basic training and experience²⁵. The trainers adapted the materials, but this meant that the training focused even more on basic knowledge and attitudes, and less on skills building. As a result, after the training, the teachers and counsellors lacked some of the basic skills to actually provide psychosocial assistance.

60 youth volunteers participated in the provision of psychosocial assistance to children. While the training was too short (1 day) to have a significant impact on the trainees, the experience of conducting activities with the children was for many, a significant one. The volunteers felt both empowered and moved by the experience, although at times overwhelmed by the injustice, oppression and violence the children had experienced.

In the Jakarta training, 23 mental health professionals and para-professionals participated in 10 days training. In this training, there was more of a change in the participants' skills, as well as their attitudes and knowledge. Key effects of the training on participants included: that non-mental health specialists can help children; knowledge about how to help parents support children; awareness of children as under 18; how to use play and expressional activities to build rapport and help children open-up.

These trainings appear to be the key training that many of participants received and that provided them with the basic skills to conduct psychosocial activities with children. For instance, the psychosocial training in Jakarta was the key training for 2-3 of the staff of Crisis Centre at the University of Airlangga, who have subsequently conducted large numbers of psychosocial trainings and activities, in Surabaya, but also in Madura with IDPs and in Sampit. Until now, they continue to use an adapted version of the material that was provided in this training.

c. What were the number and quality of the activities conducted with the beneficiaries?

In Phase I, the teachers and counsellors both focused initially on recreational activities, because as noted above, their skills of working with the children were limited. The teachers conducted activities with the children primarily during class time because they were generally not motivated, or not available to conduct activities out of school hours. Primarily they provided more 'joyous' or 'fun'

²⁴ Promoting Child Protection and Recovery through Training in Psychosocial Rehabilitation, Mission Report, Dr. Alleza and Ms. Lourdes, February 2000, p. 9.

²⁵ Monthly report, Fitri Fausiah, UNICEF consultant, June 10 2000.

time in their classes, and more opportunities for expression. A small number of teachers did conduct activities after school, including parents meetings and recreational activities. Some did not use the training at all²⁶. Their own difficult circumstances limited the level of energy and enthusiasm which they had to intervene with the children after school. The teachers generally did not identify children to refer to the counsellors – it seemed that they were unable to do so because they lacked the basic knowledge²⁷, and/or the definition of the type of problems that the counsellors should deal with was too narrow²⁸.

Counsellors conducted primarily group activities with children, rather than individual counselling as was originally planned, partly because teachers referred so few children to the. Other reasons for this included that it was easier to establish trust and rapport with the children in groups than individually, and because the teachers generally did not conduct the extracurricular group activities as planned, the counsellors had to conduct these activities. At the beginning of the project, posters were distributed to camps to help parents in dealing with their own stress, recognise problem behaviours in their children and know how to deal with these problems. Apart from this, counsellors conducted primarily recreational activities at the beginning of the project (for instance, as of March 2000, almost no counselling activities had been conducted), but as some of the counsellors became more skilled, they moved onto conducting more expressional activities with the children. However, when the trainers did their field visits in mid 2000, they still noted that the counsellors did not adequately process the activities with the children. The counsellors would encourage the children to draw or tell a story, but did not try to draw lessons about of their experience or try to find ways to deal more effectively with these issues. In short there was insufficient focus on building the skills of the children. Around mid 2000, as they became more skilled, some counsellors did start conducting activities such as support groups (these were conducted in 4 camps out of the original 10)²⁹, and community meetings with parents. They also began going more community-based activities³⁰, such as activating members of the community (primarily women and youth) to do activities for their children in the camp. This was a very positive approach, as it served to rebuild community structures, as well as providing assistance for the children. By the end of the project some of the counsellors were conducting counselling in the strict sense of the word, while others were still only able to conduct recreational activities³¹. The long and difficult travel to the camps reduced the number of hours that counsellors had available to conduct activities in the camps. There was also a big variation in how active the counsellors were – some worked full-time, while others did not do any activities, or only worked once/week for 2 hours³², often as a result of having other commitments.

The play facilitators were very active, conducting primarily recreational activities and expressional activities, such as playing, reading, drawing etc. in 17 locations throughout West Timor. The play

²⁶ Monthly report, Ali Aulia, UNICEF consultant, March 31, 2000.

²⁷ Emergency Education and Psychosocial Support Programmes for Children of Internally Displaced People in West Timor, Field Trip Report, March 5-9, Jiyono Education Officer, UNICEF

²⁸ Given the level of violence which the children were exposed to and the difficult circumstances in which they lived it is very unlikely that there were almost no children suffering psychological or social problems that would have benefited from counselling, which was suggested as one possible reason for teachers not referring children to the counsellors in the evaluations of this project.

²⁹ Monthly report, Ali Aulia, UNICEF consultant, March 31, 2000.

³⁰ Ibid.

³¹ Ibid.

³² Monthly report, Fitri Fausiah, UNICEF consultant, June 10 2000.

facilitators were from these areas, so this helped them to be able to conduct more activities as they did not have long travel times. The volunteers also tried to deal with the traumatic experiences of the children by initially listening to them and empathising with them. However, the play facilitators quickly felt that they should try to ‘make the children’ forget their experiences, and when the children began talking about their problems they would try to distract them with an activity or tell them not to worry. While this is an understandable sentiment, it was clear that the volunteers lacked the skills to help the children really overcome these problems – they noted that the children repeatedly wanted to talk about these events, and continued to have flashbacks. A longer training or a manual of structured play activities to build the children’s skills would have helped them to be able to conduct more meaningful activities. They were also hampered by insufficient supplies to conduct these activities, including some requested supplies that did not arrive. None-the-less, the benefit of the activities to help the children have fun should not be underestimated – they provided a much needed sense of normalcy and structure, as well as a sense of being cared for and listened to, for the children.

All these activities focused initially primarily on children under 12. The schools were for children under 13, and it was difficult for the counsellors to get adolescents to participate in psychosocial activities – perhaps because they were usually play-based. None-the-less over time in some camps that counsellors did manage to conduct support groups for adolescents and to get them involved in conducting recreational activities for younger children. In situations of armed conflict adolescents are particularly vulnerable to such effects as undermined value-systems, risky behaviour (drugs, participation in the conflict), problems in their social relations and/or self-esteem. Because adolescence is such a crucial stage of development and because the implications of such behaviours can be difficult to ‘undo’, such effects are often long-lasting and particularly difficult to overcome. As such there is a need to pay particular attention to adolescents in future psychosocial programming.

In Phase II, many trainees conducted recreational activities with the children. Others conducted expressional activities through play. A number also conducted activities to ‘normalise’ children’s lives, such as vocational training or skills building projects – for instance, projects to help children learn how to concentrate or relax. *Need more detail here.* In contrast to Phase I, the majority of beneficiaries were adolescents. It is not clear from the interviews how participants were able to involve so many adolescents, but it is certainly a strength of this phase of the project.

In Madura, the psychosocial training programme in both Jakarta, followed up by the training conducted in Surabaya for care-givers from Madura, did appear to have a significant impact. After the training in East Java, despite financial problems (see below), at least two of the trainees did conduct activities with significant numbers of children, and other trainees conducted activities in their neighbourhoods – it is estimated that between 300-400 children benefited from these activities. It appeared that these activities were primarily recreational/expressional with limited focus on skill building. The University of Airlangga, with support from the Ministry of Education and in cooperation with NU, are continuing to conduct psychosocial activities with the Madurese IDPs until now.

**Lessons Learnt:
Creatively Strengthening Children's Social Support**

The priority in psychosocial interventions should be to strengthen the children's existing social network, such as teachers and parents. However, it should be noted that there are limitations on what can be expected of such caregivers. In situations of armed conflict, the children's primary caregivers are often themselves exhausted and overwhelmed. Interventions which focus on ask parents or teachers to provide additional support to children, without addressing at the same time *their* psychosocial needs, may serve to add pressure to already overburdened adults, and serve little benefit to the children.

In situations of armed conflict, projects should:

1. Ensure primary care-givers are given adequate psychosocial support, to help them support children;
2. Set realistic expectations for what care-givers can be expected to do – for example, don't ask already overburdened teachers to be responsible for after school activities;
3. Strengthen other forms of social support for children – for instance, adolescents or youth can often provide excellent support for children if given the skills and opportunity to do so. Counselors or adults from surrounding areas that have been less exposed to violence can also serve as important social support for children and/or their parents.

d. What was the impact on the beneficiaries?

In Phase I of the project, the project documents indicate that the psychosocial activities helped children overcome some of their fears, and to be happier and more animated. It also helped build relations between children in the camp, and helped children to be less withdrawn and depressed. Prior to the psychosocial activities, the children tended to play only with the children in their immediate living area and were afraid to venture further. The psychosocial activities helped them to meet and make friends with children in other areas, and build a sense of community for the children. In their follow-up visit, the trainers noted that children in schools without psychosocial activities looked 'sad, silent, hopeless, and tired', while those in schools with psychosocial activities looked happier and more active. These activities, particularly when they were conducted with the active cooperation of members of the camp, helped to 'enliven' the camp and make it more of a community. As noted above, these activities did little to address children's trauma – rather it helped to address some of the other sources of psychosocial distress, such as sense of dislocation, lack of daily structure and 'normal' activities, parental distress. In addition, it must be noted that other environmental factors, such as poor camp conditions, ongoing tensions within the camp and between IDPs and locals, and uncertainty about the future were not able to be addressed in this project, and would have had a significant negative impact on children's psychosocial status. As it was not possible to meet the beneficiaries it is not possible to assess the *level* of impact that the psychosocial programme made on the children, but it is possible to conclude that it had a positive impact.

In Madura, according to trainees the psychosocial programme helped children to overcome their fears, to be calmer, less withdrawn and depressed and more cooperative. Trainees also reported that children who participated in psychosocial interventions had more positive outcomes on these issues than those

who did not. According to University of Airlangga research, the psychosocial work with the IDPs has significantly reduced the levels of depression and anxiety, but levels of PTSD continue to be high. In group discussions with adolescents they stated that issues such as grief and difficulties adjusting to the host community continue to be a problem for them. In addition, the results of the psychosocial questionnaires completed by the adolescents indicate that they still have high levels of psychosocial distress, comparable to that reported by adolescents living in high conflict zones in Aceh, and who have not received any psychosocial interventions. Thus, we can conclude that psychosocial programmes did help children to overcome acute depression and anxiety, but that other psychosocial problems continue to be evident.

It was found that children who participated in psychosocial activities had a lasting (at least one year) significantly better psychosocial outcome than those who did not have any psychosocial assistance (see Table 1), when including adolescents who had experienced significant levels of conflict in Aceh, Madura and Ambon. Benefits included that children were more able to make up their mind, were less scared, hyperactive, and regressive, had fewer psychosomatic problems, more likely to listen to and respect their parents and get along with their siblings. However, they were more moody and, more seriously, more likely to engage in risky behaviours such as drinking. This finding needs to be confirmed in other research but certainly raises questions about the relationship between healing and protection of adolescents in armed conflicts. The difference between psychosocial participants and non-psychosocial participants was even greater when comparing within an area – for instance, children in the same school in Ambon (see Table 1).

Table 1: Comparison of the psychosocial outcomes of adolescents who participated in Psychosocial Activities and those who did not participate in any activities

Item	Mean – no activity	Mean – psychosocial	Significance – psychosocial compared to no activity
Total (Aceh, Ambon and Madura)	1.81	1.75	0.00
Q6 Irrationally scared	2.43	1.76	0.00
Q10 Psychosomatic	2.38	1.87	0.00
Q12 Regression	1.53	1.15	0.00
Q13 Hyperactive	2.25	1.90	0.00
Q14 Not listening to parents	1.48	1.28	0.02
Q23 Not getting along with siblings	1.68	1.44	0.02
Q25 Moody	1.90	2.12	0.05
Q34 Uncontrollably scared	1.49	1.30	0.04
Q35 Risk taking	1.22	1.44	0.04
Q37 Difficulties to make up their mind	1.59	1.86	0.01
Total (only Ambon)	1.79	1.63	0.00

e. Where there any indirect effects on beneficiaries or other agencies?

The UNICEF training appeared to provide the framework for much of the psychosocial work that has been done in Indonesia, as it was one of the first training that many of these trainees received. Many of them are or have subsequently become psychosocial trainers. The psychosocial project has therefore had a ripple effect. It has helped to ensure a community orientation to the interventions - that is, that the programmes work with children, parents, teachers and community leaders to strengthen the capacities of the children to deal with their problems, and strengthen the children's support networks to assist in this task. While the UNICEF psychosocial project is not exclusively responsible for this orientation, as the first psychosocial training for working with children affected by armed conflict, it did play a major role.

IMPLEMENTATION

a. Was the project implemented as designed?

In West Timor, the project design was altered throughout the project to ensure effective implementation. As the UNICEF staff were present in the field to organise and guide this process, the adjustments made allowed for much more appropriate activity implementation than the initial design. Such adjustments are essential when working in a highly volatile situation such as that of IDPs in conflict zones.

In this project, the major problem faced in implementation was the very limited local capacity in this area. None of the partners had experience working with non-formal education beyond recreational activities, so the entire psychosocial approach was new for all partners. While this perhaps should have been identified more clearly in the initial assessment, the team responded logically and responsibly to this constraint – that is, by making changes to project activities, starting with simple activities and moving to more difficult ones, moving from individual to group based activities etc. An associated problem was that the selection of counsellors was problematic – some were too young, had insufficient experience, were not committed, had no opportunities to use the skills, or their participation in the project was not fully supported by their organization³³. This was largely because of the urgency of the project. One possible solution to this would have been to implement training of youth volunteers – who do not require as careful selection – first, giving more time to select counsellors.

Other problems included difficulties of coordination among counterparts, teachers, counsellors and youth facilitators³⁴. Among the IDP community and relief community there was also an initial scepticism towards the importance of psychosocial activities for their children and themselves. Other constraints on the project included: security and political tensions; language problems; difficulties with transportation; urgency of the project; high mobility and transient nature of the population. The low attendance of children at school (at times, around 50%), meant it was difficult to administer psychosocial programmes only through the schools. CSFI had difficulty conducting an in-depth impact evaluation because of the mobility of the population, the lack of security in some areas, and the limited commitment of the teachers and counsellors to the evaluation process. Overall, through

³³ Promoting Children Protection and Recovery Through Training in Psychosocial Rehabilitation, Mission Report, CSFI, December 1999.

³⁴ Monthly report, UNICEF consultant, June 10 2000

perseverance and flexibility, the project team was able to adjust the project to ensure maximum impact under the circumstances.

For Phase II, the selection of trainees was again problematic. The participants did not meet the selection criteria established by the trainers, so the training had to be adjusted upon arrival in Jakarta. This was perhaps partly due to the selection criteria being too high³⁵. It was also perhaps due to a lack of attention to detail by KOMNASPA. Also, Aceh was underrepresented in the training, with only 2 participants.

The involvement of many different organizations appeared to complicate project implementation. Particularly for the West Timor teacher and counsellor training, in which 6 organisations were involved, there were problems regarding roles, responsibilities and capabilities³⁶ - as the project needed to urgently implemented, the details of the roles of the different partners had to be worked out during implementation, an obviously less than ideal situation. However, efforts were made for the Jakarta Masters training to clarify these roles, meaning that the lessons learnt from the West Timor experience were applied in the Masters training.

There was an expectation that the local capacity of Indonesian partner organizations, particularly KOMNASPA and UI, would be built through their cooperation in these projects with CSFI and UP/CIDS-PST. For UI staff, their capacity to conduct psychosocial trainings was enhanced through this project. UI are now one of the most active organizations providing psychosocial trainings, and it appears that their participation in this project did help to further build their skills. There was an expectation that through the West Timor training, KOMNASPA staff would develop the capacity to organize and *conduct* psychosocial trainings. What happened was that by the end of the Masters training, KOMNASPA was able to organize psychosocial trainings, but not to conduct them. After the initial WT training, KOMNASPA was quite active to organize other psychosocial trainings, an important benefit of this project. However, given that KOMNASPA staff had little psychosocial qualifications or experience, it was in fact unrealistic to expect that they could conduct psychosocial trainings. The lesson to be learnt from this experience is that UNICEF should try to build the capacity of organizations that already have some experience or background in psychosocial work to conduct psychosocial trainings. To organize psychosocial activities, or to conduct basic psychosocial activities in the field, organizations do not necessarily need any psychosocial experience, but at minimum experience using active learning techniques with children.

