

Project Evaluation

Psychosocial Care for Children Traumatized by Terrorist Violence

UNICEF - Algeria

1998 - 2003

PROJECT EVALUATION

Final Report October 2003

Psychosocial Rehabilitation of Children Traumatized by Terrorist Violence

UNICEF – Algeria, 1998-2003

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 Algeria August, 22nd to October 22nd 2003

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Executive Summary

Algeria has gone through a decade of terrorist violence that has targeted all aspects of normal life. More than 100,000 people killed in collective massacres and individual assassinations. The mental health effects of this period are immense and leave substantial scars on the physical, social and psychic life of today's Algeria. The infrastructure of the public sector has been devastated with severe attrition in the number and quality of human resources. Children and adolescents, who comprise more than half of population, have been affected directly and indirectly by the violence.

Several spontaneous initiatives from the public sector and civil society came to address the issue of children traumatized by terrorist violence. Initial assessment of needs and resources done by local experts and with the help of international consultants defined the needs developing the capacity of local resources in the area of psychosocial care for children traumatized by terrorist violence. In response to the needs UNICEF has launched a project for psychosocial rehabilitation of children traumatized by terrorist violence. The project has developed through several stages from an initial response to the crises to a partnership in development with public sectors and non-governmental organization.

Evaluation methodology used a mixed method participatory evaluation framework with quantitative and qualitative approaches. Data collection depended on existing records, reports and research data collected through the project activities, interviews with key persons in the different sectors, focus groups with adolescents, psychologists and teachers, and several case studies of children and families affected by violence.

Focus groups with adolescents, teachers and psychologists, and results from the research component, point out to the complexity of violence phenomena and their effects on the psychosocial wellbeing of children. The range of child and adolescent reactions to violence were multiple and cover the areas addressed by psychology, psychiatry, education, law, community and culture. They also support the call for a global approach to child well-being in the framework of the Child's Rights Convention.

The project has achieved an important objective of developing the capacity of human resources. A large number of psychologists, psychiatrists, teachers, school counselors and general practitioners have been reached by the training component. The outcome is the emergence of an informal network of professionals active in the area of psychosocial care for children in general and with those affected by violence in particular. The project has attempted to consolidate the network through supporting a group of focal points around which project activities were planned and implemented and decentralization of the project activities to the Wilayas most affected by violence.

A major objective was the technical and material support for structures active in providing services for traumatized children. In this area project contributed with a major investment in material and equipment to more than 40 structures in the public and NGO sectors. Utilization of this mode of support was non-specific for children traumatized by terrorist violence, but extended to include children in general, and even adults e.g. mothers in several areas. Some of the material was partially used e.g. psychological tests because of lack of skills.

The project has also addressed the objective of social mobilization through its technical and material support for the associations active in the area of child psychosocial care. Several NGOs with pioneering initiatives have been reached and involved in the psychosocial care for children affected by violence. Developing and supporting spaces for expression and rehabilitation for children and women has invited better community participation and involvement and more learning about community and culture.

Communication and coordination of activities among the different sectors and partners has been a major problem since the start of the project. Several attempts and strategies have been adopted by the project to overcome this problem and managed to partly activate communication around the project objectives. Communication and coordination however remains one of the most important obstacles to further development.

The impact of the project activities extend beyond the initial objectives and has contributed to developments in mental health policies and services in general. In the remaining period the project should focus on linking the developments at each level with the development on the other levels. The network should be linked with the technical management through documentation of the experience, information and data collection. The different sectors should be connected through re-activation of the intersectorial management of the project in a new form that takes into consideration the realities of the field. The technical management should be linked with the developing through monitoring and evaluation, and supervision. In summary, the project's future focus should be on supporting communication, coordination and exchange, and re-establishing the focus on the psychosocial needs of children and adolescents affected by violence. Training seminars have been the major forum for exchange and networking. Recognition and formalization of this fact can help in developing a new process of exchange under the title of training, supervision or networking.

The training component needs to be developed to another level. Although in focus groups trainees demanded more training on long-term basis, training longterm care, specific interventions like group therapy, evaluation of competence of different interveners points to the need to consolidate basic techniques of interviewing and counseling individual, groups and families as well as different forms of outreach and community work.

In the area of research, the study on the prevalence of posttraumatic stress disorder in school children has provided justification for the project. Future needs should be directed to understanding the complexity of the phenomena of violence and its effects on a more global level of child development, and the nature and effectiveness of professional and traditional preventive and therapeutic interventions delivered in the field.

Another priority in the remaining period should be decentralization of project activities to the areas where it has developed substantial resources. More investment is needed in the Wilayas where the process of psychosocial care for children has gained momentum. Several local initiatives in the public sector and civil sector have been identified and to be highlighted and replicated.

Results of this evaluation, together with the accumulated experience of research and monitoring should assist in planning for future activities.

Major challenges and recommendations for the remaining period

The remaining period of the project, that extending up to 2006, should be used mainly to consolidate achievements already gained through the project.

I. Consolidate achievements

1. Review training content with a focus on basic skills in child mental health and psychosocial interventions
2. Re-assess resources for training, supervision and coordination. Aim at a mobile training team with standard curriculum, manuals and pedagogic skills

3. Homogenize and stabilize function and competence of focal points
4. Encourage documentation and exchange of experience

II. Refocus on child and violence

1. Use results of research, monitoring and evaluation and case studies to argue for a more global approach to the problem of violence and children
2. Reconcile theoretical and conceptual differences through operationalization of concepts within the project framework
3. Establish a simple monitoring and evaluation system with clear indicators

III. Reactivate intersectorial coordination and communication:

1. Re-activate intersectorial communication and coordination in relation to the project and in a network rather than organizational framework
2. Establish a technical group of experts with balanced participation from all sectors involved, and with involvement of civil society and community

IV. Decentralize activities

1. Reconcile conceptual differences on terms of management with partners
2. Identify and support local initiatives in public sector and community
3. Recognize and support the function of 'intermediary level' staff and functions in the different sectors
4. Encourage ownership and handover of sustainable activities to the involved partners

Description of the project

Country background

The Democratic and Popular Republic of Algeria –short: *Aljaza'er*- is a country of North Africa on the Mediterranean Sea with a vast terrain extending over more than two million Km squared varying from coastal planes to high mountains of the *auras* and African *Sahara* which forms more than two thirds of the terrain. The Algerian northern terrain where the majority of the population resides was formed as a result of collision of the European and African tectonic plates, forming a young transforming structure and predisposes the northern areas to a series of earthquakes and land transformations. Over the years, this has caused several catastrophes. The earthquakes of the eighties and nineties claimed thousands of lives.

Its population reached around 29.3 million according to 1998 estimates, the young (below 20) population making around half the total population according to the statistics of the National Office of Statistics (ONS, 1999). Algeria gained its independence in 1962, after a long struggle for liberation from French colonization that lasted 130 years. Since then, it has been governed by the National Liberation Front (FLN), with a succession of elected presidents. The government followed a one party socialist system until 1988 after the riots in Algiers and the constitutional referendum of 1989, which opened the way to a multiparty system.

Like the diversity of its terrain and politics, Algerian culture shows a wide diversity and coexistence of different, if not conflicting, beliefs and life styles. More than 80% of the population consider themselves ethnic Arabs, although the majority are descendants of Arabized *Berbers*. Twenty percent still consider themselves ethnic *Berber*, occupying the mountainous terrain east of Algiers (the *Kabyle*), the Aures Mountains (*Chaouia bereber*) and the desert (*Mzabite, Twareg*). The majority of the European *colons* that used to form 10% of the population before liberation have left the country early after in mass exodus. Intermarriages and migrations have mixed the population.

This diversity in itself has been the background of the current conflict. Islam seems to be the single, most important link among the different subcultures, and has played the major role in and used to support all claims of Islamists, nationalists and socialists alike.

The project: Psychosocial rehabilitation of children traumatized by terrorist violence is part of the child protection program of the program of cooperation between UNICEF and the Algerian Government that extends until 2006. It started in 1998 for one year, was extended through to 2002 and was then incorporated in the plan for cooperation from 2002 to 2006. The project now is in its third phase.

The context in which the project was initially conceived was that of a spread of terrorist violence that resulted in massive destructive effects on the population and infrastructure, and large scale massacres of civilians including thousands of children and women especially in rural and poor areas in the country.

Initial assessment of needs and resources

In 1998 there were several initiatives in the governmental and NGO sectors to address the psychosocial problems of children traumatized by terrorist violence. This project was a contribution from UNICEF to assist in the response to the needs of psychosocial care for

children traumatized by terrorist violence. Due to the emergency nature of the project, there was no systematic assessment of needs, it was presumed that exposure to terrorist violence will result in traumatic experiences, stress reactions and psychological distress in children and parents. No official figures on the size of the exposure existed at that stage. Needs were assessed in roundtable discussions with local experts. The project planners obtained the experience of international experts with experience in project management for children and adolescents traumatized by violence in other parts of the world. Research component planned to collect data on the situation of children in the country. Information about the target population was collected from Ministries' records. The needs assessment resulted in what is called the Algerian Consensus on the needs of children and adolescents in this country.