UNICEF stopped providing financial and technical support to the East Java and Central Java trainings after the training and before activity implementation. None-the-less, UNICEF's project was the key factor in providing the trainees with the skills to implement the activities described above, and did contribute to a sustainable, if less than ideal process of psychosocial support to Madurese IDPs. However, it is also clear it was the commitment of other partners to support activities in the field after UNICEF discontinued the project that enabled *any* children to benefit from these skills. There was a strong sense of disappointment and an undercurrent of anger among the trainees. While the main cause for stopping the project appeared to be financial mismanagement on the part of the LPA, the question remains about whether UNICEF could have taken other steps to support activity

³⁵ Promoting Child Protection and Recovery Through Training in Psychosocial Rehabilitation, A Report and Evaluation between UNICEF, CSFI and UP/CIDS-PST.

³⁶ Ibid.

implementation, such as the direct supply of materials to the trainees. In East Java, the high number of implementing partners also led to problems in both financial and technical aspects of the project, and the subcontracting partners were not adequately informed about key aspects of the project, including why the project was discontinued.

The psychosocial project was largely discontinued, with the exception of the follow-up workshops with LPA, after the introduction of EMDR due to a lack of funds. This was unfortunately since the Jakarta training was an appropriately orientated, practical and efficient project. It also had the potential to be continued and expanded. The untimely discontinuation of this project was an opportunity wasted to build on the strong foundation established, and provide more effective psychosocial assistance to larger numbers of children.

b. Was the project efficient?

The project was efficient, as it cost approximately \$7.80/beneficiary. Given the need to built capacity, the high travel costs, and the fact that no activity implementation costs were involved in Phase II, this is a very reasonable cost per beneficiary. The project was also implemented in a timely manner, given the constraints.

c. Were the projects integrated with other UNICEF activities?

In Phase I, there was excellent integration with other projects, as the psychosocial activities were integrated into the educational services, and conducted along side health, and water and sanitation activities in the camps. They were later integrated into the activities of the child centres that were a part of the child protection activities later in the project.

In Phase II, the Jakarta training was not really integrated in other activities, but this was inevitable since the trainees were from all conflict zones throughout Indonesia. The follow-up projects were part of UNICEF's overall support to the Child Protection Bodies.

d. Were the project activities coordinated with other psychosocial programmes?

In Phase I, there appeared to be very few other psychosocial programmes at that time in West Timor. In the project documents, there are references to coordination with other agencies, including Save the Children, who were conducting psychosocial activities. This project was also conducted with KOMNASPA and the University of Indonesia. While there was an expectation that other agencies from Jakarta would participate, given the level of organisational complexity already present, it was probably for the best that only one other training organisation (UI) participated. Phase II was conducted with UI, and coordinated with other psychosocial providers, such as UA and the key child protection body, KOMNASPA. It is not possible to assess at this stage whether there were other actors with whom the psychosocial programme should have been more closely coordinated.

Project #2 – EMDR Project Evaluation DESIGN

a. Who were the beneficiaries?

This project was designed to provide assistance to children and families “traumatized by violence”³⁷. It focused on assisting the victims of armed conflict, rather than on victims of domestic or social violence. Thus the project aimed to provide treatment and rehabilitation services to people experiencing serious psychological distress. While not explicitly stated in programme documents, this is taken to mean those children and families who have not only been exposed to traumatic events, but who have also developed clinical psychological problems (such as those identified as PTSD) as a result of this violence. The project did not aim to provide assistance to children who had been exposed to violence, but were suffering less acute problems – for instance, children having difficulties to adjust to their new environment, or family tension resulting from stressful living conditions.

Why did the project focus on only the most distressed beneficiaries? It appears that this was a by-product of the a priori commitment to EMDR by some members of UNICEF senior management. In other words, rather than considering first what level of distress of beneficiaries UNICEF should focus on, and then looking for the most appropriate programme, a programme was identified (EMDR) and this dictated the level of distress of the beneficiaries. This is, of course, counter to the principle of UNICEF to design programmes based on an assessment of the needs on the ground. In addition, while programmes to address the most distressed beneficiaries appeared to have been needed, they would have been more effective if implemented as part of an entire package that also addresses the needs of beneficiaries experiencing psychosocial (non-clinical) problems. This approach reaches more beneficiaries, and serves to prevent psychosocial problems developing into clinical psychological problems.

b. Where the objectives of the projects relevant to the needs of the beneficiaries?

The EMDR project is primarily a technique to help children and families overcome the effects of exposure to ‘traumatic’ events – that is, events that are sudden and life threatening. Such effects include: intrusive recollection avoidance of the event; problems controlling one’s emotions; changes in self-perception (guilt, blame etc.); changes in perception of the perpetrator; changes in relationships (isolation, distrust); and changes in systems of meaning (e.g. undermining of value systems). It is particularly useful for the symptoms of PTSD, which are intrusive recollection, avoidance of the event (and/or emotional numbing), and anxiety.

The question is whether these problems were a priority for the beneficiaries. As in the psychosocial project, while parents tend to be focused on material needs, psychosocial issues are a concern to children, and to a lesser degree parents. As such, psychosocial programmes are, in general, relevant to the needs of the beneficiaries.

The main problem with EMDR is that it only addresses one cause of psychosocial problems – that is, the psychological problems resulting from exposure to a ‘traumatic’ event. Children living in conflict zones have psychosocial problems resulting from many other sources, including dislocation, loss of family member(s), disruption of community structures and values, an uncertain future and family stress

³⁷ Promoting Child Protection and Recovery Through Psychosocial Rehabilitation of Traumatized Children and Nonviolent Conflict Resolution Initiatives through Public and Private Schools in Aceh, Project Proposal, UNICEF, August 2000, p. 3.

and/or violence³⁸. The problems resulting from these causes may include those outlined above, as well as depression, risk-taking behaviour, problems in social relations, changes in identity and attachment to family and community, difficulties adjusting to new environment, low achievement in school, stress and anxiety about the future etc. In discussions with parents and children for many it was these types of problems, not exposure to traumatic events that were their highest priority. For instance, in focus group discussions with teenage IDPs in Madura, the symptoms of PTSD (intrusive, constrictive and hyperarousal symptoms) were not mentioned among their priorities. Rather their concerns included grief, economic issues, schooling, an uncertain future, family problems, fitting into a new society and homesickness. Adults working with IDP children focused also on problems of depression (often resulting from the issues outlined above), aggression, arousal, and the need for peacebuilding (tolerance, problem-solving, communication skills). However, it should be noted that some beneficiaries did identify traumatic events as a major source of stress, such as adult torture or rape survivors who were constantly confronted with the perpetrator³⁹. In conclusion, while psychosocial programmes should include how to deal with the effects of traumatic events, this should not be the only or even the primary focus on such programmes.

c. Was the approach utilized appropriate to the context?

The approach utilised was generally inappropriate for this context for both conceptual and practical reasons. The most basic practical reason is that the EMDR is an advanced therapy that, contrary to the claims of some experts, requires a basic understanding of psychological issues and skills in counselling children – at a minimum, trainees need to be able to identify whether the beneficiaries have problems that are appropriate for EMDR and they need to be able to establish rapport with the beneficiaries and conduct the EMDR sessions. Many of the paraprofessionals working in the field in conflict zones do not have these basic skills. Many of the participants stated that they needed basic skills, such as how to identify the psychosocial problems of children, how to conduct therapeutic play groups for children, or how to conduct support groups for parents. This was particularly true in Aceh, while in Ambon at least some of the participants had the counselling skills and opportunity to use EMDR with children. Put simply, there is limited capacity in Indonesia to effectively use EMDR for children in conflict zones⁴⁰. As such, is a need to provide basic skills in counselling before introducing a more advanced therapy such as EMDR.

Secondly, as noted above, EMDR is a trauma treatment therapy. Given the lack of basic counselling skills among the majority of the trainees, this means that often the children received assistance for their trauma-related problems, and not for the other problems they were facing. This is inconsistent with the UNICEF guidelines to address the children's psychosocial needs in a comprehensive and holistic manner.

The project did contribute in some way to the healing process by helping children to overcome their traumatic experiences. However, it left many other elements of the healing process unaddressed,

³⁸ See Summerfield, D. (1998). The Social Experience of War and Some Issues for the Humanitarian Field, in Rethinking the Trauma of War. Bracken, P. and Petty, C., Save the Children.

³⁹ MSF, in their assessment of the psychosocial situation of IDPs in Ambon did identify traumatic events as a major source of stress for the adults they interviewed (personal correspondence, March 2003).

⁴⁰ In the review of the findings in both Aceh, institutions working with school counsellors stressed that school counsellors should have been trained in EMDR. The author did not have the opportunity to verify this claim.

including the reestablishment of normal routines, the rebuilding of family and community support networks etc. Most problematic was that this project did not significantly strengthen children's support networks. Children were not encouraged to consider how to better maintain and utilise social supports, and key members of the community (such as parents and teachers) were not given any tools to know how to help their children. Certainly if parents are helped to recover from traumatic events by EMDR therapy, they will be more able to provide appropriate parenting to their children. However, in this project, few of the adult beneficiaries were parents, and thus this indirect benefit to children is negligible.

Another key question is whether this approach helps to build the resilience of children. Certainly, resilience was not a key concept in this project, as the project did not try to strengthen those factors that promote resilience – individual coping mechanisms, family support, stable community environment etc. Rather the project utilised a medical model, where the beneficiaries were seen as needing 'treatment' by a trained EMDR specialist, to be rehabilitated from their psychological illness. Much research has stressed the disempowering nature of this approach for beneficiaries⁴¹. In this project, EMDR did seem to build beneficiaries resilience and to empower them to some extent, as after EMDR they often felt more able to deal with key problems they were facing, such as unreasonable fear of soldiers, or inability to relax. While there are some indications that this effect is generalized to other difficult events that they experienced, this approach did not focus on building their skills to cope with future adversity.

This project did attempt to build local capacity to deal with children's psychosocial problems. Through the series of trainings, and limited supervision, the aim was to 'develop local capacity for the rehabilitation of traumatized families and children'. The initial aim was to develop a core of EMDR practitioners and eventually EMDR trainers. This was clearly a sustainable approach, in that trainees would incorporate EMDR within their ongoing activities with children. The structure of the project, with two regional Level I trainings, followed by a central 'leadership' Level II training in Jakarta and two regional Level II trainings, and eventually a Training for Trainers was appropriate and logical. The project design did include require trainees to conduct EMDR sessions after Level I and these cases were reviewed in Level II, a form of supervised practice. However, it was clear that given the skill level of the trainees, and the difficulties they faced in applying EMDR (see below), more supervised practice could have been useful. This was stressed by some trainees who felt one of the main problems with the EMDR programme was that there was insufficient follow-up. Problems such as lack of materials with which to implement EMDR, or insufficient resources to travel to the beneficiaries limited the ability of trainees to use EMDR. As stated by a psychiatrist "You can't expect to achieve anything with a hit and run programme".

In the project design there was no clear evaluation protocol described, as far as can be discerned by the author. However, it is clear that the team made significant efforts to document and evaluate the impact of the project. Case tracking forms and questionnaires to assess the impact of EMDR were developed, and trainees were instructed in how to use them and encouraged to do so. Reports about the decrease in the level of subjective distress experienced ('SUDS' in EMDR terminology) by the clients were provided, and UNICEF tracked the number of clients of EMDR until December 2001. Given the low number of clients, and the limited commitment of trainees to document their work, evaluation proved

⁴¹ See for instance, Bracken, P. (1998). Hidden Agendas: Deconstructing Post Traumatic Stress Disorder in Rethinking the Trauma of War. Bracken, P. and Petty, C., Save the Children.

difficult. A systematic research proposal was designed to assess the impact of EMDR but this was rejected by UNICEF.

d. Did the activities conducted meet the objectives of the projects?

The process of designing the project and assessing needs was also problematic. In contrast to the psychosocial project in which the core question was ‘What are the psychosocial needs of the beneficiaries and what project could meet these needs’, in this project, the core question in the design and needs assessment was ‘Does EMDR technique fit the psychosocial needs of the children in conflict zones?’. By presenting the question in this way the assessment was more likely to confirm the appropriateness of the EMDR technique. This is particularly true in the Indonesian cultural context, where people are reluctant to contradict or say no to proposals. Secondly, having the assessment conducted by the trainers was not an independent method of assessing the appropriateness of EMDR. Third, this assessment was relatively short and did not involve any field visits by the assessment team, a key policy criteria for designing UNICEF emergency projects. Fourth, the strong support for EMDR within the top management of UNICEF at this time limited the possibility for concluding that EMDR was not appropriate for the Indonesian context. Fifth, children were not included in the assessment, design or implementation of this project. It should be emphasised that these problems in the decision-making process contributed to a decision to support a project which, as will be seen below, was ineffective. As such, in future projects, particularly innovative ones such as this, more care needs to be taken to ensure an independent and appropriate needs assessment/project design is conducted.

The selection criteria for the participants presented another problem. The project attempted to get a combination of participants who were qualified mental health professionals, and paraprofessionals who had experience working with children. Basic criteria included: basic counselling skills and opportunities to work with beneficiaries. The core problem was that the trainees with the basic counselling skills (usually the mental health professionals) did not work regularly with children in the conflict zones. Those that had regular interaction with these children generally did not have basic counselling skills, such as how to assess the problems of the beneficiaries, or how to facilitate a children’s play group. As noted above, this was particularly problematic in Aceh, whereas in Ambon more of the participants had basic counselling skills and were working with children. As such there is a serious question regarding the ability of the paraprofessionals in conflict zones in Indonesia to conduct EMDR. In these cases, EMDR is used mechanically and “the client leads the counsellor, not the other way around” (Psychiatrist, Aceh). Another problem was a lack of support and/or referral system for the trainees. Most trainees based in conflict zones stressed that they had little professional supervision or support, and they did not know what to do with children that they could not help themselves. Particularly in the high conflict zones, trainees often seemed to be suffering serious distress themselves and desperately in need of professional support. Thus, an additional criteria that should have been included was professional supervision or peer support, as participants who are living in conflict zones themselves and do not have opportunities for discussion of how they are dealing with their cases can easily become burnt-out or discouraged when dealing with trauma survivors. There is no easy solution to the problem of the selection criteria.

In relation to the specific objectives of the project to allow trainees to utilise EMDR, the training topics were appropriate. The topics included: . . . Given the limited counselling skills of many of the paraprofessionals, more attention should have been given to issues such as: how to identify people who

can benefit from EMDR; how to establish rapport with beneficiaries; and what to do if EMDR does not work. Other issues that proved to be particularly problematic in the Indonesian practice of EMDR (see below) and which could have been more fully addressed in the training included: how to help people to recognise the importance of processing their thoughts/emotions; how to help people to articulate their feelings and thoughts. More attention should have been paid to conducting EMDR with children.

The training approach was much less elicitive than that used in the psychosocial project. The participants were basically 'instructed' in the use of EMDR techniques. It was participatory in the sense that the participants were given the opportunity to practice the EMDR skills, and it did provide them with practical skills. However, little attention was given to eliciting the participants' previous experiences or knowledge in dealing with trauma, or situating EMDR within their existing knowledge and skills. Basic training techniques such as asking about the participants expectations from the training, or experience in dealing with trauma were not utilised. This was particularly true in the first training where, the trainers' attitudes appeared to be quite didactic – they had little knowledge of the Indonesian context, and little interest in altering the training to be more appropriate to this context. The main argument for this approach is that if EMDR techniques, including training methodologies, are significantly altered it no longer becomes possible to assess whether EMDR is working (since the approach is no longer, strictly speaking, EMDR). One respondent even described their approach as 'evangelical', to capture how sure the trainers were sure that EMDR was *the* answer to the problem of traumatised children in Indonesia. This approach is, at minimum, counterproductive, since the unwillingness of the EMDR trainings to adapt the training content clearly contributed to the difficulties of the participants to utilise EMDR in the field. It is also contradictory to the guidelines of UNICEF, which are to ground psychosocial programming in an 'understanding of cultural differences' and 'understanding and respect for local traditions and practices'⁴². This approach appeared to be particularly true for the first round of trainers, with later trainers adopting a more flexible, contextualised approach. In addition, the Level II training was much more participatory as it relied on discussion of the participants' cases, and approach of using the Leadership training to coach participants to become co-trainers in the provincial Level II trainings was very good. It should also be noted that participants felt much more comfortable with one of the supervisors who had a better knowledge of the Indonesian culture, and a more 'balanced' approach to EMDR (that is, he considered it as one technique among many to deal with traumatic events). They were also positive about the supervisor who combined EMDR with play therapy.

There are also broader questions about the EMDR-HAP as an organisation. First, the policy of EMDR-HAP to claim that only EMDR practitioners registered with their organisation can train in EMDR may be ethically questionable. If a technique is useful to treat trauma, is it morally acceptable for one organisation to claim a monopoly on implementation of that technique? Secondly, EMDR-HAP claims to be a 'non-profit organisation committed to relieving human suffering and breaking the cycle of violence by providing mental health intervention and professional training to traumatised communities worldwide'⁴³ staffed by 'volunteers'. However, the fees charged by the consultants (\$320/day, at a total cost of \$144,597) mean they are clearly not volunteers, and call into question to what degree are they motivated by humanitarian concerns and what degree by financial gain. This

⁴² Technical Notes: Special Considerations for Programming in Unstable Situations. Chapter 14: Protecting Psychosocial Development, p.3.

⁴³ Documentation Report: Implementation of Eye Movement Desensitisation and Reprocessing Project, December 2000-2001, UNICEF.

evaluation does not attempt to answer these questions, as this would require more knowledge of EMDR-HAP than is possible to gain in the framework of this evaluation. However, these questions would need to be clarified before engaging with EMDR-HAP as a UNICEF partner again.

e. Was the approach utilized consistent with UNICEF policies and practices?

See Section c. and d. above.

IMPACT

a. What beneficiaries were reached by this project?

According to the assessment conducted in 2003 of 32 EMDR participants, approximately 330 people benefited from EMDR, of which 132 were children and 158 were adults (the overwhelming majority of whom were not parents). In contrast, according to the evaluation conducted by UNICEF staff in December 2001, 336 people had benefited from EMDR. Thus we could estimate 500 beneficiaries, of which approximately 200 were children, which is still a very low number. This is especially true given that 51 trainees participated in Level II training (and 57 participated in Level I). The beneficiaries were primarily from conflict zones, with 20 (all children) from the Surabaya/Madura area, 182 from Aceh/Medan (126 adults, 56 children) and 25 from Jakarta (19 adults, 6 children) and 222 from Ambon (188 children, 23 parents, 11 adults who are not parents). Of the children, we know 8 were 6-12, 29 were 12-18 and the remainder we do not know their age. The beneficiaries were primarily those affected by armed conflict, with 15 being street children, and the beneficiaries in Jakarta being victims of domestic violence (rather than armed conflict)

During 2001, there was approximately 1.5 million IDPs, and at minimum 500,000 non-IDPs from conflict zones who had been affected by violence. If we assume that 40% are children, and of this 5% are in need of treatment for trauma, this means that there are 40,000 children in need of this type of intervention. As such, this project provided services to 0.50% of the total targeted population. If we restrict the target population to Aceh and the Malukus, as the project focused on these two areas, this means a total affected population of approximately 700,000. Of this, we can assume that the population of traumatised children is 14,000, and we know approximately 174 children benefited from EMDR. As such, 1.24% of the target population in Malukus and Aceh received assistance from this programme. This is a very low figure.

b. What was the impact on the trainees?

Trainees had mixed responses to the effect of participating in the EMDR project on themselves. Certainly, none reported the significant changes in attitudes or knowledge, including self-awareness that the psychosocial trainees reported.

Many trainees reported feeling relieved and empowered by EMDR, as it gave them a relatively simple tool for dealing with problems that they didn't know how to deal with before. This was particularly true for field based paraprofessionals who had few other tools for dealing with the effects of trauma, and who were constantly faced with such problems in their work. For some, it clearly was the only source of basic knowledge about the effects of trauma, and their only practical skill for dealing with these effects. These paraprofessionals are often presented with the most difficult challenge – often

unsupported and untrained they struggling to find ways to help adults and children with serious psychological and social problems. For these trainees, having at least one way to help the traumatised children and adults they were dealing with, was extremely important. In addition, many of the trainees reported using EMDR on themselves or their friends and finding it liberating to be able to overcome violent experiences.

Some other trainees with counselling skills felt EMDR was very good, as it provided them with an alternative for treating serious or severe trauma more quickly and effectively than trauma counselling or other equivalent methods.

However, other trainees found EMDR to be inappropriate and ineffective, for reasons that will be outlined below. For these trainees, the EMDR training appeared to be a frustrating and disheartening experience, as they faced repeated problems in applying EMDR in their work.

c. What were the number and quality of the activities conducted with the beneficiaries?

Of the 32 trainees contacted, 28 used EMDR. However, many of the participants have now stopped using EMDR – only 25% (8 participants) are continuing to use EMDR as of January 2003. For instance, in Aceh, all 15 participants contacted had begun to use EMDR after the training, but few (less than 5) were still continuing to use EMDR in January 2003. In Ambon, the situation was better with about half of those contacted (5 out of 11) still using EMDR in March 2003. A UNICEF report states that of the 57 trainees in Level I, 48 used EMDR, while of the 51 trainees in Level II, only 32 used EMDR (until December 2001). This indicates a pattern, also reflected in the interviews with the trainees, of trainees attempting to use EMDR after the training, but many gradually stopping using EMDR as they encountered difficulties to implement this technique. The ones who continued were those who had basic counselling techniques, regular contact with children/clients and who believed EMDR ‘worked’.

The quality of EMDR treatment varied immensely. As outlined in report of one of the EMDR supervisors, 5 of the trainees from Ambon appeared to be conducting EMDR in an appropriate manner, following the basic protocols. One of the main problems identified in this report was that the trainees did not take enough time for establishing rapport, and hence would scare the beneficiaries away by using EMDR to address their traumatic incident too quickly. However, in Aceh, some many beneficiaries reported having EMDR for only one session, and in most cases, for less than 90 minutes.

The main question to be addressed here is why was EMDR used with so few beneficiaries? What were the problems the trainees faced in implementing EMDR? Two key problems were outlined above – that is, insufficient counselling skills and professional supervision mechanisms for the paraprofessionals in the field, and that some of the trainees did not have access to traumatised children or adults.

There were other problems with using EMDR. First, the primarily individual nature of EMDR, as with other ‘therapies’, is not well understood or accepted in the Indonesian context. Group interventions with both children and adults are more accepted, as these can be framed in more acceptable terms (for example, ‘support groups’, ‘community work’). In addition, individual treatment is also simply too time consuming and costly for the numbers of children and people needing treatment in the conflict

zones. Where individual EMDR has been used, it has only reached the most privileged children – those whose parents can afford to send them to a psychiatrist, or those fortunate to have close contact to one of the trainees. Second, EMDR is very labour/time intensive. In the Indonesian context, people are not accustomed to the notion of therapy, nor the idea that psychological healing by a professional could take time – they are thus often impatient with EMDR, despite the supposedly ‘quick’ nature of EMDR compared to other therapies. For instance, in hospital setting the patients would come for psychosomatic problems expecting to receive drugs and if they received EMDR they would often not return as it didn’t meet their expectations. Third, many clients rejected EMDR since they felt it was ‘weird’ or, particularly in the villages, they were suspicious that the trainee was trying to put a spell on them. In fact, it appeared that EMDR was primarily used by the trainees for beneficiaries with whom they already had an established relationship of trust for another reason, as this was the way in which the beneficiaries would accept to participate in EMDR. Fourth, they stressed that for adults, EMDR needed the person to be able to articulate their feelings and thoughts, to engage in self-reflection, which the trainees stressed was an uncommon and difficult thing for Indonesians to do. Fifth, EMDR requires high levels of concentration by the beneficiaries, and a quiet location which were often difficult. Sixth, they noted that it had been difficult to access beneficiaries because the security situation prevented travel. Finally, the danger of opening up traumatic memories and not being able to appropriately process them was stressed by a number of trainees. This is particularly problematic in a context like Aceh, where trainees reported that they are struggling to control the desire for revenge among the youth.

Some trainees did find ways to overcome these problems. For instance, for children the process was easier since the children were less suspicious of the ‘strange’ nature of EMDR. In addition, the techniques used with children required less self-reflection and articulation, so it was easier for them to do EMDR than adults. In addition, EMDR can be easily done in a group with children. With children, EMDR appeared to be most effective when used as part of a broader group play counselling programme. However the ‘tapping’ of children needs many volunteers. Gender barriers can also create a problem, necessitating mixed group of volunteers to do the tapping. Some trainees came up with innovative solutions to these problems, such as having the children do the tapping to each other when in large groups.

With adults, the most successful use of EMDR was when it was inserted as one technique among other therapies, such as counselling, cognitive behavioural and relaxation therapy. This was done primarily by psychiatrists or counsellors who already had the other skills. A number of psychiatrists noted that basic counselling was needed initially to help the ‘client’ overcome their expectation that they could just take drugs to deal with the psychosomatic aspects of their problem. These professionals took the necessary time to establish rapport with the clients to reduce the likelihood that clients would be scared off by EMDR and not return⁴⁴. Counsellors who continued to use EMDR used it as one technique among their range of therapies to deal with clients problems.

⁴⁴ This was one of the mistakes of some of the Ambon trainees – that is, to use EMDR before establishing rapport – that the supervisor strove to correct. See *Trauma Among Young Children in North Maluku*, Report on North Maluku Mission, 17-23 November 2001, Reyhana Seedat.

d. What was the impact on the beneficiaries?

Among the participants who used EMDR, the majority felt that EMDR does work to reduce the effects of trauma. In Ambon, 5 trainees who met with the supervisor there in November 2001 stated that they ‘see the positive results constantly’⁴⁵. In Madura, both participants who used EMDR said that EMDR worked to reduce trauma, and the psychiatrist stated that his clinical interviews proved this, and the counsellor stressed that EMDR has a clear relaxation and healing value. They both stressed that it works particularly well with children, for the reasons outlined above. In Aceh, the trainees also stressed that EMDR does reduce the symptoms of trauma. For the adults, most participants were basing this assessment on the beneficiaries’ self-reported levels of distress (or ‘SUD’ in EMDR terminology). A psychiatrist showed us figures for his 25 EMDR patients that indicated that SUD decreased dramatically for all but one patient over a period of 3-4 months (1 session/week), and that this was even true if the person experienced multiple traumatic events during the therapy. He stressed that he found a combination of EMDR, cognitive therapy and relaxation more effective than cognitive therapy and relaxation alone. For children, trainees were basing their assessment on their observations of the children. For children, they stressed that EMDR combined with play counselling worked more effectively than play counselling alone. In a focus group of 8 beneficiaries in Bireuen, and an interview with a torture survivor in Lhokseumawe, the beneficiaries all reported that they felt less afraid after EMDR. One reported “Before I used to run away screaming whenever I saw a soldier, now I can even talk to them”. For people living in a conflict zone, where reminders of traumatic events are common, being less afraid of these symbols of the event was obviously a priority for them.

However, it should be noted that the positive effects described above were not only due to EMDR. In almost all cases, EMDR was used in combination with other interventions – for children, it was often used with play counselling, for adults it was used with basic counselling, social support and/or therapy. Almost all stressed that EMDR should not or could not be used alone. Participants agreed that EMDR was particularly useful for PTSD, but there was little agreement as to the other types of problems for which it is useful. In addition, some beneficiaries reported positive effects from one 10 minute session of EMDR – in such cases, it appears that EMDR is no more than a placebo (that is, it works only because people believe it works, not because it has any intrinsic effect). Certainly, many participants perceived EMDR as ‘magical’, which in the context of the widespread belief in magic in Indonesia, meant that EMDR worked like ‘faith healing’ in some cases. None-the-less, from these interviews it appears that EMDR does ‘add something’ to other types of interventions, and that this effect most clearly noticeable in terms of the reduction of fear associated with traumatic events.

However, the results from the questionnaires distributed to teenage EMDR beneficiaries found no difference between children who participated in EMDR activities and those who did not participate in any activities. The specific differences found were as follows: EMDR participants were found to be more likely to have adults they trusted in their lives, more likely to feel able to learn new things, and less nasty, but more likely to be grumpy, less able to make up their mind and feel less connected to their community. These findings are erratic and are not especially those that would be expected to be produced by EMDR – for instance, no effect was found on levels of fear or intrusive memories. In addition, on half the items the non-EMDR group had a better outcome than the EMDR group. As such, these specific findings do not appear to be meaningful. Taken together with the findings above,

⁴⁵ Trauma Among Young Children in North Maluku, Report on North Maluku Mission, 17-23 November 2001, Reyhana Seedat, p. 10.

these results suggest that while EMDR appears to have had a positive effect on some beneficiaries, it did not produce significant changes in the majority of children beneficiaries. The interviews suggested that EMDR was the most beneficial for beneficiaries who were uncontrollably afraid of the perpetrators of violence and who were confronted with these perpetrators on a regular basis.

Table 2: Comparison of the psychosocial outcomes of adolescents who participated in EMDR and those who did not participate in any activities

Item	Mean – no activity	Mean EMDR	Significance – EMDR compared to no activity
Total (Aceh and Madura)	1.83	1.79	0.28
Q8	1.70	1.29	0.00
Q16	1.42	1.78	0.00
Q20	1.73	1.51	0.03
Q27	1.77	1.99	0.04
Q28	1.84	1.61	0.05
Q37	1.59	1.86	0.02
Q42	1.45	1.81	0.00

e. Where there any indirect effects on beneficiaries or other agencies?

There were no noticeable indirect effects. There was however, an indirect effect on UNICEF’s reputation and credibility in psychosocial programming. Many of the Indonesian professionals and trainees were disappointed that the psychosocial programming was stopped, and were sceptical of EMDR. There programming decisions were perceived by many Indonesian experts as, at best, questionable.

IMPLEMENTATION

a. Was the project implemented as designed?

As noted above, one of the main problem with this project was that many of the trainees did not have sufficient basic counselling skills, or those that did have these skills did not work with children affected by armed conflict. Another problem was that some organisations that sent participants did not have the financial capacity to implement EMDR activities. The question is whether through more careful selection, participants could have been found that fulfilled these criteria. Initially, there was a lack of interest among organisations contacted to send staff to participate in EMDR training⁴⁶. This partly explains why some of the participants were not appropriately qualified. For instance, the Ministry of Health sent administrators rather than practioners – this problem could have been overcome. In addition, UNICEF staff did state that after the training, they found organisations better equipped financially and organisationally to implement EMDR activities with children and parents. However, it is unclear whether their staff had the basic counselling skills necessary to effectively implement EMDR.

⁴⁶ Ibid.

Various trainees stressed in their interviews that there is a serious lack of basic counselling skills among paraprofessionals working in the field with children affected by armed conflict. Similarly, they noted that few mental health professionals work in the field in conflict zones. As such, a more careful selection of participants would not have identified trainees who fit the selection criteria for the UNICEF-sponsored EMDR training.