Justification of the project:

The needs and resources assessment shows a discrepancy between the size of the problem on the one hand and the existence and capacity of existing services and human resources to address the problem on the other hand. Lessons drawn from experiences of projects in other countries related to type and route of service delivery for children, empowering parents, families and communities to take active part in the psychosocial care of children and involving children and their families in the planning and delivery of psychosocial care for children. In this part, there was emphasis on the role of teachers and school counselors as resources for the support of children traumatized by violence.

Goal and objectives

Title:

Psychosocial rehabilitation of children traumatized by terrorist violence

« Réhabilitation psychosociologique des enfants traumatisés par la violence liée au terrorisme »

Goal and objectives:

« Assurer La prise en charge des enfants traumatisés victimes de la violence terroriste et accroître leurs bien être psychosociale ». The goal reflects the emergency nature of the initial project. The need is defined as the absence of effective psychosocial care for children traumatized by terrorist violence. No specific objectives were defined in the original project document.

The project objectives developed hand in hand with the identification of needs and resources, and together with the understanding of the context and culture. A strategic planning approach was adopted by the project since inception.

A set of strategies was listed and cover the following areas:

1. The national policy level
 - a. Promoting the effective application of the Child Rights Convention
 - b. Development of a psychosocial approach for care of children traumatized by terrorist violence
 - c. Promote intersectorial vision of the problem and decentralization of activities to the areas most affected.
 - d. Develop a system of information, documentation and data collection on the impact of violence
2. Mental health services:
 - a. Strengthening the capacity of existing care system with material and equipment

- b. Adopt a psychosocial approach for the care of children traumatized by violence in a family and community context.
- 3. Human Resources:
 - a. Upgrade the expertise and skills of child mental health specialists in the area of children trauma and crisis psychology and care techniques.
 - b. Exchange of experience and study visits to countries that have developed successful experiences.
- 4. Mental health situation of children:
 - a. Study on the impact of violence on children especially school children and women
 - b. A psychosocial research to determine culturally appropriate methods and local practices addressing trauma in children
 - c. Information and Documentation center
- 5. Family and community:
 - a. Re-establishing normal family life through development and strengthening of activities to reduce stress related symptoms
 - b. Contribute to social reintegration of adolescents and young women through training and education
 - c. Advocacy and social mobilization

Main components identified over the course of project development

The project activities were related to one of the following components:

- 1. Training and capacity building
- 2. Research, Information and documentation
- 3. Technical and material support
- 4. Community mobilization and advocacy

A schematic representation of the project structure will facilitate evaluation of its components (Figure 1).

**PSYCHOSOCIAL REHABILITATION OF CHILDREN
TRAUMATIZED BY TERRORIST VIOLENCE, UNICEF ALGERIA, 1998-2003**

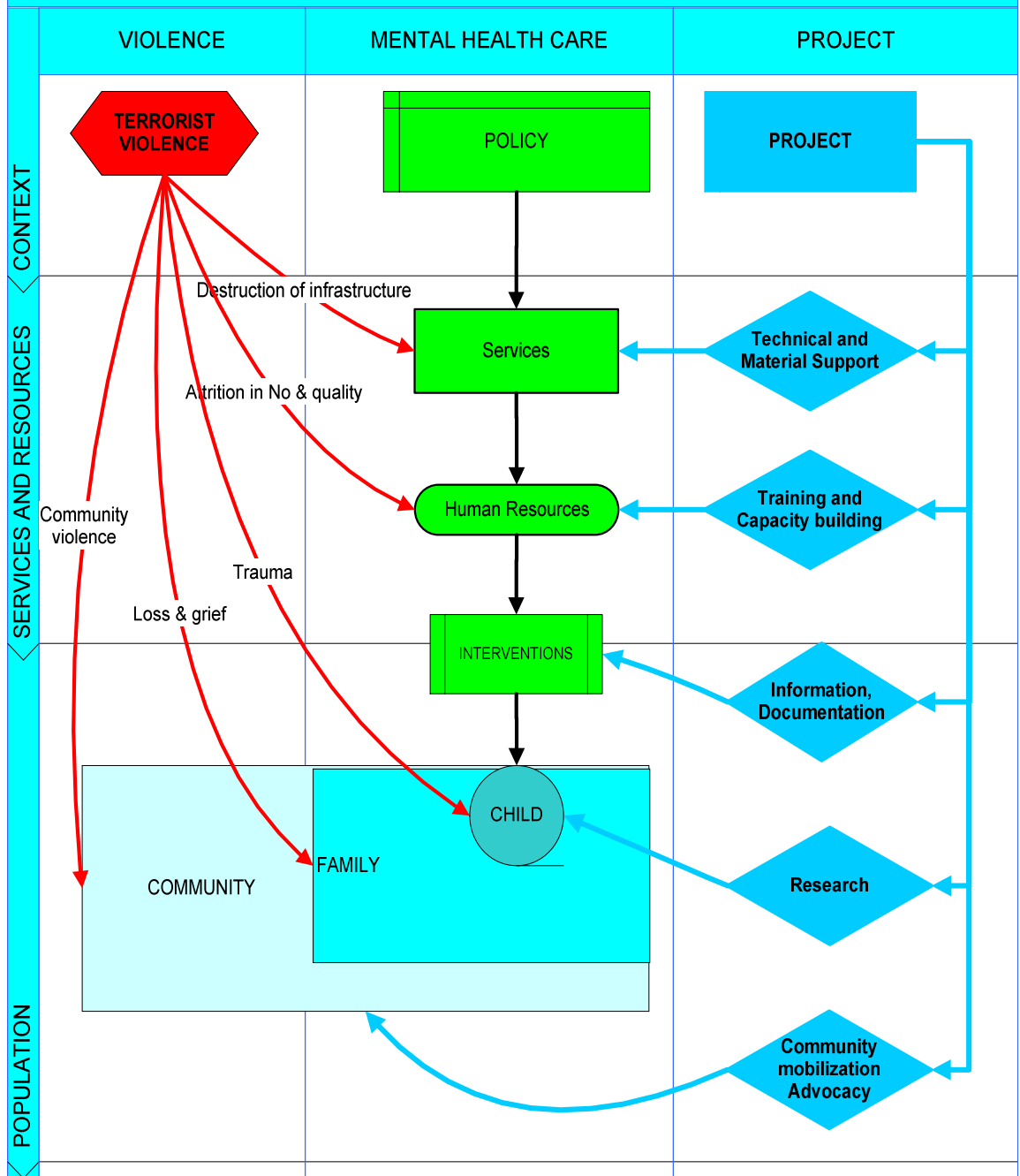


Figure 1 Schematic representation of the project

Management of the project

In 1999-2000 a national committee for the program of cooperation assisted by a inter-ministerial technical group under the Ministry of foreign Affairs was assigned the responsibility of implementation and monitoring of the project.

In 2001, and following several changes in administration on the national level, the project was assigned to the Ministry of health and Population and Hospital reform. The main partner was the MSP through its DASS (Direction des actions Sanitaire Specifiques) and the Sous Direction de Promotion de Sante Mentale.

Conclusion

The project came as a response to an expressed need by the experts in the country for support in addressing an urgent problem. The initial preparation of the project falls in line with this emergency situation and depends on rapid assessment of needs and resources. Expert assistance from the crisis psychology center in Bergen was essential and helped initiate the project through technical advice and training of the core group of trainers. Planning for the project activities took the form of strategic planning through addressing all levels from policy and decision making mechanism to social mobilization and advocacy. Initial assessment of resources scanned the available human and institutional resources in the country through reports and records in the ministries. Results of the initial assessment pointed out the lack of experience in dealing with issues of traumatic effects of terrorist violence on children and identified training as a priority need.

The need for information and better understanding of the problem and of the context is reflected in the repeated statements in project objectives related to information and data collection. It is important to note here that the information about the problem of terrorism in general, and its effects on the population and children in particular are severely lacking.

A wide net of approaches and activities is spread to cover the problem at all potential levels of influence. In a sense, the project was seeking entry points through which the problem can be effectively addressed. Following the achievements of the project shows how the different components were effective in clarifying the extent of the problem and its ramifications.

Evaluation Methodology

Aim and objectives

The overall aim of the evaluation is assess and analyze the Algerian experience of psychosocial care for children exposed to trauma caused by terrorist violence. It is an opportunity to document the experience, assess the strengths and weaknesses and identify priorities for the coming years.

The objectives to be achieved by this evaluation relate to the relevance, efficacy, effectiveness and impact of UNICEF supported project activities in addressing the problem of child problems related to terrorist violence:

- Describe the nature and scope of the problem of trauma caused by terrorist violence and the diverse approaches to care and support of victims of violence by different structures, groups and the community.
- Analyze the relevance, role, effectiveness, efficiency and quality of the psychosocial approach in projects supported by UNICEF in Algeria to assist children traumatized by terrorist violence in the areas most affected.
- Analyze and evaluate the capacity of services and community networks to provide effective care for children victims of terrorist violence.
- Assess the contribution made by UNICEF supported psychosocial work in Algeria towards development of social policy and an increased awareness by the Government and the general public of problems and consequences of trauma caused by terrorist violence.
- Identify and analyze the lessons learnt from the Algerian experience and recommend priority strategies and actions for the future.