This project appeared to be, overall, well coordinated. There were fewer partners than the psychosocial project which made coordination easier, and there was sufficient time to clarify roles before the beginning of the project. In Aceh, after the training the participants continued to meet once a month until late 2001 to network, discuss EMDR implementation, and provide peer support – these meetings were hosted by UNICEF. In this way, EMDR was to a large degree, integrated into the existing (albeit limited) psychosocial services in Aceh, at least while it was being practiced.

The main constraints on this project was the limited local capacity for counselling children affected by armed conflict, and the security problems which restricted the ability of service providers to access the most affected populations. While the second constraint was unavoidable, the first implied that another type of programme to deal with traumatised children would have been more appropriate.

b. Was the project efficient?

The project cost approximately \$258,000 (\$167,290⁴⁷ for project costs and approximately \$90,000 in supports costs) and benefited approximately 500 people. Thus the cost per beneficiary was approximately \$516. As only approximately half of the beneficiaries were children or parents, **the cost per beneficiary targeted by UNICEF was approximately \$860**. Given that project did not include any costs for field activity implementation, and that the children received an average of only 3-4 sessions of EMDR, this is extraordinarily inefficient⁴⁸.

c. Were the projects integrated with other UNICEF activities?

This project was not integrated with any other UNICEF activities. Rather, due to budgetary limitations, the implementation of the EMDR project meant that the psychosocial programme was stopped. This was a questionable decision, since the psychosocial project was more effective, more efficient, and more in line with UNICEF policies and guidelines. In addition, the EMDR project may have been more effective if paired with the psychosocial programme – for instance, EMDR could have been given to children who still were facing problems after participation in psychosocial activities.

d. Were the project activities coordinated with other psychosocial programmes?

There is no indication in the project documents that the project was coordinated with other psychosocial programmes.

⁴⁷ Ibid.

⁴⁸ As a comparison, the project to provide treatment to traumatised children in the Occupied Palestinian Territory cost \$11.50/beneficiary. While this project did not require any capacity building, as qualified local staff already existed, it did cover all activity implementation costs, including salaries, transportation etc. See Psychosocial Interventions, Evaluation of UNICEF Supported Projects, UNICEF West Bank and Gaza, 1999-2000.

Recommendations

Initial Assessment of the Psychosocial Needs of Children in Different Areas

The psychosocial needs of the children were assessed through interviews with the trainees, focus group discussions with IDP children in Madura and Lhokseumawe, and distribution of questionnaires to children in Madura, two locations in Aceh (who had participated in psychosocial, EMDR or no activities). Interviews with mental health professionals and para-professionals were also used in this assessment. This was only a bi-product of the assessment and should be considered at best, an indicative initial assessment.

In Madura, the IDP children were living in a non-conflict zone, and appeared to have been relatively well integrated within the host community⁴⁹. Adults working with them reported that although they had many psychological and behavioural problems (such as aggression, lack of concentration, depression) when they first arrived, over the previous 2 years these problems have largely disappeared. As noted above, results from the UA study indicate that PTSD remains highly prevalent, among both the local and IDP children. It was however, difficult to assess the degree to which the symptoms of PTSD are a priority concern among IDP children and the care-takers. The social problems noted above, are certainly a concern, including grief for their lost family members and home, uncertainty about their future, schooling concerns, lack of economic opportunities and adjustment problems to integrate in Madura. Among the adults working with them, the perceived low rate of enrolment in school (figures were not provided) and the need for peacebuilding programmes were stressed as two priorities. While there remain tensions in the community between IDPs and locals, including tensions between host and IDP family members living in the same house, there was little indication during this visit that this was an issue requiring outside intervention. The questionnaires did indicate significant that the adolescents are still suffering significant levels of psychosocial problems – for instance, children in Madura reported more problems than children in Banda Aceh. In summary there appears to be a need for psychosocial programmes, which include a focus on peace-building and specialised treatment for children who still display problems.

In addition, staff from the UA stated that the need for psychosocial programmes is greater in Kalimantan where the children there are still living in the area where the conflict occurred. Although it was unclear whether the Dayak children really were more exposed to the conflict than the Madurese children, it is an issue worth investigating further.

In Aceh, the psychosocial needs of the children appeared to be greater. Children had, until 2 months ago, been living in an active conflict zone. Many had been displaced at some time, and they are still living in an atmosphere of fear, uncertainty and mistrust. The repression by the armed forces of their families, the lack of clarity of who is the enemy which undermines social cohesion, and the targeting of schools has all contributed to children in conflict zones being very afraid. Social stigma for children whose families are associated with the ‘wrong side’ of the conflict is also a problem. Children are experiencing the usual range of problems caused by living in such a violent atmosphere – aggression, lack of concentration, rejection of authority, fear, social isolation and depression,

⁴⁹ The IDPs heritage is Madurese, and hence they share at least partly common identity, culture, religion and family with the non-IDPs.

questioning of their value systems, including themselves, lost of trust and hope in the future and adults, disempowerment etc. Adults stressed that the most concerning problems were the increases in violent behaviour, including a desire for revenge, a sense of worthlessness and social isolation, and lack of opportunities for schooling and recreation. The problems of the parents, particularly mothers who husbands were killed or disappeared and victims of torture, to provide adequate care for their children were also stressed. Children living in high conflict zones, particularly villages who had been displaced, and unaccompanied children seem to be particularly at risk. In the current environment there is a window of opportunity to focus on healing and rebuilding children's lives.

The sources of resilience among children appear to an appropriate support network (family, community, friends), their own coping mechanisms (how do they understand what is happening to them, how do they deal with their emotions, can they maintain normal routines and interests) and the economic situation of their family. The current cessation of hostilities and 'peace' process is perhaps the most important development that could assist in the healing of psychosocial distress of children. However, there is a clear need to rebuild community networks and trust that have been damaged, and to strengthen children's support networks. There is also a need for some process of accountability and justice to restore the communal moral order, heal wounds in the community and lessen the likelihood that children would take revenge. Parents and children need to 'tell their stories', to build a sense of shared experience and to feel their experience is legitimate. They need to participate in rebuilding their communities.

From initial indications, there appears little on-going need for psychosocial activities in West Timor now, according to the participants. Rather there is a need for back-to-school campaigns for children who have dropped out of school. Separated children is also an issue that was highlighted for West Timor. This would need to be confirmed through further investigation.

In Maluku, children's psychosocial vulnerability appeared to be very much determined by their living conditions. In interviews with trainees, they stressed that among the most vulnerable children were those who were living in IDP 'camps' for long periods of time (3 years) where the families had no privacy, and children had no place to play or study. According to the trainees, in these conditions, families were highly stressed, normal family patterns had been severely disrupted (for instance, parental authority was undermined, children would stay away from home until late), parents had little or no opportunity for dignified sexual interaction, violence was common (particularly domestic violence), children were not able to study, hygiene was very poor, and a general apathy/inertia was apparent in these communities. Advocacy and support to resettle or return these IDPs was seen as the highest priority for these children and their families. Trainees also stressed that, while special attention needs to be given to these children, the psychosocial needs of all conflict affected children should be taken into account. For these children, opportunities and spaces for recreation, expression, participation and healing (including breaking down stereotypes, contact with the other community) were seen as crucial. Trauma-related problems were seen as important, but should not be the focus of interventions – rather they should be integrated into, or addressed in a follow-up intervention for those who are identified as suffering post-traumatic problems. Children's behavioural problems in schools, particularly aggression and hyperactivity, were identified as another priority. Parents were also often at a loss as to how to deal with the behavioural changes in their children and needed support. Domestic violence was identified as a major problem throughout the community. Separated children were seen to be highly vulnerable but trainees had no information about the number of these children.

The needs of adolescents, including normal adjustment and social problems such as school difficulties, family conflicts, as well as high-risk behaviours, especially drug use and early sexual activity, were highlighted. The effect of children's participation in the conflict is an issue that warrants further investigation. Friends, family and religious leaders were seen to be the major source of support for parents and children, and specialised services such as general or mental health services were seen as a last, highly stigmatised resort.

No information was collected about the psychosocial needs children in North Maluku, Kalimantan, South Sulawesi or Papua in this evaluation.

Future Psychosocial Response – Strategy

In this evaluation, recommendations for the UNICEF psychosocial strategy and activities will be broadly outlined. Once these broad outlines have been agreed-up through consultation internally within UNICEF, and with relevant stake-holders in the community, a more detailed plan of action for psychosocial activities will be developed.

It is recommended that the UNICEF Indonesia psychosocial programming should have two primary goals:

- Strengthening community-based social supports for children, including re-establishing stable family life, and mobilising para-professionals
- Building Children's Resilience, including normalisation of their life, healing past wounds and building their psychosocial skills

Activities could be of two types:

1. Psychosocial Promotion activities

All members of the community are responsible for the promotion of psychological and social well being of children and their families. Psychological well-being depends on the existence of a number of supportive factors enabled by the entire community. Such factors include strong parental care and family support, effective social and community participation, and access to quality health care, good nutrition, developmentally-appropriate education, adequate financial resources and appropriate expressional and recreational activities within a safe and protected environment. Parents, siblings, peers, doctors, teachers, community and youth workers, municipalities, etc. all participate in and have a responsibility for creating the building blocks of psychosocial well-being.

This can be achieved through the implementation of specific psychosocial interventions such as information campaigns, self-expression, recreational and support/mentoring programmes, life skills training, and community activities. After relevant training, such interventions can be implemented by professionals such as teachers, social workers, medical, community or children workers and, whenever possible, within existing health, education and social services.

Structured psychosocial promotion activities include:

- Recreational and expressional activities for children
- Parents/community meetings to address their own and their children's psychosocial wellbeing
- Psychosocial information material for parents and teachers

- Training and support of psychosocial para-professionals, including teachers, youth volunteers, health workers

Supporting psychosocial activities include:

- Promoting family reunification
- Promoting family self-sufficiency
- Ensuring adequate emergency shelter
- Ensuring continuous schooling
- Ensuring appropriate health and sanitation services
- Supporting community structures and cultural activities/traditions

2. Psychosocial Prevention activities

Prevention work involves consolidating the ‘building blocks’ and strengthening the resilience of children/families in times of crisis, so that they can cope with and overcome their problems. It will also help them to recognise the initial signs of psychological and social distress (or ‘stress’), and provide basic mechanisms to deal with this stress. Such interventions help the beneficiaries deal with their problems more effectively and prevent complications and the need for psychological treatment in the vast majority of cases. Such activities can be implemented by psychosocial professionals, such as social workers trained in counselling, or counselling psychologists. Advocacy and community rituals can be conducted by community leaders, including in some cases children themselves.

Psychosocial prevention activities include:

- Group, including art and play, counselling for children
- Individual and/or family counselling
- Support groups for care-givers
- Community healing rituals
- Advocacy to decision makers to improve the environmental situation

Treatment?

One question remains whether UNICEF Indonesia should be involved in treatment of clinical psychological problems of children and their families. There is clearly a need for this type of intervention in the conflict zones. Promotion and prevention services will be undermined if there are no treatment services to refer children to who are not able to be adequately assisted through the two lower levels of assistance. However, before a final decision is made more investigation is needed into the currently existing initiatives, particularly with WHO. At minimum, UNICEF should work to lobby other organizations to ensure that these services are available for children.

The main reason for UNICEF to support treatment interventions is if no other organization which is able or willing to provide or support these services for children in conflict zones. The main disadvantages with supporting these types of programmes are that they require high levels of technical expertise, are costly and are not the standard focus of UNICEF psychosocial programming.

Lessons Learnt and Guidelines for Psychosocial Programme Implementation

The lessons learnt and recommendations for future programming from this evaluation are summarised below for easy reference:

DESIGN

- Psychosocial projects are a child's right. Such programmes are important to children in armed conflict but sometimes have to overcome adult focus on material needs.
- Programme decisions and priorities must derive from a situation analysis on the ground.
- Children should have an active role in designing and implementing programmes.
- Where possible, projects should have multilevel design. Promotion activities, to help parents, teachers, youth volunteers and children themselves better support children, should be combined with prevention activities, by counsellors and other psychosocial specialists, to help children who need more specialised assistance.
- Structured psychosocial activities should be integrated with 'supportive psychosocial activities', such as family reintegration and educational programmes. Often these supportive psychosocial activities will be managed under a separate project, but they should form an integrated assistance package.
- Incorporate clear evaluation protocol from beginning of project
- Support activity implementation and follow-up trainings for all projects
- Should take care to ensure that approaches are culturally appropriate and 'workable' before implementation

APPROACH

- Psychosocial programmes should focus on strengthening child resiliency and children's support networks
- Projects should focus on healing, including normalizing life. Should not only focus on expressional or recreational activities, but should take children through a 'healing process' to help build their skills to overcome their problems.
- Treatment of psychological problems resulting from trauma should be dealt with as part of an intervention that deals with other sources of stress for the beneficiaries, such as those resulting from dislocation, family tension/violence, grief or schooling/economic pressures
- Need to ensure trainees have or are trained in basic counselling skills before providing a training in a treatment methodology such as EMDR
- Should not use 'medical' model where the *active* expert is seen as having the knowledge to cure the sick, *passive* patient
- Ensure integration of peace-building concepts in psychosocial projects, such as tolerance, cooperation etc, particularly in areas where there conflict levels have significantly reduced.

IMPLEMENTATION

- Implement activities by youth volunteers and teachers first, to build confidence with community/children, and after implement activities by counsellors
- Training topics should have a balance between knowledge/attitude change and skills building. Need to include specific art/play group counselling techniques for children.
- Need longer than 5 days to train counsellors
- Training should be elicitive, participatory, flexible and culturally sensitive
- Should carefully select trainees

Suggested psychosocial projects

Outlined below are some suggested activities to be implemented in two 6-month phases of psychosocial programming over 1 year.

PHASE I – Consolidation

February – July 2003

- Revitalise psychosocial network, including key participants from EMDR and psychosocial projects, including to develop psychosocial guidelines
- Begin 1 year, 20-day training course for paraprofessionals in the conflict zones on basic counselling skills, including play/art counselling
- Establish and support psychosocial networks in Aceh, Maluku and possibly North Maluku
- Conduct psychosocial training for teachers and support implementation of activities in schools in 4 conflict zones (Aceh, Maluku, North Maluku and one other)
- Develop and publish key resource materials, including psychosocial activity manual for mental health professionals and paraprofessionals, brochure for parents, comic book for children
- Develop integrated community-based psychosocial interventions for key locations in Aceh, and integrate this with other activities (school in a box)
- Make assessment of needs in Malukus to design and implement similar community-based interventions
- Design psychosocial communication strategy
- Make initial psychosocial needs and capacities assessment for West Kalimantan, South Sulawesi, and Papua

PHASE II – Expansion

August – December 2003

- Continue 1 year, 20 day training course for paraprofessionals
- Conduct psychosocial training for teachers and support implementation of activities in schools in 4 conflict zones (Aceh, Maluku, North Maluku and one other)
- Continue support for community-based interventions in Aceh, Maluku and North Maluku
- Replicate teacher psychosocial training in 3 zones not covered in Phase I (i.e. Papua, South Sulawesi, West Kalimantan or Madura)
- Establish psychosocial provincial networks and community-based interventions in two of the above four areas
- Integration of psychosocial projects into other areas (health, education, CNSP)?

Appendix 1: Evaluation Framework

ISSUE	GENERAL QUESTIONS	CSFI SPECIFIC QUESTIONS	EMDR SPECIFIC QUESTIONS	METHODOLOGY
1. Background	<i>General Context</i>			UNICEF documents
	<i>Psychosocial Needs of Children</i>			Reports/Assessments by other organizations Monthly reports
	<i>Other Programmes</i>			Meetings with other organizations
	<i>Overview of Psychosocial Programmes</i>			CSFI evaluation Programme proposals
2. Design				
a) Who were the beneficiaries?	<ul style="list-style-type: none"> ▪ Who were the beneficiaries? ▪ How was the decision made to focus on particular beneficiaries? ▪ Where the beneficiaries clearly defined? ▪ Was the age, geographical region and level of distress of the chosen beneficiaries appropriate? 			
b) Were the objectives of the two projects relevant to needs of beneficiaries?	<ul style="list-style-type: none"> ▪ What were the priority needs of the beneficiaries? ▪ Did the programme address these needs? ▪ What level (primary, secondary or tertiary) of assistance did this project provide to the beneficiaries and was this appropriate to their needs? 		<ul style="list-style-type: none"> ▪ Is EMDR an effective treatment methodology? ▪ Is EMDR appropriate for use on children? 	Interviews with beneficiaries and parents Interviews with trainees Interviews with UNICEF staff Literature review
c) Was the approach utilised appropriate to the context?	<p><i>Conceptual orientation</i></p> <ul style="list-style-type: none"> ▪ Was a clear strategy/approach developed? ▪ Was the conceptual orientation utilized in this project appropriate? Discuss key concepts including: resilience, traumatised, community participation, holistic approach etc. 	<ul style="list-style-type: none"> ▪ How did project deal with tensions between locals and refugees? 	<ul style="list-style-type: none"> ▪ Was intervention at the treatment level appropriate to this context? ▪ Was the EMDR the most appropriate treatment methodology? Is it suitable to the Indonesian cultural and social context? 	CSFI Evaluation Gemma's Review Interviews with UNICEF staff Interview with trainees Interview with children and parents using EMDR Literature review

	<p><i>Design process.</i></p> <ul style="list-style-type: none"> ▪ Did the design process involve consultation within UNICEF? ▪ With professionals? ▪ With the community and beneficiaries? 			
	<p><i>Project design</i></p> <ul style="list-style-type: none"> ▪ Did the project design incorporate evaluation protocol from the start? ▪ Where the beneficiaries addressed in a holistic manner? ▪ Was the approach involve and mobilise the community? ▪ Did the project empower the beneficiaries and strengthen their resilience? ▪ Was the design appropriate given local capacities? ▪ Did the project appropriately involve children? 	<ul style="list-style-type: none"> ▪ Who else could have benefited from training? ▪ Why were they not trained at the time? ▪ Would it have been better to have a more holistic project, or focus more on the two groups i.e. teachers and counsellors? 		<p>Interviews with UNICEF staff</p> <p>Interviews with trainees</p>
	<p><i>Sustainability</i></p> <ul style="list-style-type: none"> ▪ Was the project sustainable? ▪ What kind of sustainability did the project achieve? 			
d) Did the activities conducted meet the objectives of the projects?	<p><i>Needs Assessment</i></p> <ul style="list-style-type: none"> ▪ Was the design of the needs assessment appropriate? 			CFSI Assessment
	<p><i>Training topics.</i></p> <ul style="list-style-type: none"> ▪ Did the training topics serve the objectives of the project? 			<p>Training Agendas</p> <p>Training evaluations</p> <p>Questionnaire/Interview with trainees</p>
	<p><i>Style of training.</i></p> <ul style="list-style-type: none"> ▪ To what degree was the training participatory? 			<p>Training evaluations</p> <p>Questionnaire/Interview with trainees (TOT)</p>
	<p><i>Trainers.</i></p> <ul style="list-style-type: none"> ▪ Where the trainers appropriately qualified for the project? 			<p>Interviews with UNICEF staff, partner organizations and trainees</p> <p>Training evaluations</p>
	<p><i>Selection criteria for the trainees</i></p>		<ul style="list-style-type: none"> ▪ Can para-professionals conduct EMDR? 	<p>Literature review</p> <p>CSFI Evaluation</p> <p>Gemma's Evaluation</p>

	<p><i>Structure of training and follow-up design</i></p> <ul style="list-style-type: none"> ▪ Was the training long enough? ▪ Did the project provide structured opportunities to practice the skills? ▪ Was there sufficient supervision/follow-up during this practice? 			CSFI Evaluation Gemma's Evaluation Interviews with UNICEF staff
	<p><i>Design of activities with beneficiaries in the post-training period</i></p>	<ul style="list-style-type: none"> ▪ What was the design of the activities conducted by the teachers and counsellors? ▪ What was the design of the activities implemented in follow-up projects? 		Monthly reports Interviews with trainees
	<p><i>Materials, including training materials and materials</i></p> <ul style="list-style-type: none"> ▪ Was there sufficient written material to support the training? ▪ Was this training material of high quality and appropriate to the needs of the trainees? ▪ Were the trainees provided with sufficient supplies to conduct the activities? Where these supplies provided in a timely manner? 			Monthly reports Interviews with trainees Training manuals
e) Was the approach utilised consistent with UNICEF policies and practices?				UNICEF policy documents
	<ul style="list-style-type: none"> ▪ Did the projects appropriately utilise UNICEF's comparative advantage in this context? 			Interviews with UNICEF staff, partners and other organisations
	<ul style="list-style-type: none"> ▪ What was the decision-making process to choose particular approaches? ▪ How consultative was this process within UNICEF? 			
3. Impact				
b) What beneficiaries were reached by this project?	<p><i>Number of beneficiaries</i></p> <ul style="list-style-type: none"> ▪ How many children benefited? ▪ How many adults (parents, youth etc.) benefited? 			Monthly reports Interviews with UNICEF staff and trainees
	<p><i>Type of beneficiaries</i></p> <ul style="list-style-type: none"> ▪ Including % of affected community, age, ethnicity and level of distress 			Monthly reports Interviews with UNICEF staff and trainees

c) What was the impact on trainees?	<ul style="list-style-type: none"> ▪ <i>Short-term impact</i> from the reports. ▪ <i>Long-term</i> through percentage of trainees who continued in this field, and their self-rating about the importance of this training in helping them to continue. ▪ What if anything did the trainees keep with them from this training? 			CFSI evaluation Monthly reports Interviews with trainees Short-term impact from the reports.
d) What were the number and quality of the activities conducted with beneficiaries?	<i>Scope of activities conducted with children after the training.</i>	<ul style="list-style-type: none"> ▪ How many activities were conducted with children in the schools following these training of teachers? ▪ How many of the teachers or counsellors actually conducted psychosocial activities in the short-term? ▪ How many children were referred to counselling? 		
	<i>Quality of the activities conducted with the children.</i>	<ul style="list-style-type: none"> ▪ Current level of competence of counsellors and trainees in TOT. ▪ Level of competence of trainees (teachers, counsellors and participants in TOT) after the training. 		Monthly reports Interviews with beneficiaries and parents Interviews with trainees Interviews with UNICEF staff
	<i>Materials.</i> <ul style="list-style-type: none"> ▪ Where the materials appropriate and timely? 	<ul style="list-style-type: none"> ▪ Where materials provided to the teachers and counsellors to conduct activities with children or not? 		Interviews with UNICEF staff Monthly reports
e) What was the impact on beneficiaries?	<i>Impact of the activities on the children.</i>		Clinical reports from the therapists who used EMDR.	Monthly reports Interviews with UNICEF staff Interviews with trainees Interviews with beneficiaries and parents Comparison on Impact scales for children
f) Where there any indirect effects on beneficiaries or other agencies?		<ul style="list-style-type: none"> ▪ To what degree was KOMNASPA empowered in this project? ▪ Indicators: subsequent projects conducted? Qualifications of the staff now? Interest of staff in receiving further training after this project. 		

4. Implementation				
a) Was the project implemented as designed?	<i>Trainees</i> <ul style="list-style-type: none"> ▪ Why were there so many problems with selecting the participants? ▪ Was it logistical or was it due to the extremely limited qualifications of the people? 	<ul style="list-style-type: none"> ▪ What were the qualifications of the teachers? ▪ What were the qualifications of the ‘counsellors’? Did they have any previous experience? 		CFSI Evaluation Interviews with UNICEF staff and partner organisations
	<i>Partnerships and networking</i> <ul style="list-style-type: none"> ▪ How well were the project coordinated? ▪ How well did the networking between trainees function? 	<ul style="list-style-type: none"> ▪ How effective was the coordination between implementing agencies? ▪ Was there appropriate coordination for the children with psychosocial services once they returned to East Timor? 		CFSI Evaluation Gemma’s evaluation Interview with UNICEF staff Interviews with trainees Interviews with partner organisations
	<i>Follow-up</i> <ul style="list-style-type: none"> ▪ How much follow-up was conducted? ▪ Was the follow-up sufficient? 	<ul style="list-style-type: none"> ▪ Why exactly was the advanced training not conducted? ▪ Why do we have no information on the follow-up supervision by the consultant? Why was so little follow-up done on the activities in the schools? ▪ Was it really impossible to conduct longer-term training of the teachers or counsellors in WT? 		CFSI Evaluation Gemma’s evaluation Interview with UNICEF staff and partner organisations
	<i>Constraints</i> <ul style="list-style-type: none"> ▪ What were the constraints on the implementation of this project? ▪ How were or could these constraints have been overcome? ▪ Where the constraints sufficient explanation for the limitations of the projects? 			CFSI Evaluation Interview with UNICEF staff and partner organisations
b) Was the project efficient?	<i>Cost efficiency</i>			Project proposals Staff interviews
	<i>Timely implementation</i>			Interviews with staff, trainees and partner organisations
	<ul style="list-style-type: none"> ▪ Did the project relate well to the peace building work? ▪ Were the projects integrated with other UNICEF projects, particularly in the emergency section? 			Monthly reports Interviews with UNICEF staff

c) Were the projects integrated with other UNICEF activities?				Interviews with UNICEF staff and partner organizations Interviews with other organisations
d) Were the project activities coordinated with other psychosocial programmes				Interviews with other organizations with psychosocial programmes
5. Recommendations				Interviews with UNICEF staff, trainees, beneficiaries and other organizations UNICEF planning documents
a) Future psychosocial response – strategy				Interviews with UNICEF staff, trainees, beneficiaries and other organizations
b) Illustrative examples of projects				
c) Psychosocial materials needed				

Appendix 2: Focus Group Interview Questions

Parents

- What was your family situation (at the time of the activity)?
- Did you notice any changes in your child as a result of the difficulties you were facing?
- If necessary - Did you notice any changes in the psychosocial indicators (list indicators)?
- Where there any changes for the good? What were some of the problem behaviours?
- What kind of (psychosocial) activities did your child participate? How long and how often did they participate in these activities?
- Did you notice any changes in your child during the time they participated in these activities? Do you think these changes were due to their participation in the activities or due to other things?
- What kind of other things helped your child to overcome the problems they were facing at this time?
- Was there any other assistance that you think would have helped your child more than the assistance they received in the psychosocial programme?
- Does your child still have some problems from that time?
- If yes, what do you think your child needs now to help them overcome these problems?

Children (9 years or older)

Open ended questions (simplify for younger children – use stories):

- Can you tell me what your life was like at this time (the start of the project)?
- What did you do during these activities?
- Did you notice any changes in yourself at this time (prompt with psychosocial indicators if necessary)?
- Which of these changes were you happy about? Which ones didn't you like?
- Did you notice any changes in your friends? In yourself after doing these activities? Why did these changes happen?
- What kind of things helped you to overcome your problems? What did you do? What did other people do for you?
- Was there some things you think would have helped you at that time but you couldn't get?
- Are there still some problems you face from this time? Are there any good things still in your life from this time?

Trainees

- What were the main needs of the beneficiaries at this time?
- Do you think that this psychosocial project meet those needs?
- What was the most significant learning of the programme?
- What were the most significant outcomes of the programme?
- What, if anything, would have been done differently?⁵⁰
- Where the training topics appropriate? Should any other training topics been added? Where there any topics that were not relevant or that should not have been used?
- What were the most important things you learnt in this programme that helped you to provide psychosocial assistance to children?
- After this programme, what were the difficulties you faced in providing psychosocial assistance to children? Where there some skills you felt you needed but didn't gain from this training?
- What other areas have you learnt since, and what do you think would have been most important to include in the training then?
- How long did you continue conducting psychosocial activities for? What activities did you conduct exactly?
- Did you stay in contact with any of the other trainees? If yes, how and for what purposes?
- Are you still conducting psychosocial activities now?

Continue only if trainee is still active in psychosocial work

- What type of psychosocial programmes do you think are most needed now?
- What kind of things would you like to support you to conduct further psychosocial activities?

⁵⁰ Questions asked of the trainers from the psychosocial help project in the final report.

Appendix 3: Staff, Trainees and Beneficiaries Interviewed, Questionnaires Completed and Documents Reviewed

Staff Interviewed:

- Ali Aulia, former Project Manager, Psychosocial Projects, UNICEF Indonesia
- Dr. John Hartung, EMDR trainer, EMDR-HAP
- Ms. Shinto Adelar, Psychosocial Co-Trainer, UI
- Ms. Brigitte Lund-Henriksen and Julie Lebague, Children in Need of Special Protection Section, UNICEF Indonesia

Trainees interviewed and completed questionnaire:

Aceh:

- Diana Devi BHsc, RATA Chairperson
- Hayatullah, RATA – Banda Aceh
- Jannatul Wardani, RATA – Bireuen
- Cut Samsumniati, RATA – Lhokseumawe
- Nur Amir Yetty, RATA – Lhokseumawe
- Muzakir, RATA – Sigli
- Drs. Abubakar, Syiah Kuala University (UNSYIAH)
- Dr. Abdul Wahab, UNSYAH – Med faculty
- Dr. Reza Syah, Lhokseumawe Psychiatric Hospital
- Mutia Prima Dara, Psi., RSUZA Banda Aceh
- Dr. Harnold Harun, Aceh Mental Hospita – Banda Aceh
- Dra. Kartini Hasan, BKKBN Banda Aceh
- Linda Hyawata, PCC Banda Aceh
- Rismawati, PCC Banda Aceh
- Syarifah Soraya, KKTGA Banda Aceh
- Suhaita, YAB Banda Aceh
- Faidaturrajni, YAB Banda Aceh
- # Total: 17 participants (from 23)

Surabaya:

- Sudaryono, Crisis Centre – Airlangga University (UNAIR)
- Endang RS, Crisis Centre UNAIR
- Ilham Nur Alfian, Crisis Centre UNAIR
- Dr. Albert Maramis, RS dr. Soetomo
- Sony Karsono, University of Surabaya (UBAYA)
- Yeni Lutfiana, PMII
- # Total: 6 participants (from 6)

Madura:

- Untung Rifa'i, Pondok Siswa Bahagia – Sampang
- # Total: 1 participant (from 2)

Jakarta:

- Hera Lestari M, Crisis Centre, Faculty of Psychology-University of Indonesia
- Shinto B. Adelar, Crisis Centre-University of Indonesia (UI)
- Ramches Merdeka, KOMPAK
- Adam TH Toto, Christian Children's Fund (CCF)
- Dr. Jonli Indra, Health Department
- Dr. Kusman S, Health Department
- Ellydar Risman, Psi., Kita & Buah Hati (via Fax)
- # Total: 6 participants and 1 via fax (from 14)

Ambon:

- Patrick Rahaban, Lembaga Pemberdayaan Anak Marginal (LPAM)
 - Iskar BN, Lembaga Eksistensi Muslim Maluku (LEMM)
 - Dr. A. Rivai, Alfatah Hospital
 - Bace Pattiselano, GPP/Yayasan Ekaleo/Counselling bureau of Pattimura Univ.
 - John Dumatubun, Yayasan St. Theresia
 - Ny. Yos Mustamu, Child division-General Hospital
 - Mrs. Lou Soumokil, General Hospital
 - Dr. Robert, Health Centre (Puskesmas)
 - Ibiham Samium, Psychiatric Hospital / Trauma Centre
 - Bay Tualeka, Lembaga Pemberdayaan Anak dan Perempuan (LAPAN)
- # Total: 10 participants (from 21)

Sulawesi:

- Rusdin Tompo, LISAN-South Sulawesi
 - Ridwan Ade, PIARA-South East Sulawesi
- # Total: 2 participants (from 5)

Medan:

- Rupinawati, PKPA-North Sumatra
 - Irmawati, Psi.
- # Total: 2 participants (from 3)

West Kalimantan:

- Eli Hakim Silaban, Yayasan Perlindungan Hak Anak (YPHA)
- # Total: 1 participant (from 2)

Ende:

- Yulita Lake, Yayasan Tapenmasu
- # Play facilitator programme in West Timor

Ternate: 0 from 2 participants

NTB : 0 from 1 participant

TOTAL: 45 participants interviewed or completed questionnaire

Beneficiaries focus groups:

- Pesantren Darussalam, Sampang – Madura : 40 children
- EMDR beneficiaries in Bireuen – Aceh, RATA : 5 adults, 1 child

List of Beneficiaries and Questionnaires completed:

Psychosocial + conflict:

- Pesantren Darussalam, Sampang – Madura : 40 children
- Psychosocial beneficiaries, Ambon : 50 children

EMDR + conflict:

- EMDR beneficiaries in Bireuen – Aceh, RATA : 5 adults, 1 child
- EMDR beneficiaries from PCC, Lhokseumawe : 27 children, 10 parents
- EMDR beneficiaries from PCC, Pidie : 20 children

EMDR + no conflict:

- EMDR beneficiaries from YAB, Banda Aceh : 15 street children

No therapy + conflict:

- IDP camp, Kampus Politeknik – Lhokseumawe : 125 children
- Junior highschool, Ambon : 50 children

No therapy + no conflict:

- Junior highschool student, Banda Aceh : 50 children

Documents Reviewed

- United Nations Economic and Social Council (1995) 'A Review of UNICEF Policies and Strategies on Child Protection', UNICEF Executive Board Annual Session June 1996 Item E/ICRF/1995/13
- United Nations Economic and Security Council (1995), A Review of UNICEF Policies and Strategies on Child Protection, UNICEF Executive Board Annual Session June 1996 Item E/ICRF/1995/13, item (b)
- Technical Notes: Special Considerations for Programming in Unstable Situations. Chapter 14: Protecting Psychosocial Development
- Promoting Children Protection and Recovery Through Training in Psychosocial Rehabilitation, Mission Report, CFSI, December 1999.
- Basic Training on Psychosocial Help for Children in Situations of Armed Conflict. Training 1. A trainers manual (2000). CFSI, UP/CIDS
- Promoting Child Protection and Recovery through Training in Psychosocial Rehabilitation, Mission Report, Dr. Alleza and Ms. Lourdes, February 2000.
- Promoting Child Protection and Recovery through Training in Psychosocial Rehabilitation, A Report and Evaluation on the collaboration between UNICEF, CFSI and UP/CIDS-PST (date unspecified, but probably mid 2001)
- See Emergency Education and Psychosocial Support Programmes for Children of Internally Displaced People in West Timor, Field Trip Report, March 5-9, Jiyono Education Officer, UNICEF
- Monthly Report, Reporting Period 1-31 March 2000, Ali Aulia Ramly, UNICEF Consultant.
- Monthly report, Fitri Fausiah, UNICEF consultant, June 10, 2000.
- Psychosocial Activities, Progress Report, Ali Aulia, UNICEF Consultant, July 2000
- Promoting Child Protection and Recovery Through Psychosocial Rehabilitation of Traumatized Children and Nonviolent Conflict Resolution Initiatives through Public and Private Schools in Aceh, Project Proposal, UNICEF, August 2000.
- Summerfield, D. (1998). The Social Experience of War and Some Issues for the Humanitarian Field, in Rethinking the Trauma of War. Bracken, P. and Petty, C., Save the Children.
- Bracken, P. (1998). Hidden Agendas: Deconstructing Post Traumatic Stress Disorder in Rethinking the Trauma of War. Bracken, P. and Petty, C., Save the Children.
- Documentation Report: Implementation of Eye Movement Desensitization and Reprocessing Project, December 2000-2001, UNICEF.
- Trauma Among Young Children in North Maluku, Report on North Maluku Mission, 17-23 November 2001, Reyhana Seedat.
- Psychosocial Interventions, Evaluation of UNICEF Supported Projects, UNICEF West Bank and Gaza, 1999-2000.

Appendix 4: List of Acronyms

CPB – Child Protection Bodies
EMDR – Eye Movement Desensitisation and Reprocessing
IDP – Internally Displaced People
NGO – Non-Governmental Organisation
OCHA – Office for the Coordination of Humanitarian Affairs
TOT – Training of Trainers
UA – University of Airlangga
US – University of Surabaya
WT – West Timor

Appendix 5: Questionnaires

Note: The English version of the Questionnaires are presented first, followed by the Indonesian version which was the version actually used with respondents



UNICEF Indonesia Questionnaire for Trainees

1. **Name:**
2. **Organisation:**
3. **Contact Details**
Address:
Phone:
Email and/or fax:
4. **What UNICEF-sponsored trainings did you participate in?**
 Training for Psychosocial Help (Jakarta, April 2001)
 EMDR Training Level I
 EMDR Training Level II
5. **What were the main needs of the beneficiaries at this time? Do you think that this psychosocial project meet those needs?**
6. **What were the positive things of this programme?**
7. **What, if anything, should have been done differently?**
8. **What were the most important things you learnt in this programme that helped you to provide psychosocial assistance to children?**
9. **After this programme, what were the difficulties you faced in providing psychosocial assistance to children? Where there some skills you felt you needed but didn't gain from this training?**
10. **Did you stay in contact with any of the other trainees? If yes, how and for what purposes?**
11. **Did you use the skills that you learnt in this training?**
12. **If yes,**
 - **What activities did you conduct?**
 - **For how long did you conduct these activities?**
 - **How many children benefited from these activities**
 - **How many times did you meet with each child (on average)**
 - **Are you still conducting psychosocial activities now?**
13. **What type of psychosocial programmes do you think are most needed for children in this area now?**
14. **What kind of things would you like to support you to conduct further psychosocial activities?**



UNICEF Indonesia

Kuesioner untuk Peserta Training

1. **Nama:**
2. **Organisasi:**
3. **Data untuk dihubungi**

Alamat:

Telepon:

Email dan/atau fax:

4. **Anda berpartisipasi pada training apa, yang disponsori oleh UNICEF?**

_____ Training untuk Bantuan Psikososial (Psychosocial Help) - Jakarta, April 2000

_____ EMDR Training Level I – Jakarta, April 2000

_____ EMDR Training for Leadership group - Jakarta, Juli 2001

_____ EMDR Training in Ambon, 14-18 Mei 2001

_____ EMDR Training Level II - Aceh, Juli 2001

5. **Menurut Anda, apa kebutuhan utama dari anak-anak dan keluarga mereka saat ini?
Apakah proyek Psikososial ini dapat memenuhi kebutuhan tersebut?**

6. **Apakah ada hal-hal positif dari program ini?**

7. **Apakah ada hal-hal yang seharusnya dilakukan dengan cara yang berbeda? Bila ada, hal-hal apa saja?**

8. **Apakah topik dari training tersebut sesuai dengan konteks?**

9. **Apakah ada topik lain untuk training yang ingin Anda tambahkan?**

10. **Apakah di antara topik-topik dari training yang Anda ikuti tersebut sudah tidak relevan atau seharusnya tidak digunakan lagi?**

11. Bidang apa saja yang sudah Anda pelajari sejak saat itu, dan bidang apa yang menurut Anda penting untuk dimasukkan dalam materi training?
12. Apa hal yang paling penting yang Anda pelajari dari program ini untuk menyediakan bantuan psikososial bagi anak-anak?
13. Setelah mengikuti program ini, kesulitan-kesulitan apa saja yang Anda hadapi dalam memberikan bantuan psikososial kepada anak-anak? Apakah ada keahlian tertentu yang Anda rasa dibutuhkan namun tidak Anda dapatkan dari Training ini?
14. Apakah Anda tetap menjalin hubungan dengan peserta training yang lain? Bila ya, bagaimana dan untuk tujuan apa?
15. Apakah Anda menggunakan keahlian-keahlian yang Anda pelajari dari Training ini?
16. Bila ya,
 - Kegiatan apa yang Anda lakukan?
 - Untuk berapa lama Anda melakukan kegiatan/aktifitas tersebut?
 - Berapa banyak anak yang menerima manfaat dari kegiatan ini?
 - Kira-kira berapa kali Anda bertemu (mengadakan pertemuan) dengan tiap anak?
 - Apakah Anda masih melakukan kegiatan psikososial sekarang?
17. Menurut Anda program seperti apa yang paling dibutuhkan oleh anak-anak di area ini sekarang?
18. Hal-hal apa yang Anda inginkan untuk mendukung Anda melakukan kegiatan psikososial selanjutnya/di masa mendatang?

Appendix 6: Questionnaires for Children and Parents
Children's Behaviour Checklist

This checklist is part of UNICEF's programme to help the Indonesian children living in conflict areas. UNICEF is the United Nations organization that helps children all over the world.

This checklist is designed to give an indication of your child's behaviour. As all children react differently to living in conflict areas, there are no right and wrong answers.

All information will be confidential and used only by UNICEF. Participation in this study is entirely voluntary. You do not have to complete the questionnaire.

If you choose to participate, the information will be used only to determine whether children who participated in certain types of activities, such as playgroups, behave differently than children who did not participate in such activities. Your responses will not be looked at alone but will be combined with the responses of parents of similar children and compared to children who participated in different activities. This information will be used to improve the quality of the activities for children living in conflict areas.

If your child is 12 years old or more, we will also ask them to complete a questionnaire about their behaviour and feelings.

If you have any questions or comments about this study, please contact Dr. Amanda Melville, UNICEF Indonesia (PO Box 8318/JKSMP Jakarta 12083, phone: 021 570 5816, email: amelville@unicef.org.id).

Please continue if you agree to participate in this study.

I _____ agree to participate in the UNICEF study on psychosocial projects.

I agree that my child _____ can participate in the UNICEF study on psychosocial projects.

Signature: _____ Date: _____

Children's Behaviour Checklist

Please answer this checklist for your child who participated in the UNICEF-sponsored activity. If you have more than one child who participated in this activity, please just choose one child to write about.

Background information

Name of your child:

Current age of your child:

Age of your child when they participated in the activity:

Type of Activity (please tick one):

Individual therapy

Play group

Group counseling

School-based activity

For how long did your child participate in this activity?:

Sex of your child:

Current address:

How many years did you live in a conflict zone:

Did you live most of the time in (please tick one):

A very dangerous area

A somewhat dangerous area

A slightly dangerous area

A safe area

How many times have you moved in the last 3 years:

What is your highest level of education:

Are you or your husband/wife working? If so in what field?:

**PARENTS QUESTIONNAIRE
CHILDREN 0-5 YEARS OLD**

For each behaviour described below, please mark whether your child *never, sometimes or often* displays this behaviour. For each line please put a cross in only one box - that is, choose between never, sometimes and often for each behaviour.

Please answer as honestly as you can. Remember, there are no right or wrong answers.

Description of Behaviour	Never	Sometimes	Often
Cries easily or is very sad			
Shows interest in what is happening around them and/or is responsive to things around them			
Is withdrawn and doesn't interact with people around them			
Has sleeping problems, nightmares, doesn't sleep enough or sleeps too much			
Is able to be separated from care-takers or to be alone at appropriate times			
Is frightened of real or imagined objects of people more than needed			
Trembles or appears frightened for no obvious reason			
Is able to trust others and is not overly suspicious or fearful of others			
Has eating problems, such as not eating or eating too much			
Gets sick or has problems such as headaches; dizziness, backaches, eyestrain or stomach upsets for no physical reason.			
Bangs his or her head or rocks backwards and forwards			
Seems to be going back to an earlier stage of development (e.g. acting like a younger child, resuming thumb sucking)			
Is overly active (can't sit still)			
Respects the authority of their parents or other adults			
Is physically aggressive or very loud and rough with others			
Is irritable or in a bad mood for long periods of time (eg hours or days)			
Works well with others			
Is restless and has difficulty to complete a task			
Is able to concentrate			
Is able to learn new knowledge and skills			
Began behaviours such as smiling, sitting, walking or talking at the appropriate time			

For children who are not yet talking: My child is “babbling” or talking “baby talk”			
For children who have been toilet-trained: My child wets the bed at night or wets itself in daytime			
For children who have been toilet-trained: My child loses control over their bowels			

**PARENTS QUESTIONNAIRE
CHILDREN 6-12 YEARS OLD**

For each behaviour described below, please mark whether your child *never, sometimes or often* displays this behaviour. For each line please put a cross in only one box - that is, choose between never, sometimes and often for each behaviour.

Please answer as honestly as you can. Remember, there are no right or wrong answers.

Description of Behaviour	Never	Sometimes	Often
Cries easily or is very sad			
Shows interest in what is happening around them and/or is responsive to things around them			
Is withdrawn and doesn't interact with people around them			
Has sleeping problems, nightmares, doesn't sleep enough or sleeps too much			
Is able to be separated from care-takers or to be alone at appropriate times			
Is frightened of real or imagined objects of people more than needed			
Trembles or appears frightened for no obvious reason			
Is able to trust others and is not overly suspicious or fearful of others			
Has eating problems, such as not eating or eating too much			
Gets sick or has problems such as headaches; dizziness, backaches, eyestrain or stomach upsets for no physical reason.			
Bangs his or her head or rocks backwards and forwards			
Seems to be going back to an earlier stage of development (e.g. acting like a younger child, resuming thumb sucking)			
Is overly active (can't sit still)			
Respects the authority of their parents or other adults			
Is physically aggressive or very loud and rough with others			
Is irritable or in a bad mood for long periods of time (eg hours or days)			
Works well with others			
Is restless and has difficulty to complete a task			
Is able to concentrate			
Is able to learn new knowledge and skills			
Concentrates well in school			

Forms friendships easily, and able to maintain some friendships			
Gets along well with their siblings			
Had a particularly difficult time to cope with the death of someone close to them			
Is moody – that is, their mood and behaviour changes significantly in a short time			
Is overly fearful that bad things will happen in the future			
Does not seem to react emotionally to situations (eg does not seem afraid, or happy when appropriate)			
Seems <i>deliberately</i> spiteful, cruel or annoying			
Feels guilty more than necessary			
Can let people know when they are angry without being aggressive			
My child's mind seems to go blank (eg they forget what they were talking about, or suddenly 'space out')			
Is able to talk about difficult events that happened to themselves or others around them			
Has deliberately hurt themselves or talked about hurting themselves			
Has panic attacks (difficulties breathing and uncontrollably scared for no apparent reason)			
Takes unnecessary risks or engages in dangerous behaviours (smoking, drinking, going to dangerous places)			
Has sudden, strong, reoccurring memories that they can't control of difficult events			

**PARENTS QUESTIONNAIRE
CHILDREN 12-18 YEARS OLD**

For each behaviour described below, please mark whether your child *never*, *sometimes* or *often* displays this behaviour. For each line please put a cross in only one box - that is, choose between never, sometimes and often for each behaviour.

Please answer as honestly as you can. Remember, there are no right or wrong answers.