Evaluation Design

A mixed method design was adopted. Such design serves well the requirements of information in this context. The design combines quantitative and qualitative methods of data collection and data analysis. The five-tiered approach developed by Jacobs (1988) and modified by several investigators (Collar et al., 2000) to adapt the approach for evaluation of community based programs for children youth and families at risk.

Analysis framework

The project is perceived as a self-organizing adaptive system. That learns and adapts its behavior to the environment as well as assimilates the experience from the environment (including its own effects) into its structure and behavior. Evaluation is perceived as a learning experience that draws on and adds to the project's experience.

The design follows the recommendations of the UNICEF for reporting evaluation on the project/activity level (UNICEF, 2002).

- The evaluation approach is Participatory in the sense that the evaluation process is a collaborative effort in which learning and empowerment of the project staff and other stakeholders.
- Field work –field visits, interviews, participatory observation- characterize the major approach of evaluation.

- Evaluation is both formative and summative in order to evaluate completed as well as ongoing project components.
- Evaluation questions are categorized as: descriptive, normative (criteria referenced) and impact (cause and effect) each having its relevant methods and analysis requirements.
- Data collection and analysis depend on both quantitative and qualitative approaches.
- The evaluation findings will be weighted against the countries policies related to the subject (The National Mental Health Plan), the UNICEF mission and policies and the needs assessment.

Scope of the evaluation:

The context and problem: The Algerian context, related to the development of terrorist violence in several stages until the current time.

The response: The response of the formal and informal service systems to the problem this includes Governmental, NGO and Community initiatives in the field.

UNICEF activities in supporting Governmental and Non-Governmental organizations working in the field of child mental health.

Areas of assessment: The evaluation questions relate to one or more of the following areas: Relevance, Efficacy, Effectiveness

Data Collection

Some external information has been collected from mental health workers in the field before evaluation started. The consultant has a two years experience of working in Algeria in areas of training, research and project development. Data from the database on those two years forms the background of his data collection plan.

The qualitative nature of the data collected dictates an iterative process of data-collection/data analysis (Figure 2). Ongoing review and preliminary analysis will start with the accumulation of qualitative data from records, reports, interviews, groups and observation. The ongoing analysis steers the data collection process.

Tools and method

Quantitative data collection methods:

Available Research databases: (pilot study, major research)

Monitoring records related to the project activities

Qualitative data collection methods:

Existing records, evaluation reports, and databases available

In-depth interviews with stakeholders

Focus Groups with community representatives, mental health workers and paraprofessionals involved directly in the field of mental health for children

Participatory observation of groups of children and adolescents, interviews performed by professionals and paraprofessionals, role plays designed to reflect the delivery of services as it takes place in the field, training seminars and workshops occurring in and outside the framework of the project.

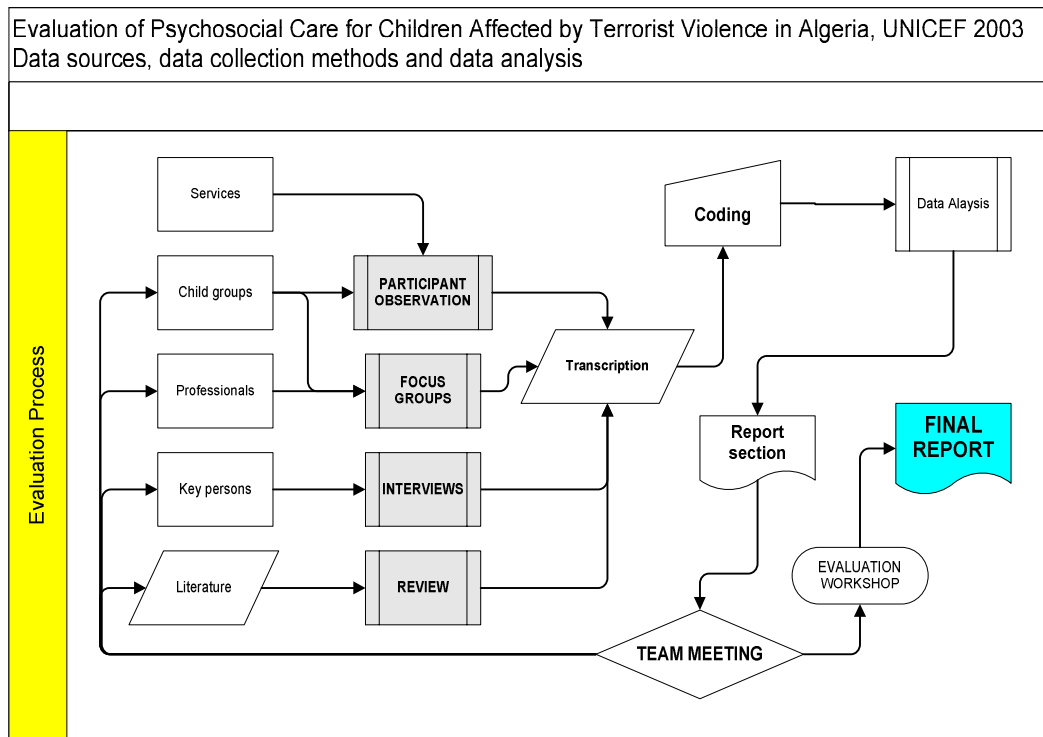


Figure 2 Data Collection and Analysis scheme

Data analysis

Qualitative data analysis: The report will heavily depend on accumulating, categorizing and analysis of qualitative data. An analysis framework using qualitative data analysis method developed by Miles and Huberman (1996) used through in a process of coding and memoing. All data from participant observation, interviews, focus groups, literature, and project documents are transcribed and stored in a database. Initial codes were derived from experience in working in Algeria, while new codes emerged from the transcribed text. The Evaluation Database is a computer based program designed by the consultant for the purpose of qualitative data analysis is based on the grounded theory approach (Galser and Strauss, 1967; Glaser 1998).

Quantitative data analysis: Descriptive statistics will be generated for quantitative data. Inferential statistics will be calculated for project effects and outcomes. Computer software package will be used for quantitative data entry and analysis SPSS.

Synthesis: Both qualitative and quantitative evaluations were synthesized in a draft evaluation report. The draft was presented in a workshop with stakeholders to obtain feedback and recommendations.

Report writing and dissemination

Due to the participatory nature of the approach, the report writing and dissemination phases are combined in one phase. Also, report compilation will start with the data collection and analysis. The first draft of the completed report was ready by the third phase of the evaluation. A major objective in this regard is to attempt to present the evaluation results in a format that can be understood and utilized by a wide range of stakeholders. The strategy to achieve this objective is in collaboration with the project staff and stakeholders, the quality and utility of the report were improved through consultation with participants in a workshop

format where the results of the evaluation and the draft report were presented. The structure of the completed report will be decided in consultation with UNICEF evaluation unit to fit the reporting criteria of UNICEF.

Monitoring and evaluation

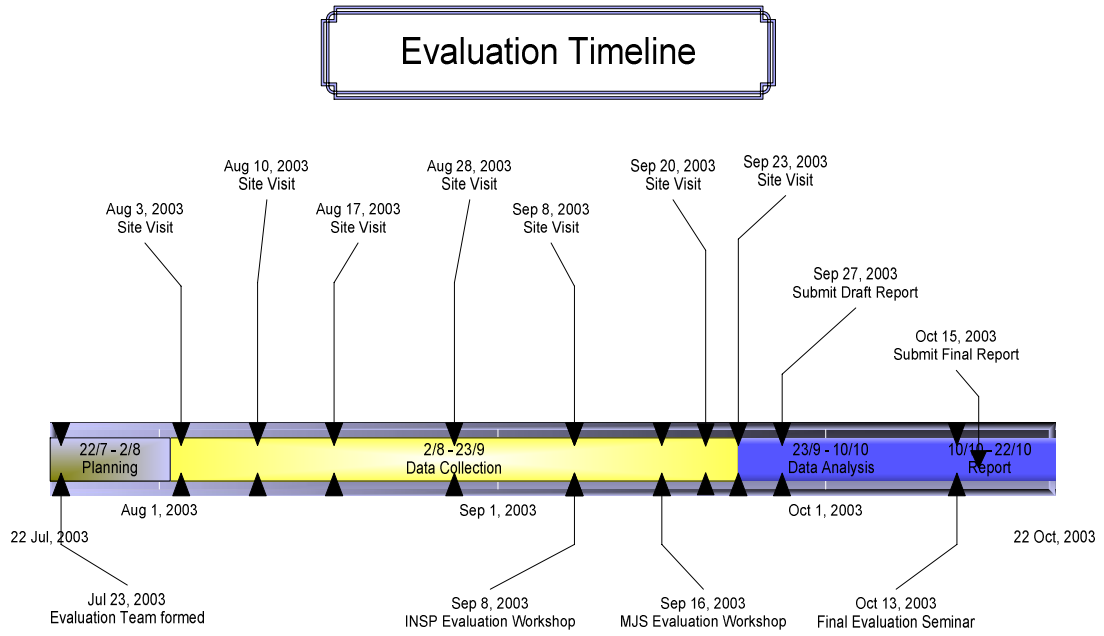
The consultant reported regularly on the progress of the evaluation process. A progress report will be issued at the completion of each phase in the evaluation plan. The Monitoring and Evaluation Unit of UNICEF Algeria will evaluate the progress against the evaluation standards criteria adopted by the UNICEF and the evaluation work plan.