Description of Behaviour	Never	Sometimes	Often
Cries easily or is very sad			
Shows interest in what is happening around them and/or is responsive to things around them			
Is withdrawn and doesn't interact with people around them			
Has sleeping problems, nightmares, doesn't sleep enough or sleeps too much			
Is able to be separated from care-takers or to be alone at appropriate times			
Is frightened of real or imagined objects of people more than needed			
Trembles or appears frightened for no obvious reason			
Is able to trust others and is not overly suspicious or fearful of others			
Has eating problems, such as not eating or eating too much			
Gets sick or has problems such as headaches; dizziness, backaches, eyestrain or stomach upsets for no physical reason.			
Bangs his or her head or rocks backwards and forwards			
Seems to be going back to an earlier stage of development (e.g. acting like a younger child, resuming thumb sucking)			
Is overly active (can't sit still)			
Respects the authority of their parents or other adults			
Is physically aggressive or very loud and rough with others			
Is irritable or in a bad mood for long periods of time (eg hours or days)			
Works well with others			
Is restless and has difficulty to complete a task			
Is able to concentrate			
Is able to learn new knowledge and skills			
Concentrates well in school			
Forms friendships easily, and able to maintain some friendships			

Gets along well with their siblings			
Had a particularly difficult time to cope with the death of someone close to them			
Is moody – that is, their mood and behaviour changes significantly in a short time			
Is overly fearful that bad things will happened in the future			
Does not seem to react emotionally to situations (eg does not seem afraid, or happy when appropriate)			
Seems <i>deliberately</i> spiteful, cruel or annoying			
Feels guilty more than necessary			
Can let people know when they are angry without being aggressive			
My child’s mind seems to go blank (eg they forget what they were talking about, or suddenly ‘space out’)			
Is able to talk about difficult events that happened to themselves or others around them			
Has deliberately hurt themselves or talked about hurting themselves			
Has panic attacks (difficulties breathing and uncontrollably scared for no apparent reason)			
Takes unnecessary risks or engages in dangerous behaviours (smoking, drinking, going to dangerous places)			
Has sudden, strong, reoccurring memories that they can’t control of difficult events			
My child is able to form their own views			
My child has seen or heard things that do not exist			
Communicates well with others			
Behaves irresponsibly (lying, thinking only of themselves, skipping school)			
Causes problems in the family			
Has found their place in the community			
Displays inappropriate emotions (eg laughing in sad situations)			
Think about the effect of their actions on others			
My child has lost hope in the future			
My child is overly critical of themselves or does not believe they are good at anything			
Is good at making decisions when necessary			
My child is questioning or has changed their fundamental beliefs and values			

**TEENAGER QUESTIONNAIRE
12-18 YEARS OLD**

Name:

Age:

Sex:

Current address:

Type of activity that you participated in (please tick one):

Individual therapy

Play group

Group counseling

School-based activity

For how long did you participate in this activity?:

How many years did or do you live in a conflict zone:

Did you live most of the time in (please tick one):

A very dangerous area

A somewhat dangerous area

A slightly dangerous area

A safe area

How many times have you moved in the last 3 years?:

What is your highest level of education?:

Are you mother or father working? If so in what field?:

For each behaviour described below, please mark whether you *never*, *sometimes* or *often* do this. For each line please put a cross in only one box - that is, choose between never, sometimes and often for each behaviour.

Please answer as honestly as you can. Remember, there are no right or wrong answers.

Description of Behaviour	Never	Sometimes	Often
I cry easily or feel really sad for hours or days			
I am interested and involved in things in my daily life			
I feel shy around other people			
I sleep too much, too little, wake up really tired or have nightmares			
I like to be alone or away from my parents at times			
I get really scared, even when I know I shouldn't			
I get so scared I feel out of control			
I have some adults in my life that I can trust			
I eat much more than other kids, or much less			
I have physical illnesses or problems such as headaches; dizziness, backaches, eyestrain or stomach upsets for no obvious reason.			
I find myself banging my head or rocking backwards and forwards			
I have started doing things, such as sucking my thumb or wetting the bed that I used to do when I was younger			
I have so much energy that I have trouble to sit still			

I listen to and respect my parents and other adults			
I get so angry I can't control myself			
I am 'grumpy' for hours or days			
I am good at working with my friends or family to get things done together			
I find it difficult to finish things that I start			
I am able to concentrate on things when I need to			
I am able to learn new things			
I am able to concentrate in school and on my homework when I have to			
I can easily make friends and keep some of my friends			
I get along well with my siblings			
I found it more difficult than other people to deal with the death of someone close to me			
My mood changes a lot in a short time – ie sometimes I feel great and then suddenly I will feel bad			
I feel sure that something bad will happen, even if when I am thinking clearly I know it probably will not happen			
At times I find I don't feel anything (eg happy or sad) even when I know I should			
I find myself being nasty to other people on purpose			
I feel guilty more than I should			
I get so angry that I can't speak or I explode			
My mind seems to go blank (eg I forget what I was talking about, or suddenly 'space out')			
I am able to talk about difficult events that happened to me or others around me			
I have tried to hurt myself or thought about hurting myself			
I have had difficulties breathing and felt uncontrollably scared for no obvious reason			
I like to do risky things such as drinking or going to dangerous places			
I have had sudden, strong, distracting memories of difficult things that happened to me or other people around me			
I am able to make up my own mind on things			
I feel that things are "unreal" or that I am outside my body			
I am able to understand other people and be understood by them			

I do things that I know I shouldn't (such as lying, thinking only of myself, skipping school)			
I have problems to get along with my family			
I feel that I 'fit in' with my community			
I find myself laughing when other people are sad, or sad when others are happy			
I try to think about the effect of what I do on the people around me			
I feel there is no hope for a better future			
I think I am not good at anything			
I am good at making decisions when necessary			
I feel that I don't know what I believe in any more			

ADULT QUESTIONNAIRE

Background information

Name:

Age:

Sex:

Current address:

Type of Activity that you participated in (please tick one):

Individual therapy

Play group

Group counseling

School-based activity

For how long did you participate in this activity?:

How many years did you live in a conflict zone:

Did you live most of the time in (please tick one):

A very dangerous area

A somewhat dangerous area

A slightly dangerous area

A safe area

How many times have you moved in the last 3 years:

What is your highest level of education?:

Are you or your husband/wife working? If so in what field?:

Behavioural information

For each behaviour described below, please mark whether you *never*, *sometimes* or *often* do this. For each line please put a cross in only one box - that is, choose between never, sometimes and often for each behaviour.

Please answer as honestly as you can. Remember, there are no right or wrong answers.

Description of Behaviour	Never	Sometimes	Often
I cry easily or feel really sad for hours or days			
I am interested and involved in things in my daily life			
I feel shy around other people			
I sleep too much, too little, wake up really tired or have nightmares			
I like to be alone or away from other family members at times			
I get really scared, even when I know I shouldn't			
I get so scared I feel out of control			
I have some people in my life that I can trust			
I eat much more than other people, or much less			
I have physical illnesses or problems such as headaches; dizziness, backaches, eyestrain or stomach upsets for no obvious reason.			
I find myself banging my head or rocking backwards and forwards			
I have no energy or time to look after other people, like my children or family			

I have so much energy that I have trouble to sit still			
I listen to and respect other adults			
I get so angry I can't control myself			
I am 'grumpy' for hours or days			
I am good at working with my friends or family to get things done together			
I find it difficult to finish things that I start			
I am able to concentrate on things when I need to			
I am able to learn new things			
I am able to concentrate when I have to			
I can easily make friends and keep some of my friends			
I get along well with my family			
I found it more difficult than other people to deal with the death of someone close to me			
My mood changes a lot in a short time – ie sometimes I feel great and then suddenly I will feel bad			
I feel sure that something bad will happen, even if when I am thinking clearly I know it probably will not happen			
At times I find I don't feel anything (eg happy or sad) even when I know I should			
I find myself being nasty to other people on purpose			
I feel guilty more than I should			
I get so angry that I can't speak or I explode			
My mind seems to go blank (eg I forget what I was talking about, or suddenly 'space out')			
I am able to talk about difficult events that happened to me or others around me			
I have tried to hurt myself or thought about hurting myself			
I have had difficulties breathing and felt uncontrollably scared for no obvious reason			
I like to do risky things such as drinking or going to dangerous places			
I have had sudden, strong, distracting memories of difficult things that happened to me or other people around me			
I am able to make up my own mind on things			
I feel that things are "unreal" or that I am outside my body			
I am able to understand other people and be understood by them			

I do things that I know I shouldn't (such as lying, thinking only of myself)			
I have problems to get along with my family			
I feel that I 'fit in' with my community			
I find myself laughing when other people are sad, or sad when others are happy			
I try to think about the effect of what I do on the people around me			
I feel there is no hope for a better future			
I think I am not good at anything			
I am good at making decisions when necessary			
I feel that I don't know what I believe in any more			



Daftar Perilaku Anak

Daftar ini adalah bagian dari program UNICEF untuk membantu anak-anak Indonesia yang tinggal di daerah konflik. UNICEF adalah organisasi Perserikatan Bangsa-Bangsa (PBB) yang membantu anak-anak di seluruh dunia.

Daftar ini dirancang untuk mengetahui indikasi-indikasi dari perilaku anak. Karena anak-anak yang tinggal di daerah konflik bereaksi secara berbeda-beda, maka tidak ada jawaban salah ataupun benar.

Semua informasi akan dirahasiakan dan hanya digunakan untuk kepentingan UNICEF. Partisipasi dalam penelitian ini bersifat sukarela. Anda tidak diharuskan menyelesaikan kuesioner ini

Bila Anda memutuskan untuk turut berpartisipasi, informasi yang Anda berikan hanya akan digunakan untuk mengetahui apakah anak-anak yang ikut dalam jenis kegiatan tertentu, seperti ikut kelompok bermain, mempunyai perilaku yang berbeda dari pada anak-anak yang tidak ikut serta dalam kegiatan apa pun. Jawaban Anda tidak akan dinilai secara pribadi, tetapi akan dikombinasikan dengan jawaban dari orang tua yang memiliki anak dengan karakteristik serupa dengan anak Anda dan dibandingkan dengan anak-anak yang ikut dalam kegiatan berbeda. Informasi ini akan digunakan untuk meningkatkan kualitas kegiatan anak-anak yang tinggal di daerah konflik.

Apabila usia anak Anda 12 tahun ke atas, kami akan meminta mereka untuk mengisi sendiri kuesioner tentang perilaku dan perasaan mereka.

Bila Anda memiliki pertanyaan atau komentar mengenai penelitian ini, Anda bisa menghubungi Dr. Amanda Melville, UNICEF Indonesia (PO Box 8318/JKSMP Jakarta 12083, telepon: 021 570 5816, email: amelville@unicef.org.id).

Silakan melanjutkan ke halaman selanjutnya, bila Anda setuju untuk turut berpartisipasi dalam penelitian ini.

Saya _____ setuju untuk berpartisipasi dalam penelitian proyek Psikososial UNICEF.

Saya setuju bahwa anak saya _____ dapat berpartisipasi dalam penelitian proyek Psikososial UNICEF.

Tanda Tangan: _____

Tanggal: _____



Daftar Perilaku Anak

Silakan menjawab daftar ini apabila anak Anda pernah berpartisipasi dalam kegiatan yang disponsori UNICEF. Bila Anda mempunyai lebih dari satu anak yang berpartisipasi dalam kegiatan ini, pilihlah hanya satu anak untuk daftar ini.

Tolong menjawab sejujur-jujurnya. Ingat, tidak ada jawaban benar atau salah.

Informasi mengenai latar belakang Anak:

Usia anak Anda sekarang:

Usia anak Anda ketika mengikuti kegiatan UNICEF:

Jenis kegiatan (Silakan tandai kegiatan yang diikuti anak Anda):

- Terapi pribadi (individual)
- Kelompok bermain (play group)
- Kelompok konseling
- Kegiatan di sekolah

Berapa lama anak Anda ikut dalam kegiatan tersebut?:

Jenis kelamin anak Anda:

Alamat saat ini:

Berapa tahun Anda tinggal di daerah konflik?:

Anda tinggal kebanyakan di (tandai daerah yang Anda tinggali):

- Daerah yang sangat berbahaya
- Daerah yang cukup berbahaya
- Daerah yang tidak begitu berbahaya
- Daerah yang aman

Berapa kali Anda berpindah tempat tinggal dalam 3 tahun terakhir:

Apa pendidikan terakhir Anda:

Apakah suami/istri Anda bekerja? Bila ya, di bidang apa?:



**KUESIONER UNTUK ORANG TUA
DARI ANAK USIA 0-5 TAHUN**

Untuk setiap perilaku di bawah ini, silakan tandai *tidak pernah*, *kadang-kadang*, atau *sering* mengenai perilaku anak Anda. Untuk setiap pernyataan pilihlah hanya satu pilihan jawaban dan berikan tanda silang di kotak jawaban itu.

Tolong menjawab sejujur-jujurnya. Ingat, tidak ada jawaban yang benar atau salah.

Deskripsi Tingkah Laku	Tidak pernah	Kadang-kadang	Sering
Mudah menangis dan sedih berlebihan			
Menunjukkan minat dan/atau tanggap terhadap apa yang terjadi di sekelilingnya.			
Menarik diri atau tidak berinteraksi dengan orang di sekitarnya			
Mempunyai masalah tidur, mimpi buruk atau tidak dapat tidur, atau tidur berlebihan.			
Dapat dipisahkan dari pengasuh, atau berada sendirian.			
Takut pada orang, baik orang secara nyata atau dalam bayangan/imajinasi secara berlebihan			
Kelihatan takut atau gemetar tanpa alasan yang jelas			
Bisa mempercayai orang lain atau tidak curiga dan takut secara berlebihan pada orang lain.			
Punya masalah makan, seperti kehilangan selera makan atau makan berlebihan			
Sakit atau mempunyai masalah fisik seperti sakit kepala, pusing, sakit punggung, sakit pada mata, atau masalah pencernaan tanpa adanya sebab yang jelas.			
Membentur-benturkan kepalanya atau mengayunkan tubuhnya ke depan dan ke belakang			

Sepertinya mengalami penurunan ke tahap perkembangan awal (misalnya: berperilaku seperti anak yang lebih kecil, kembali menghisap jempol)			
Terlalu aktif (misalnya: tidak bisa duduk diam, berlarian setiap saat)			
Menghormati otoritas orang tuanya ataupun orang dewasa lainnya			
Berperilaku agresif secara fisik atau sangat berisik dan kasar selama bermain.			
Merasa tidak nyaman, atau mengalami perasaan atau sikap yang tidak menyenangkan dalam jangka waktu yang cukup lama (misalnya beberapa jam atau hari)			
Bekerja sama dengan baik dengan orang lain			
Gelisah dan mempunyai kesulitan untuk menyelesaikan tugas			
Mampu berkonsentrasi			
Mampu mempelajari pengetahuan dan keahlian baru			
Anak saya melakukan hal-hal seperti tersenyum, duduk, berjalan, atau bicara tepat pada waktunya			
Untuk anak-anak yang belum bicara: Anak saya mengeluarkan suara-suara atau mengoceh			
Untuk anak-anak yang sudah dilatih mengenai buang air: Anak saya mengompol di tempat tidur pada malam hari atau mengompol pada siang hari			
Untuk anak-anak yang sudah dilatih mengenai buang air: Anak saya tidak dapat mengontrol pencernaannya			



**KUESIONER UNTUK ORANG TUA
DARI ANAK USIA 6-12 TAHUN**

Untuk setiap perilaku di bawah ini, silakan tandai *tidak pernah*, *kadang-kadang*, atau *sering* mengenai perilaku anak Anda. Untuk setiap pernyataan pilihlah hanya satu pilihan jawaban dan berikan tanda silang di kotak jawaban itu.

Tolong menjawab sejujur-jujurnya. Ingat, tidak ada jawaban yang benar atau salah.