The evaluation period extended from August 22, 2003 to October 18, 2003 (Figure 3)

Evaluation Plan

Phase	Objectives/activities	Person responsible	Output indicators
Planning	<i>With the participation of stakeholders, prepare evaluation methodology design and refine evaluation questions</i>		
2 weeks	Team building, meetings Interviews with key stakeholders Field visits to project site Review project documents and reports Develop measurement indicators Design of the evaluation instrument Pilot testing of methods	Consultant Evaluation team	Evaluation team formed and functional Set of refined evaluation questions Set of indicators Battery of tools and methods Analysis framework Project background evaluated <i>First phase progress report</i>
Data Collection	<i>Using a mixed design and a participatory approach, collect qualitative and quantitative data and prepare for analysis</i>		
4-6 weeks	Data collection: Focus Group Interviews, Observation, Field visits (3 sites) Data coding, Data entry	Consultant Evaluation team	Data sets available: - Quantitative data categorized and tabulated - Qualitative data classified, coded and displayed <i>Second phase progress report</i>
Data Analysis	<i>Interpret data using standard quantitative and qualitative data analysis techniques</i>		
2 weeks	Categorization and tabulation Interpretation of results	Consultant Research assistant	Data tables, displays and flowcharts Results lists Draft Evaluation Report <i>Third phase progress report</i>
Reporting	<i>Refine, finalize and disseminate the evaluation report</i>		
2 weeks	Report writing (Draft) Evaluation Workshop Final report	Consultant Evaluation team	Workshop recommendations <i>Final Evaluation Report</i>

Figure 3 Evaluation timeline



Assessment of Needs and Resources

The problem of violence in Algeria

This is not an empirical research. It is only an attempt to develop the context, the backdrop over which this project was conceived, planned and implemented. In a participatory approach, the context is drawn directly from the field. From how people perceive their world and how this world is perceived differently from one person to another, from one area to another and in the same person from one state of mind to another. The relative 'reality' of the past and present context remains an issue for historical and sociological research. Collecting information proceeded back and forth from children and adolescents to professionals working in the field, to experts and officials. Analyzing the data proved to be a tedious task which as it will appear, is largely unfinished.

The political dimension: Terrorism

While exploring the topic in focus groups, psychologists seemed to slide into an endless time tunnel, was it 1992, or 1985 or even earlier, following the war of liberation. What about the French colonizer. Does the oppression of more than a century of colonial rule have links to the violence of today. What are the antecedents of violence in Algeria? Who to blame? and why? The search for reliable information on what happened and its meaning continues at all levels. Some adolescents and youth are still living in the shock of what happened. In focus groups, the discussion of violence is not an issue of the past, but of ongoing and distressing reality, and not an issue of terrorism, but of a wider circle of violence physical, psychological and structural that affects their lives.

For the operational sake of this study we take the date between 1985 and 1992 for the following reasons: First, we are studying the effects of this phenomenon on children and adolescents, by now, a baby born in 1985 is 18 years old falling in the definition of an adolescent. Second: to avoid sensitivities and confusion associated with this exercise leaving the task to Algerian historians and sociologists.

The wider issue of violence and trauma

The environmental dimension: natural disasters

An important dimension in the Algerian problem is its environmental correlates. The importance of this dimension as a mental health concern is multiplied by the fact that the Algerian infrastructure has also been devastated by violence and corruption. The capacity to respond to crises has been severely impaired, which led to multiplication of victims and secondary injuries. Earthquakes, floods, draughts, mud slides, water crises are themes in Algerian history and folklore. In Algeria, boundaries between man-made and human made disasters are blurred. Human mediation is intertwined with natural 'causes' both in predisposition and consequences.

The psychosocial dimension: community violence

Discussion of violence to children opens the psychosocial dimension of the issue. Groups tended to move back and forth between the individual and collective levels on this dimension. As children exposed to terrorist violence become adolescents who

have to find a role and form their identity in relation to the prevailing culture. In this dimension, violence by children is visited in several forms. School teachers could recite incidents of violent behavior by adolescents in and outside the school. Psychologists working in liaison with courts reported incidents where the adolescent was the perpetrator or tool of a crime. Suicide, completed and attempted by adolescents was related more to relational disillusionment, to anomy and to identity confusion more than to poverty and depression.

The cultural dimension: Cycle of violence

Adolescents' adaptation and identity problems turn the discussion back and round in time and scope. Psychologists revisit culture from a different perspective. Historical roots of identity formation in Algerian psyche extend very deep in time. The area is on crossroads between east and west, north and south. It has been in turmoil for long periods of time. Many migrations, invaders, colonizers, and passers by left their marks in language, religion and culture. Algerian psychologists see their own identity (cultural-national identity) as a mosaic from east and west and from north and south. For moments they could please themselves –and the observer- with the kaleidoscopic wonders of this versatile mix of dress, religion, language and cuisine. However, several experiments of socio-cultural engineering by invaders, governments, and extremists confused what was destined to be a colorful versatile and impressive piece of art called Algeria. The professionals noted that a culture of violence is being created among children and especially among adolescents.

Individual and collective effects and their mental health correlates

Loss of life and family fragmentation: The official figures point to 100,000 victims who lost their lives in the violence. Many observers suggest figures that are higher. Such figures include only those who were directly attributed to the violence and do not account for scores of indirect victims that lost their lives due to the lawlessness and chaos that followed. The intensity of loss of life that occurred gives a sense of grief and trauma, often in a pathological combination. In Bab-el-oued the 2000 people lost their lives in flash mud-slide, and in May 2003 an earthquake claimed the lives of 3000 people and more than 10,000 injuries in the Boumerdes and neighboring Wilayas. Traffic accidents yearly claim 4000 lives, a rate that is one of the highest in the world.

Population movement and internal displacement: Social fragmentation is the most striking demographic outcome of this period. Many villages have been deserted and many random bizarre collections of people extend around the suburbs of main cities, and even infiltrated urban areas to inhabit the streets. Displacement and homelessness have evident mental health correlates, and are the background of more severe and complex psychosocial problems. They are impossible to organize and administer, and they provide the bases and outlets for crime and social violence.

Collapse of the country's infrastructure: As terrorist organizations fragmented and lost direction, destruction was directed to the country's infrastructure –factories, bridges, transportation etc- Which complicated the problem for the population and made it difficult for people to move, work or live a normal life. At first sight, Algerians seem to be traumatized mainly by the hassles of everyday life which are usually attributed to factors outside their control. Only in hind-sight can they relate their current misery to the individual traumata they suffered and realize their own contribution to –and control over- their own problems.

Collapse of the economy, deterioration of public services and poverty: Economy has been fragile to begin with, even before the onset of terrorist violence. The deterioration of security and the destruction of the infrastructure led the economy down to final collapse, giving the last blow to a swaying economy. The outcome is a severe decline in the value of the *Dinar* and employment and driving large portions of middle class salaried and non-salaried below the poverty line.

Insecurity, uncertainty and mistrust: Lack of security extended beyond the safety in everyday life. Shortages of all kinds have characterized life in Algeria. Some areas in the capital itself receive clean drinking water twice a week, sometimes less. The sense of insecurity and mistrust prevails in the social fabric, weakening the ties among people and preventing coordinated group action against the myriad of problems threatening the existence of Algerians.

Revival of ethnic conflicts and social prejudices: Collapse of the collective value system led to fragmentation on higher dimensions. Historic conflicts, differences and prejudices which have been made dormant for a long time have gained momentum and supporters.

Impunity, criminality and organized crime: A consequence which is painfully felt by Algerians is the destruction of the moral codes and social norms that previously regulated social life. The relative lawlessness created a sense of impunity that started with individual transgressions and developed into a convoluted matrix of organized crime, economic monopolies and protectionism. The effects of these developments run deep in the fabric of today's Algeria, and undermine attempts at reconstruction and reconciliation.

Mental Health Situation of Children and Adolescents

Prior to launching the pilot study there were no information on the prevalence of mental and psychosocial problems in Algerian children. Conclusions from the study point to the large prevalence of exposure to violence and to the fact that the majority of those exposed come from socio-economically deprived families (NMHP).

Children and adolescents make up to one half of Algerian population. They have to live, go to school, socialize and find a place in a chaotic world. Their trajectory: creating a normal adaptive adult life on this background is a paradox of creating order out of disorder. Astonishingly, the majority of them succeed in doing that. Our objective here is identifying those who are unable to traverse this abyss. We attempted to explore the psychosocial effects of violence on children and adolescents using available data sources from research and through direct participant observation of children and adolescents, individually and in groups. Unless the observation can be exclusively categorized within a recognized disorder, they are described as 'problems' for Algerian psychologists, psychiatrists and sociologists to study.

In describing the psychosocial reactions of children to violence it is important to distinguish between mental illness (psychiatric disorders), and mental health and psychosocial problems. The first are a group of health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Mental health problems and psychosocial problems on the other hand are signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder. Almost everyone has experienced mental health problems in which the distress one feels matches some of

the signs and symptoms of mental disorders. Mental health problems may warrant active efforts in health promotion, prevention, and treatment.

Effects of violence on children and adolescents

Exposure to events related to terrorist violence

One of the most shocking characteristics of terrorist violence in Algeria was its intentional targeting of children. Children were slaughtered in front of their mothers. Mothers were killed and maimed in front of their children. Many children were intentionally left alive after the massacres to tell the stories of horror. Some of them could not speak afterwards, and remain mute until today. Some were able with the help of their therapists to speak. But until today there was no hearing for their stories. We can say that exposure to terrorist violence in Algeria was universal. The Wilayas differed according to the level, nature and time of exposure of children to terrorist violence.

Posttraumatic symptoms

Posttraumatic symptoms were found to be prevalent in Algerian children and adolescents. Preliminary results from the UNICEF supported study on the prevalence of posttraumatic stress disorder in school children and adolescents in Algeria show a clear correlation between the level of exposure to terrorist violence and the prevalence of Posttraumatic stress disorder (Figure 4).

They are seen as fresh presentations in disaster survivors, or in case histories reported by professionals. Posttraumatic symptoms were usually related to the most recent of events. Other symptoms were usually complex and psychosocial in nature. Posttraumatic stress disorder (DSM-IV) as a single disorder in clinical presentation seems to be rare. The clinical picture is more often a mix of posttraumatic and other pathology, or with complex psychosocial problems.

Emotional and early behavior symptoms were observed in young children exposed to traumatic events: Bedwetting, poor school achievement, phobias (school refusal, specific phobias, agoraphobia). Only a few of those were directly or indirectly exposed to terrorist violence. The majority were seen after the recent earthquake in May 2003 or in the context of family or school violence.

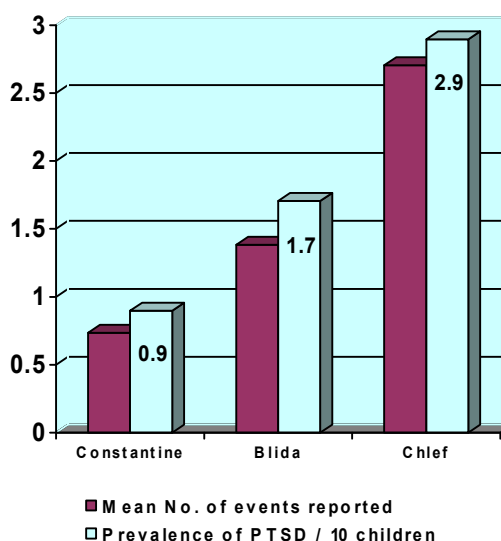


Figure 4. Degree of exposure to terrorist violence and the prevalence of posttraumatic stress disorder in three Wilayas

Emotional symptoms

Depressive symptoms and demoralization

Hopelessness and helplessness, loss of interest, despair and demotivation:

The symptoms follow long history of exposure to multiple losses and traumatic events. Mainly seen in adolescents and youth and is very common in females and young mothers. Social support is usually dysfunctional and the family may disintegrate into poverty and marginalization. (Davidson et al., 1993)

Grief reactions

Related to depressive symptoms, but distinct in presentation. Usually follow single loss in violent situations (Killing or disappearance of father or family member in relation to terrorism), especially when the family member disappears and it is known if he is still alive or not.

Somatic and physical symptoms

Usually mixed and often hard to distinguish from physical illness. Help-seeking starts in the GP's consultation room. Psychosomatic presentations reported included bronchial asthma, skin diseases, 'failure to thrive', and even juvenile diabetes, starting after a severe trauma.

Behavior problems and hyperactivity

Adolescents in particular show a tendency towards violent behavior with peers, in school and in the family. In poor areas mainly they tend to drop out of school. School teachers in focus groups described cases with a full picture fitting the criteria of behavior disorders. Their impression is that such problems are new or at least more prevalent among school children than before. The excess activity observed in many children could be attributed to the context, to hyperarousal as a posttraumatic symptom, or to ADHD. The differential diagnosis was difficult. In one case the difference between two groups of children was striking, both came from the same relief camp in Burj Menail. In one group, there was only material losses, while in the 70% of the children in the second group lost a family member in the earthquake. The second group was clearly more hyperactive than the first as measured on an observation checklist on several occasions.

Conduct problems and delinquency

Teachers and psychologists noted the role of media in relation to premature sexual behavior and imitation of pornographic satellite channels. Premature adolescent sexual experimentation leads in some cases to attempts to sexually abuse children in the same family or in the street. Sexual abuse and molestation of children by adolescents and adults has been raised as a concern in focus groups with psychologists and teachers of several Wilayas.

Theft, property destruction substance abuse: Even in schools, teachers complained that some adolescents are using illicit drugs, mainly glue sniffing. In cities, adolescents form and join peer groups and gangs that at times take political, religious or criminal nature.

Dissociative symptoms and identity problems

Dissociative symptoms are prevalent in children and adolescents seen by psychologists. In participant observation we have seen several forms of dissociative phenomena. Numbness and ‘blacking out’ were observed directly in some adolescents. Somatic dissociation gives rise to peculiar puzzling presentations. In a few children, excessive compliance was explained by some psychologists as cuddliness. The pilot study points out an extremely high prevalence of dissociative reactions in immediate reactions to traumatic events. Eleven percent were stupefied, 8% had transitory aphonia and 7% lost consciousness (without head trauma).

In adolescents, severe identity crises could be observed in the field and especially after disasters. Psychologists were not familiar with dissociative pathology. They can observe the symptoms but may interpret the behavior as resistance (during assessment) or psychosis (in the diagnostic profile). Focus groups with adolescents gives the experiential dimension of the above symptomatology and shows that much of it might be attempts at adjustment or maladjustment with extraordinary situations. Many adolescents and youth feel alienated, forgotten and marginalized. Their sense of belonging and hope in the country are undermined by the realities they are facing and by their frustration with adult and authority figures.

Complex psychosocial problems

Complex psychosocial problems have their origins in the decline in the socio-economic conditions that started in the eighties, which was escalated by the growth of the population; rural exodus that followed the industrialization of labor after liberation, internal displacement of a large portion of rural population –escaping from terrorist attacks- into and around cities in the nineties; high unemployment rates (above 30% in some reports).

Psychosocial problems are both predisposing and maintaining factors for the clinical symptoms. They can also be seen as consequences of long-term symptoms. Psychosocial problems complicate diagnosis and treatment. Classical clinic based intervention are usually insufficient and inefficient and give temporary improvement only.

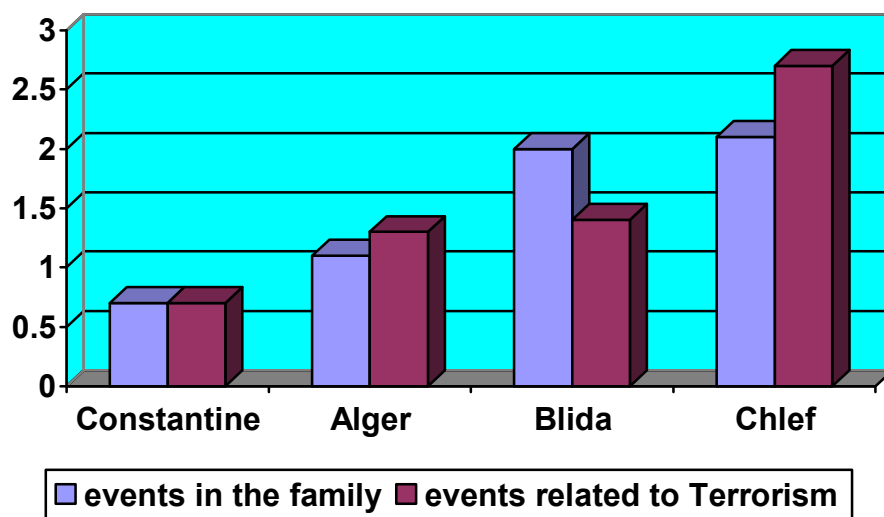


Figure 5 Violent events experienced by children in the family and those related to terrorism

Two useful hints form the results of research. First, there was a clear and strong correlation between the number of events related to terrorist violence, and the number of events related to family violence (Figure 5). Second, points to the poverty and marginalization in areas heavily affected by violence. In Chlef 18% of the youth described the socioeconomic situation of their families as poor compared to Constantine were only 7% described it as poor. In a report from the Conseil National Economique et Social (CNES), nineteen percent of the population in Algeria live under poverty conditions.

Teachers have raised the concern about the spread of community violence: bullying in the street and school, juvenile crime. Adolescent school dropouts seem to be more at risk for becoming entangled in these problems.