Deskripsi Perilaku	Tidak Pernah	Kadang-kadang	Sering
Mudah menangis dan sedih berlebihan			
Menunjukkan minat dan/atau tanggap terhadap apa yang terjadi di sekelilingnya.			
Menarik diri atau tidak berinteraksi dengan orang di sekitarnya			
Mempunyai masalah tidur, mimpi buruk atau tidak dapat tidur, atau tidur berlebihan.			
Dapat dipisahkan dari pengasuh, atau berada sendirian.			
Takut pada orang, baik orang secara nyata atau dalam bayangan/imajinasi secara berlebihan			
Kelihatan takut atau gemetar tanpa alasan yang jelas			
Bisa mempercayai orang lain atau tidak curiga dan takut secara berlebihan pada orang lain.			
Punya masalah makan, seperti kehilangan selera makan atau makan berlebihan			
Sakit atau mempunyai masalah fisik seperti sakit kepala, pusing, sakit punggung, sakit pada mata, atau masalah pencernaan tanpa adanya sebab yang jelas.			
Membentur-benturkan kepalanya atau mengayunkan tubuhnya ke depan dan ke belakang			
Sepertinya mengalami penurunan ke tahap perkembangan awal (misalnya: berperilaku seperti anak yang lebih kecil, kembali menghisap jempol)			
Terlalu aktif (misalnya: tidak bisa duduk diam, berlarian setiap saat)			
Menghormati otoritas orang tuanya ataupun orang dewasa lainnya			

Berperilaku agresif secara fisik atau sangat berisik dan kasar selama bermain.			
Merasa tidak nyaman, atau mengalami perasaan atau sikap yang tidak menyenangkan dalam jangka waktu yang cukup lama (misalnya beberapa jam atau hari)			
Bekerja sama dengan baik dengan orang lain			
Gelisah dan mempunyai kesulitan untuk menyelesaikan tugas			
Mampu berkonsentrasi			
Mampu mempelajari pengetahuan dan keahlian baru			
Berkonsentrasi dengan baik di sekolah			
Berteman dengan mudah dan mampu menjaga beberapa hubungan pertemanan			
Akur dengan saudara-saudaranya			
Mengalami masa yang sangat sulit untuk menerima kematian orang yang dekat dengannya			
Tidak stabil perasaannya, yaitu perasaan dan tingkah lakunya dapat berubah secara drastis dalam waktu yang singkat			
Mempunyai ketakutan yang berlebihan bahwa sesuatu yang buruk akan terjadi di masa yang akan datang			
Tidak bereaksi secara emosional terhadap situasi yang dihadapinya (misalnya: tidak terlihat takut, atau senang secara tepat/ wajar)			
Kelihatan curiga, kejam, atau mengganggu secara menonjol			
Merasa bersalah secara berlebihan			
Dapat memberitahu orang lain bahwa mereka marah tanpa berlaku agresif			
Pikiran anak saya kelihatannya tidak fokus (misalnya: lupa tentang apa yang dikatakannya, atau tiba-tiba pikirannya kosong)			
Mampu membicarakan kejadian-kejadian sulit yang terjadi pada diri mereka atau yang terjadi pada orang lain di sekeliling mereka			
Dengan sangat jelas menyakiti dirinya sendiri atau bicara tentang menyakiti diri sendiri			
Mempunyai serangan rasa panik (seperti kesulitan untuk bernafas dan ketakutan tanpa alasan yang jelas secara tidak terkontrol)			
Mengambil resiko yang tidak perlu, atau berada dalam situasi berbahaya (seperti merokok, minum-minuman keras, pergi ke tempat-tempat berbahaya)			

Teringat akan kejadian-kejadian sulit dengan sangat jelas dan tiba-tiba, tanpa bisa dikontrol			
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**KUESIONER UNTUK ORANG TUA
UNTUK ANAK USIA 12-18 TAHUN**

Untuk setiap perilaku di bawah ini, silakan tandai *tidak pernah*, *kadang-kadang*, atau *sering* mengenai perilaku anak Anda. Untuk setiap pernyataan pilihlah hanya satu pilihan jawaban dan berikan tanda silang di kotak jawaban itu.

Tolong menjawab sejujur-jujurnya. Ingat, tidak ada jawaban yang benar atau salah.

Deskripsi Perilaku	Tidak Pernah	Kadang-kadang	Sering
Mudah menangis dan sedih berlebihan			
Menunjukkan minat dan/atau tanggap terhadap apa yang terjadi di sekelilingnya.			
Menarik diri atau tidak berinteraksi dengan orang di sekitarnya			
Mempunyai masalah tidur, mimpi buruk atau tidak dapat tidur, atau tidur berlebihan.			
Dapat dipisahkan dari pengasuh, atau berada sendirian.			
Takut pada orang, baik orang secara nyata atau dalam bayangan/imajinasi secara berlebihan			
Kelihatan takut atau gemetar tanpa alasan yang jelas			
Bisa mempercayai orang lain atau tidak curiga dan takut secara berlebihan pada orang lain.			
Punya masalah makan, seperti kehilangan selera makan atau makan berlebihan			
Sakit atau mempunyai masalah fisik seperti sakit kepala, pusing, sakit punggung, sakit pada mata, atau masalah pencernaan tanpa adanya sebab yang jelas.			
Membentur-benturkan kepalanya atau mengayunkan tubuhnya ke depan dan ke belakang			
Sepertinya mengalami penurunan ke tahap perkembangan awal (misalnya: berperilaku seperti anak yang lebih kecil, kembali menghisap jempol)			
Terlalu aktif (misalnya: tidak bisa duduk diam, berlarian setiap saat)			
Menghormati otoritas orang tuanya ataupun orang dewasa lainnya			

Berperilaku agresif secara fisik atau sangat berisik dan kasar selama bermain.			
Merasa tidak nyaman, atau mengalami perasaan atau sikap yang tidak menyenangkan dalam jangka waktu yang cukup lama (misalnya beberapa jam atau hari)			
Bekerja sama dengan baik dengan orang lain			
Gelisah dan mempunyai kesulitan untuk menyelesaikan tugas			
Mampu berkonsentrasi			
Mampu mempelajari pengetahuan dan keahlian baru			
Berkonsentrasi dengan baik di sekolah			
Berteman dengan mudah dan mampu menjaga beberapa hubungan pertemanan			
Akur dengan saudara-saudaranya			
Mengalami masa yang sangat sulit untuk menerima kematian orang yang dekat dengannya			
Tidak stabil perasaannya, yaitu perasaan dan tingkah lakunya dapat berubah secara drastis dalam waktu yang singkat			
Mempunyai ketakutan yang berlebihan bahwa sesuatu yang buruk akan terjadi di masa yang akan datang			
Tidak bereaksi secara emosional terhadap situasi yang dihadapinya (misalnya: tidak terlihat takut, atau senang secara tepat/ wajar)			
Kelihatan curiga, kejam, atau mengganggu secara menonjol			
Merasa bersalah secara berlebihan			
Dapat memberitahu orang lain bahwa mereka marah tanpa berlaku agresif			
Pikiran anak saya kelihatannya tidak fokus (misalnya: lupa tentang apa yang dikatakannya, atau tiba-tiba pikirannya kosong)			
Mampu membicarakan kejadian-kejadian sulit yang terjadi pada diri mereka atau yang terjadi pada orang lain di sekeliling mereka			
Dengan sangat jelas menyakiti dirinya sendiri atau bicara tentang menyakiti diri sendiri			
Mempunyai serangan rasa panik (seperti kesulitan untuk bernafas dan ketakutan tanpa alasan yang jelas secara tidak terkontrol)			
Mengambil resiko yang tidak perlu, atau berada dalam situasi berbahaya (seperti merokok, minum-minuman keras, pergi ke tempat-tempat berbahaya)			

Teringat akan kejadian-kejadian sulit dengan sangat jelas dan tiba-tiba, tanpa bisa dikontrol			
Anak saya mampu mengeluarkan pendapatnya/pemikirannya sendiri			
Anak saya melihat atau mendengar hal-hal yang tidak nyata/tidak ada			
Berkomunikasi dengan baik dengan orang lain			
Berperilaku dengan tidak bertanggung jawab (berbohong, hanya memikirkan diri sendiri, membolos dari sekolah)			
Menyebabkan banyak masalah dalam keluarga			
Telah menemukan tempatnya dalam masyarakat/merasa diterima dalam masyarakat			
Menunjukkan emosi yang tidak pada tempatnya (misalnya: tertawa pada situasi sedih)			
Memikirkan akibat dari tindakan mereka, pada orang lain			
Anak saya kehilangan harapan akan masa depan			
Anak saya terlalu mengkritik dirinya sendiri dan tidak percaya bahwa dia mampu berbuat sesuatu yang baik			
Mampu membuat keputusan bila diperlukan			
Anak saya mempertanyakan atau telah merubah kepercayaan atau nilai-nilai dasarnya			



**KUESIONER UNTUK REMAJA
USIA 12-18 TAHUN**

Nama:

Usia:

Jenis kelamin:

Alamat saat ini:

Jenis kegiatan (Silakan tandai kegiatan yang Anda ikuti):

- Terapi pribadi (individual)
- Kelompok bermain (play group)
- Kelompok konseling
- Kegiatan di sekolah

Berapa lama Anda ikut dalam kegiatan tersebut?:

Berapa tahun Anda tinggal di daerah konflik?:

Anda tinggal kebanyakan di (tandai daerah yang Anda tinggali):

- Daerah yang sangat berbahaya
- Daerah yang cukup berbahaya
- Daerah yang tidak begitu berbahaya
- Daerah yang aman

Berapa kali Anda berpindah tempat tinggal dalam 3 tahun terakhir? :

Apa pendidikan terakhir Anda? :

Apakah Ayah/Ibu Anda bekerja? Bila ya, di bidang apa?:

Untuk setiap perilaku di bawah ini, silakan tandai *tidak pernah*, *kadang-kadang*, atau *sering* mengenai perilaku anak Anda. Untuk setiap pernyataan pilihlah hanya satu pilihan jawaban dan berikan tanda silang di kotak jawaban itu.

Tolong menjawab sejujur-jujurnya. Ingat, tidak ada jawaban yang benar atau salah.

Deskripsi Tingkah Laku	Tidak pernah	Kadang-kadang	Sering
Saya mudah menangis atau merasa sangat sedih selama berjam-jam atau sehari-hari			
Saya tertarik dan terlibat dalam hal-hal di kehidupan saya sehari-hari			
Saya merasa malu bila berada di sekitar orang lain			
Saya terlalu banyak tidur, atau terlalu sedikit tidur, bangun dengan perasaan lelah atau mengalami mimpi buruk			
Saya suka sendirian atau tidak berada di dekat orang tua saya pada waktu-waktu tertentu			
Saya bisa menjadi sangat ketakutan, walaupun saya tahu bahwa tidak seharusnya saya ketakutan			
Bila saya sangat ketakutan, saya seperti kehilangan kontrol atas diri saya			

Saya memiliki orang-orang dewasa dalam hidup saya yang bisa saya percayai			
Saya makan jauh lebih banyak dari anak-anak lain, atau makan jauh lebih sedikit			
Saya menderita sakit kepala, pusing, sakit punggung, sakit mata, atau masalah pencernaan tanpa adanya sebab yang jelas.			
Saya mendapati diri saya membentur-benturkan kepala atau mengayunkan tubuh ke depan dan ke belakang			
Saya mulai menghisap jempol lagi atau mengompol di tempat tidur, seperti waktu saya kecil			
Saya mempunyai begitu banyak energi sehingga saya tidak bisa duduk diam			
Saya mendengarkan dan menghormati orang tua saya dan orang dewasa lain			
Ketika saya sangat marah, saya tidak bisa mengontrol diri saya			
Saya menggerutu selama berjam-jam atau sehari-hari			
Saya dapat bekerja dengan baik dengan teman-teman atau dengan keluarga saya untuk melakukan sesuatu bersama-sama			
Saya kesulitan untuk menyelesaikan hal-hal yang saya mulai			
Saya mampu untuk berkonsentrasi bila diperlukan			
Saya mampu belajar hal-hal baru			
Saya mampu berkonsentrasi di sekolah dan pada Pekerjaan Rumah (PR) saya bila saya harus			
Saya mudah berteman dan tetap berteman dengan mereka			
Saya akur dengan saudara-saudara saya			
Saya merasa lebih kesulitan dari pada orang lain, dalam menghadapi kematian seseorang yang dekat dengan saya			
Perasaan saya berubah drastis dalam jangka waktu yang pendek – misalnya: kadang-kadang saya merasa hebat/senang dan sesaat kemudian saya merasa buruk/sedih			
Saya yakin sesuatu yang buruk akan terjadi, bahkan ketika saya sudah memikirkannya dengan jelas dan tahu bahwa hal itu kemungkinan tidak akan terjadi			
Pada saat-saat tertentu saya tidak dapat merasakan apa-apa (misalnya: senang atau sedih) walaupun saya tahu bahwa saya seharusnya merasakan sesuatu			

Saya mendapati diri saya bersikap buruk pada orang lain dengan sengaja			
Saya merasa bersalah lebih dari yang seharusnya			
Saya merasa sangat marah sehingga saya tidak bisa bicara atau saya akan meledak			
Pikiran saya seperti kosong (misalnya: saya lupa apa yang sedang saya katakan, atau tiba-tiba pikiran saya melayang-layang)			
Saya mampu membicarakan kejadian-kejadian sulit yang dialami oleh saya ataupun oleh orang lain di sekitar saya			
Saya pernah mencoba menyakiti diri saya atau pernah berpikir tentang hal itu			
Saya mempunyai kesulitan untuk bernafas dan merasa takut secara tidak terkontrol tanpa ada alasan yang jelas			
Saya suka melakukan hal-hal beresiko seperti minum-minuman keras atau pergi ke tempat-tempat berbahaya			
Saya mempunyai ingatan yang kuat, mengganggu, dan muncul secara tiba-tiba tentang kejadian-kejadian yang sulit, yang terjadi pada saya atau pada orang-orang di sekitar saya			
Saya mampu menetapkan pikiran saya sendiri			
Saya merasa hal-hal yang ada di sekitar saya tidak nyata atau seakan-akan saya berada di luar tubuh saya			
Saya mampu mengerti dan dimengerti oleh orang lain			
Saya melakukan hal-hal yang saya tahu tidak seharusnya dilakukan (seperti berbohong, hanya memikirkan diri sendiri, membolos dari sekolah)			
Saya punya masalah untuk akur dengan keluarga saya			
Saya merasa bahwa saya cocok di lingkungan saya			
Saya mendapati diri saya tertawa ketika orang lain sedih, dan sedih ketika orang lain senang			
Saya coba memikirkan efek dari tindakan saya terhadap orang-orang di sekitar saya			
Saya merasa tidak ada harapan untuk masa depan yang lebih baik			
Saya pikir saya tidak mampu mengerjakan apapun dengan baik			
Saya mampu membuat keputusan ketika diperlukan			
Saya merasa bahwa saya tidak tahu lagi apa yang harus saya percayai			



KUESIONER UNTUK ORANG DEWASA

Informasi mengenai Latar Belakang Anda

Nama:

Usia:

Jenis kelamin:

Alamat saat ini:

Jenis kegiatan (Silakan tandai kegiatan yang Anda ikuti):

- Terapi pribadi (individual)
- Kelompok bermain (play group)
- Kelompok konseling
- Kegiatan di sekolah

Berapa lama Anda ikut dalam kegiatan tersebut?:

Berapa tahun Anda tinggal di daerah konflik?:

Anda tinggal kebanyakan di (tandai daerah yang Anda tinggali):

- Daerah yang sangat berbahaya
- Daerah yang cukup berbahaya
- Daerah yang tidak begitu berbahaya
- Daerah yang aman

Berapa kali Anda berpindah tempat tinggal dalam 3 tahun terakhir? :

Apa pendidikan terakhir Anda? :

Apakah Suami/Istri Anda bekerja? Bila ya, di bidang apa?:

Informasi mengenai Daftar Perilaku

Untuk setiap perilaku di bawah ini, silakan tandai *tidak pernah*, *kadang-kadang*, atau *sering* mengenai perilaku anak Anda. Untuk setiap pernyataan pilihlah hanya satu pilihan jawaban dan berikan tanda silang di kotak jawaban itu.

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Saya suka sendirian atau tidak berada di dekat orang tua saya pada waktu-waktu tertentu			
Saya bisa menjadi sangat ketakutan, walaupun saya tahu bahwa tidak seharusnya saya ketakutan			
Bila saya sangat ketakutan, saya seperti kehilangan kontrol atas diri saya			

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Saya mendapati diri saya membentur-benturkan kepala atau mengayunkan tubuh ke depan dan ke belakang			
Saya mulai menghisap jempol lagi atau mengompol di tempat tidur, seperti waktu saya kecil			
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