Coping strategies and Help seeking behavior

In adolescent boys, the major coping strategy observed was affiliation to a peer group in which emotional support and validation of experience and identification occurs. Recreational activities and sports –also in a group context- were important coping and socialization mechanisms. However, the scarcity of safe, equipped and supervised spaces for this form of expression limits their efficacy. Spaces for expression affiliation and support for adolescent girls were even scarcer, and in rural or conservative areas girls were not allowed access to many such facilities even if they existed. For many of them, day dreaming and identification with TV actresses was strikingly recurrent observation even in the earthquake crisis. Television sets were brought into the tents, and some even had a satellite dish. Girls' chat groups were an important outlet for ventilation and sharing. In cities where internet outlets are available for a reasonable price, chatting and video games were very popular.

The ministry of youth and sports, and youth clubs scattered around the country try to provide spaces for recreation, communication and sharing and cultural activities. The equipment and material however is lacking, as well as the preparation of the staff responsible for running these clubs and their number cannot cover the size of the target population.

Understanding mechanisms of help-seeking behavior in a large country with versatile subcultures and life-styles needs an intensive anthropological study. The time available to us in this evaluation allowed only a glimpse of recurrent patterns observed over the different areas assessed. It seems that the majority of child problems are first dealt with in the family as advice from older family members is sought. Two parallel pathways could then be discerned after the initial family intervention. The first runs through the public health sector, while the second passes through a series of traditional methods. Only a minority of children exposed to different forms of violence –as measured by research in this case- ever come to the attention of mental health professionals.

Conclusion

Attempting to trace the exact date of onset for Terrorist violence in Algeria is not an easy task. Not only because of the lack of reliable records on the phenomenon, but also because of its sensitivity. There have been no attempts to systematically study the subject. Therefore, mental health professionals in the field have a vague

understanding of the origins of violence in their country, while experts are divided over the valid explanation (Kepel, 2000).

The focus on specific forms of violence and trauma has complicated psychosocial work in different areas. For examples: problems of victims of terrorism came up among clients for programs targeting victims of the earthquake, while ‘victims of the earthquake’ repeatedly minimized their losses in relation to the severe precarious socio-economic situation they were enduring before the earthquake. This compartmentalization is very difficult to apply in a practice setting and reflects the tendency by many mental health professionals and researchers to focus on a narrow range of violence directed to children, and the fact that other forms of violence e.g. child abuse, are less easy to detect (UNICEF, 1997). The history of exposure to violence is obtained by practitioners usually after the initial intake for a medical, emotional, educational or juridical problem. Children are rarely brought to treatment for a single identifiable diagnosis like PTSD for example. There is usually a confluence of factors that find expression in their behavior, feeling, family relation, community or school performance. That said, we conclude that a child or an adolescent with a mental health problem related to violence will present, referred by family, school or law in any of a wide range of settings: mental health or psychosocial facilities for children and adolescents are only one of them. Others include general medical, pediatric, educational and juridical settings as well as the traditional settings for helping and healing.

Child, and especially adolescent trauma in Algeria has the characteristics of being multiple, repeated and inter-generational. The ‘cycle of violence’ is not unique to Algeria. Studies in the US and UK found that experiencing early loss (separation or death of a parent or significant person) or being abused or neglected as a child increased the likelihood of arrest as a juvenile or committing a serious crime as an adult (Boswell, 1995; Spatz Widom, 1992). Violence by children and adolescents is a worrying phenomenon around the world, not only in Algeria. Researchers have studied the effects of modern world media technology on the behavior of children and adolescents, and noticed a trend towards increasing incidents of violent behavior related to exposure to violent scenes.

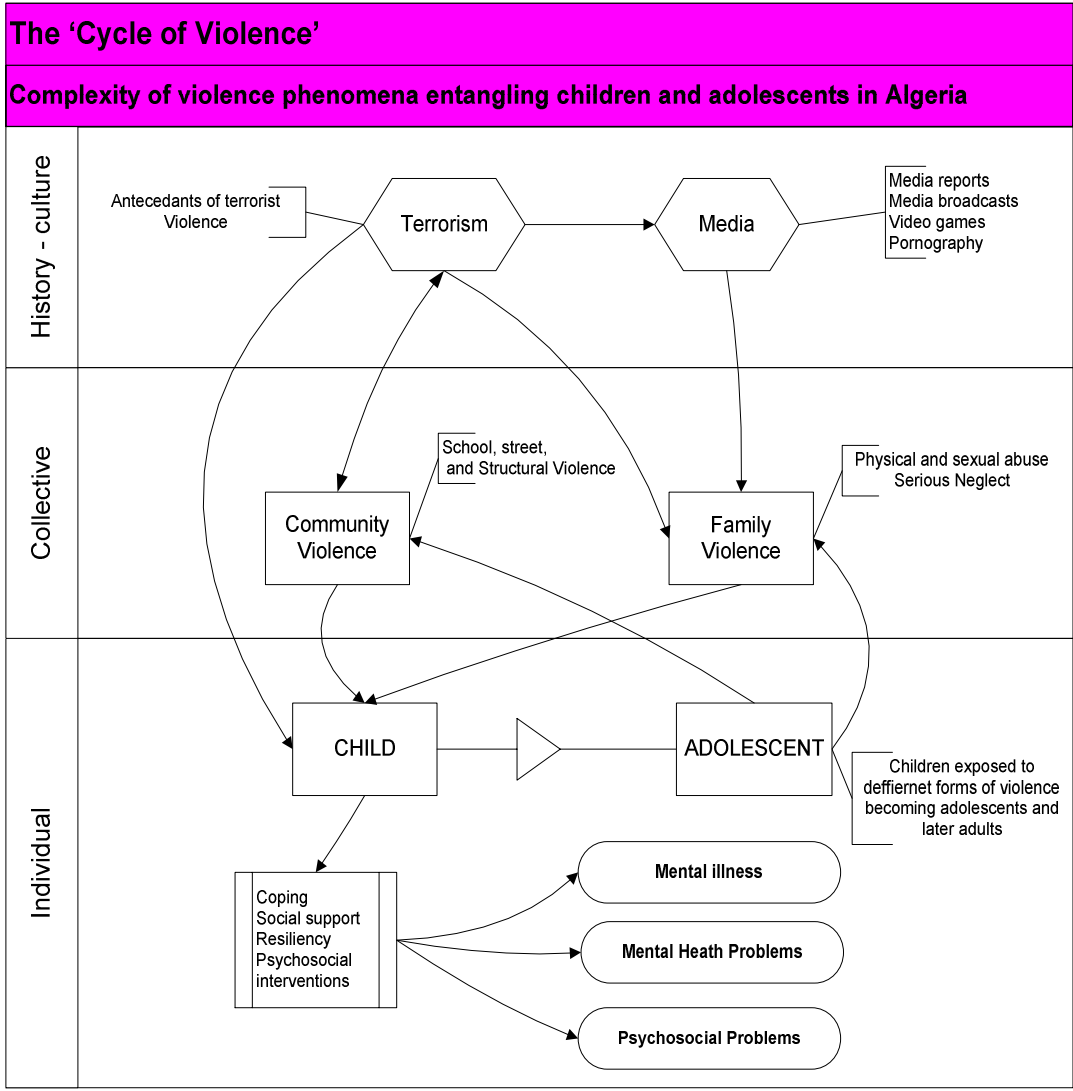
Research in economically advanced countries shows that 8 to 20% of children and adolescents suffer from some type of mental disorder (Cohen, 1998. Young, 1998 for a review of finding from different studies). These figures rise when children are exposed to adversities. In developing countries, and especially those going through war, internal conflicts or natural disasters, children and adolescents become at higher risk for mental illness. In situations of interpersonal violence, they are usually more prone to victimization than adults (Finkelhor, 1994) and the rate of prevalence of child violence-related mental health problems increase (Miller et al, 1999).

In Algeria, the prevalence of PTSD reaches up to 29% in adolescents in some Wilayas (Chlef). These figures are in line with prevalence rates in other war stricken countries. The lowest figure obtained for prevalence of PTSD in adolescents was 6% which is still several times higher than that in developed countries (Cuffe, 1998). The prevalence of dissociative and identity problems seems to be high. Character change is a known aftermath of long-term and even severe single-event traumatization (Terr, 1991).

The above breakdown of symptoms into posttraumatic, depressive etc. was only descriptive. It does not reflect the true picture of presentation seen in real life Algeria. Neither does it fit the scientific knowledge about child mental health presentations today (Offord, 1995). The effects of cataclysmic life events is a unique blend of the event itself, past experience of the child, the dynamics of family, culture and service delivery (Shooter, 1997). The true nature of posttraumatic phenomena is that they multiple and versatile, forming a plethora of suffering, disorder and dysfunction over the domains of psychiatry, psychology, sociology, law and culture. This observation seems true also in Algeria (Salhi, 2003). The narrow focus on PTSD obtained from research is not replicated in direct observation or in focus groups and case studies. Pure psychological pathology presenting as PTSD or any other single disorder was rare and could be observed only in a few cases. However, PTSD remains a useful but crude indicator for the distribution and prevalence of trauma and violence related pathology.

Besides the high prevalence of PTSD, the 'profile' of symptoms presented does not differ from the clinical diagnostic profile of child and adolescent mental health problems in other countries. However, the prevalence and distribution of these presentations in Algeria is not clear and have not been studied yet.

Complex psychosocial problems usually form the background of many complaints. They form a concern for community and professional circles. Some are discussed openly like community violence while others are discussed in closed professional circles like the spread of sexual abuse and delinquency in boys and girls. The clinical implications of these observations are important. Working with such complex psychosocial problems in the context of community wide trauma is difficult (Lira et al, 1998). Several illustrative case studies were described by Houria Salhi in her very useful book together with clinical advice, suggestions and hints for psychologists working with traumatized children in Algeria (Salhi, 2003).



Existing Mental Health Services and resources for children and adolescents

The public sectors human resources and facilities

The details are described in the Programme of Cooperation and the National Mental Health Plan. We cite here only relevant information to the evaluation of the project with a focus on human resources.

The trauma file was open in 1995 by the Ministry of Interior, in its mission to provide care for victims of terrorism. Mental health care for children was provided at the primary health care level '*réseau sanitaire de base*' until in 1998, the first project addressing mental health and psychosocial needs of children traumatized by terrorist violence was initiated with the support of UNICEF. Specialized mental health services for children exist only in psychiatric hospitals. Other services provide mental health care for the general population including children. As noted in the NMHP the existing system is incoherent and its function is based on emergency response, and is hindered by an archaic and rigid division of services. Before the training done in the framework of the project in its first phase, working with child and adult trauma survivors posed a great challenge to professionals with no prior experience in the subject.

The effects of the security crisis have touched the public sector. It suffered a loss of infrastructure that was not compensated and significant attrition of competent staff, some of whom have been killed by terrorists or disappeared. The remaining staff members have themselves gone through stressful and traumatic situations for long periods of time and had to move and work under dangerous conditions. Reform and rehabilitation of services is an ongoing process in all sectors, but the process is slow due to immense size of the problem and lack of resources.

Human resources

The number of psychiatrists in the country does not exceed 300 in best estimates. They are overwhelmed by demand and care for the major psychiatric disorders in psychiatric hospitals and mainly concentrated in the capital and main cities. The MSP employs 16,783 medical doctors in general practice, and 42,223 registered nurses, 86,214 qualified nurses and 13,562 paramedics. They form main bulk of the work force for primary health care and are distributed more evenly than specialized services.

A large number of psychologists graduate each year from the different universities in the country. An average number of 2000 students study psychology –all specialties: clinical, social, educational, and speech therapy- in the department of Human Sciences in the university Algiers alone. The government employs only a small percentage of the graduates who are distributed over the different sectors (MSP, MEN, MPS, MJS, MASSN). The ministry of youth and sports has recruited more than 300 psychologists in its youth reception and orientation cells (CEPJ). The Ministry of education employs more than 230,000 school teachers, 1000 out of them are educational counselors *Conseiller pédagogique* in schools all around the country.

Models and approach

The public health system is oriented towards preventive rather than curative services. In all the sectors, there is no specific mental health policy for children.

The medical sector employs clinical psychologists. Service is offered to the general population. The only mental health model that is specifically directed to children is psychiatric or pediatric or primary health care in the PMI (Protection Maternelle et Infantile) i.e. medical in nature and procedures. The spread several *cellules d'écoute* added a psychosocial component to the model that was based on crisis response. The educational model is presumably adopted by school counselors. The educational sector employs educational psychologists, but their job is hindered by several administrative and technical obstacles. In other sectors, the psychosocial component is more evident and they do not filter job candidates. Psychologists work in teams with medical doctors, social assistants and pedagogues. Professional role is restricted exclusively to reception, listening and orientation in a disaster response model, and in calm periods staff in these *cellules* has little to do.

In theory, psychoanalytic orientation, in its classical form seems to be the major influence on thinking of psychiatrists and psychologists. Recently cognitive-behavioral and systemic influences were brought to the scene by psychiatrists and psychologists trained in non-francophone countries. However, the expression of competence and creativity in dealing with child mental health problems is greatly hindered by a set of rigid administrative rules and procedures and by lack of supervision and guidance for young creative staff.

The model is demand-led and the client is usually the individual child that is referred to the service with a specific demand. Family interventions are practiced sometimes as well as groups. The focus however is mainly on the individual pathology. Outreach occurs usually in response to crises. In May 2003, the different sectors mobilized multidisciplinary teams and psychologists to intervene in supporting the victims of the earthquake.

Communication and coordination among the sectors

There seems to be little coordination of services among the different sectors. Referrals among them are minimal and usually informal. Contact and cooperation take place more freely during outreach only in times of crises where teams from the different sectors are mobilized to the area of disaster. Although the different service sectors have gone through several crises, in which they had to act, they still have difficulties coordinating their interventions. Observation of the official response to the most recent crisis (earthquake that hit *Boumerdes* in may 2003) witnessed the repetition of the same problem. Too many psychologists requisitioned from different Wilayas were sent to the field without preparation or coordination. This has caused duplication and confusion among the people, some of whom were 'debriefed' several times.

Non-governmental sector

The Associations movement

The association movement (Non-Governmental Organizations) is a relatively recent phenomenon in Algeria. It is the active expression of an emerging civil society that

became active in social development. NGOs are embedded in the context and culture of the country which gives them at times a provocative and oppositional image. In the ten Wilayas targeted by the project, 23 NGOs working with children were identified. Eleven (48%) are positioned in Algiers, while the others are mainly situated in main cities.

NGOs see their role as prevention and crisis intervention. They see their task as complementary to that of the public sector in areas where it is overwhelmed by demand or unable to provide services. Children with severe traumatic reactions are usually referred to psychiatrists or to psychiatric hospital centers. During crises, their main aim is the restoration of normal human life through empathic, authentic encounter with the victims in the field. In long-term, the aim becomes the restoration of social ties severed by the collective trauma, and reactivation of the expression of culturally determined helping and healing mechanisms¹. It is important to note here that these observations do not apply to all NGOs, some of them with a more 'orthodox' theoretical ideology fail to reach out to the population and remain encapsulated and active only in spreading that ideology through training courses. The description here does not apply to those few.

There is a focus in NGO interventions on the group approach. Although used in application as a preventive technique 'groupe de parole', activity groups, vocational training, they are sometimes given names that imply therapeutic effect 'therapeutic milieu'. The terminology does not make much difference as long as the aims are clear.

NGOs are more active in outreach. Their interventions are usually community based. Outreach targets families, adolescents and community resources. Schools are one of the favorite targets for NGO outreach despite the administrative problems limiting access to school children and adolescents, but their activity in networking manages to bypass these obstacles to some degree. NGOs seem more aware of cultural and contextual issues related to trauma. They address these issues more openly in the reception and outreach for children and their mothers. NGO staff prefer to work with children in their natural environment –homes, schools, neighborhoods and have more facilities for outreach. In the centers they use group approaches (play groups, expressive [drawing, art] groups).

Adolescents are a major area of concern for NGO outreach activities: Their problems with identity, delinquent behavior and tendency to violence. Outreach programs were organized to reach these adolescents at risk through schools, families and community. Analysis of intervention in NGO services shows that the models are mainly psychosocial and community based. Psychoanalytic theory again has the main influence on thinking, but little influence on practice. Staff discuss the need for diversification of theoretical models and intervention techniques based on the actual needs of children and the realities of the field practice.

¹ Some pioneering examples among the NGOs supported by the project are the ANSEDI 'Association National de Soutien aux Enfants en Difficulté et en Institution, in Algiers, and ARPEIJ 'Association pour la Réhabilitation Psycho-Educative Infanto-Juvenile' in Blida

More innovation and flexibility were seen in NGO initiatives. They introduced developmental changes on the initial interventions, added and improved. NGOs seem more at ease in diversifying and experimenting with different techniques.

Some remarks about the innovative models that NGOs have improvised:

1. They are suited for specific environments or target populations
2. Success depends on the innovators' personality, motivation, preferences, contacts, authority etc.
3. NGOs have little intention in replicating their models, and more in scaling up their interventions by expanding to new areas and new target populations
4. They are concentrated in and around the capital and main cities, but tend to position their services in areas highly affected or infested by violence.
5. Staff -psychologists or psychiatrists- also work in the public sector. They find outlets for innovations and creativity.

While things move slowly in public sectors regarding expansion of services, NGOs seem to be flourishing and expanding their services to new areas and new targets. However, they have difficulties finding trained staff, even then they have difficulty paying them on permanent basis. Cultural and context factors also contribute, female professionals (the majority among psychologists) are not able to displace to remote areas.

Such models should be looked upon as experiments, whose results need to be standardized and weighted against the resources-challenges of the particular NGO. The tendency to expand by scaling up their interventions is a natural evolutionary outcome in a competitive co-operative system. However, the temptation to replicate particular models created by particular NGOs should be thought through very carefully, as mere replication may not give the desired results in different settings. NGO successes have been linked to their 'ability to stay small' (Barclay, 1979) or to maintain the small size and scale of their activities. Growth in size and scaling up reduce the flexibility of NGOs which is considered an essential factor in their success. Successful NGOs should be encouraged to network with other NGOs and government sectors rather than grow in size and scale.

Traditional resources

Like any other culture, traditional methods of dealing with mental illness and psychosocial problems exist in many forms. Mental illness is not stigmatized, but explained through different religious and traditional metaphors. Mentally retarded children and adults are looked upon as '*blessed by Allah*' and receive attention and care from family and neighborhood. In rural areas, several traditional healing rituals exist especially for women with psychosocial problems. It is important to note here that some vast areas in the country especially in the south do not have psychologists or psychiatrists. Mental health and psychosocial problems are managed within the traditional and public health sectors.

Traditional healing methods were rarely referred to spontaneously in focus groups or interviews with mental health professionals. Exploration of the topic based on previous knowledge of their existence and activities leads to flow of information on the types of traditional methods and healers in the country. From the *taleb* to the *raqi* to a spectrum of medical or mental health professionals using religious counseling or herbal and alternative techniques in their practice. We had interviews

with some of these traditional or traditionally inclined helpers. They use cultural models that are understandable and non-stigmatizing to their clients. In the suburbs of Algiers 20 minutes from the city center, a *raqi* opens his consultation daily under the title of 'Herbal Medicine'. On the wall he keeps a flowchart of his consultation room displaying a 'developmental psychopathology' from basic instincts to the *Al nafsul-mutma'enna*². He did not deny the parallels with the Freudian psychosexual development. He does not directly deal with children, but start a *Hewar*³ with the parents who are responsible for the child's physical and moral development. He stressed the need to be patient and persistent in this dialogue since people here have problem expressing themselves. Another *Raqi* in the city center deals with children by *Ruqia* and by religious counseling for parents in child rearing. The differentiation between epilepsy and spirit possession was especially challenging, and he prefers to refer the child first to a psychiatrist.

Previous interest in this sector by researchers has died down. We could only find a few articles on the traditional helping and healing methods in Algeria in the archives. The rapid development in this sector is striking as it is appealing to many dissatisfied patients and professionals alike. Help-seeking behavior explored in case studies and focus groups seems to pass regularly through this sector before the public sector in suburban and rural areas, and even in cities. Focus group information and case studies indicate that they are visited often and before or in parallel to the medical or psychosocial consultation. Adolescent girls with emotional or mental illness in particular are referred to traditional healers by preference. In one case study, an eighteen year old girl with posttraumatic stress disorder was seen in outreach after the earthquake. She has been seen by at least two traditional healers before she came to the attention of psychologists.

Conclusions

Mental health service structures in Algeria have been deeply touched by the effects of violence. Attrition in the number of competent mental health workers complicates the deficiency in infrastructure. The Algerian government tries to compensate for the losses by building, renovating and rehabilitating services. The need however is compounded by the series of human made and natural disasters that have befallen the community in the last decade. Awareness of and demand for mental health services is rising and not only for chronic or severe major mental disorders. Child and adolescent mental health needs have been brought into focus recently and mainly through the pressing need to attend to a large number of children affected by terrorist violence.

Only a small number of children and adolescents in need for psychosocial interventions ever reach mental health services out of the 15 to 20% usually identified in epidemiological research in developed countries (Costello et al, 1993; Rutter, 1989). This is expected to be the case in Algeria as well, though the rate of prevalence of mental health problems may be higher. Static mental health services based in hospitals and health centers do not expect to receive the majority of children and adolescents traumatized by terrorist violence. Research shows that in Algerian adults with PTSD, less than a quarter ever consulted a doctor or any other professional for their symptoms (Elmasri, 2001).

² The serene soul [Arabic, Holy Koran] the ultimate degree of spiritual development, the person who has settled down all instinctive earthly conflicts

³ Dialogue [Arabic]

A look at the above figures shows the great potential manpower that can be mobilized and enhanced to address child and adolescent mental health and psychosocial problems. UNICEF identifying this potential has directed efforts at capacity building for interveners with children and adolescents in all the sectors. Early in the project more than 1600 school teachers, educational inspectors and counselors were given two-days training on the detection of psychosocial problems in children and adolescents. A few attempts have been made to train school teachers in basic counseling using trainers from NGOs. Unfortunately, there was no follow up for that effort, and the momentum was lost.

In the Medical sector, more than 140 psychologists and psychiatrists were trained in the frame of the project by the core group of trainers. The MSP has followed up and trained 80 general practitioners and a number of nurses.

The general characteristics of the effort are:

- A training of trainers approach
- Short term focused training by local trainers (the core group)
- Based on emergency response
- Practice oriented and has recently been documented in a manual
- Introduction to trauma theory and practice
- Focus on prevention and detection of cases
- Providing some techniques for intervention: debriefing, expression groups

In the field, the project has supported the functioning of psychologists by providing material and equipment (mainly psychological test batteries). To facilitate the training, documentation, information UNICEF has supported the establishment of the Center for Information, Documentation and Communication on Trauma in the INSP⁴, equipped with material and equipment, the center was planned to start functioning in 2000, Unfortunately, the center is not open yet.

NGOs have benefited from the material support to open spaces and facilities to receive children and women. The majority of these facilities are being used for this purpose as well as for providing psychosocial care in general. The effect of this support is more pronounced in NGO interventions than in public sector.

⁴ Institut Nationale de Santé Publique [National Institut of Public Health]

Mental health Professionals: A focus on psychologists

In providing mental health services for children and adolescents, the Algerian government and non-governmental organizations have relied heavily on psychologists. This is in no way a professional performance evaluation of any individual or group of psychologists. It is an overview of performance within the different service delivery situations. The results are intertwined with contextual and institutional factors that are themselves different in different sectors. The results portray an imposed average over a wide range of experience levels and service delivery situations.

Undergraduate education and professional development

In focus groups, answering questions about preparation for field work with children psychologists regularly referred to problems in their undergraduate education.

BASIC TRAINING IN PSYCHOLOGY

1. Provides a wide theoretical base, mainly based on classical psychoanalysis
2. Delivered in Arabic as lecture notes, but lacks references
3. Deficient in areas of psychopathology, trauma and violence
4. Little chance for practical application
5. Has not been evaluated systematically
6. Different according to specialty: clinical, educational, social psychologists and speech therapists, with different curricula beyond the second year of undergraduate education

Psychologists are usually recruited with no prior experience. Algerian government invested in recruiting a large number of psychologists in the public sectors. NGOs are competing for those with talent and experience, but employ them for short time and with restrictive working conditions.

Diverse educational background: They have a diverse background and experience. Clinical psychologists usually employed by the MOH form only part of the

whole body. Educational psychologists, speech therapists (orthophonists), and social psychologists form the main bulk of the body. The non-clinical psychologists have even more problems adapting and developing their approach to the requirements of the situation.

Role and professional identity confusion: In most sectors, psychologists see that their role and status are not clearly defined. Even if the psychologist matures and defines her own role and identity, they find the administrative structure non-responsive nor cognizant.

Post graduate training: Patchy, irregular, not systematized and not directed to the needs of psychologist and client. Content usually defined by the interests and availability of trainers. Training institutes for post-graduate training charge high fees compared to the psychologists' income. Nonetheless, psychologists are in fervent search for training seminars and workshops on diverse subjects that are based on different models and approaches.

In the absence of M&E and supervision, professional development of psychologist is irregular and not integrated. They tend to be self-reliant and have to build their stock of knowledge and skills.

Field work is the main source of professional experience. Lessons are learned by psychologists in working with this population in this context. Crises and emergency situations offer them freedom from the rigid administrative and professional structures and allow them to experiment with non-orthodox techniques and models.

Psychologists performance

The quality of performance varied widely. The factors were postgraduate training, work setting and motivation. We observed the performance of psychologists with clients in day-to-day practice and through participant observation of role-plays. Focus on collecting factual data through persistent questioning. Resort to reassurance and giving advice. They may find it difficult to provide emotional support, this maybe due to being part of the distressed community, or to survivor guilt, or even

to feelings of incompetence and insecurity. When faced with complex challenges (working with adolescents, cases of severe multiple trauma, etc) some psychologists took defensive positions in posture and behavior leading to blocks in communication with the client.

An interesting observation in role plays: in the role of the psychologists they show anxiety and defensiveness, non-verbal physical protective gestures and repetitive behavior. In the role of observer, they give valid and solid observations and comments. When switching roles, one psychologist -a senior- committed the same mistake she observed in another psychologist! (forgetting to introduce herself to the client)...

In the field the psychologist is torn by the conflicting demands of the situation, institution and profession. For example keeping a therapeutic frame "le cadre" in some institutional contexts where this is impossible. The therapeutic frame, which has been sanctified by their teachers, is not even recognized by the administrators. Psychologists thus are torn between the requirement of their profession and the demands of their job.

Psychologists were active in organizing outreach activity even though it was not a work requirement by the institution. They could relate and communicate freely with the community and could mobilize community resources when administrative constraints denied them of material and equipment they see necessary for their work. In groups they were able to take a problem solving approach and facilitate group dynamics in homogenous groups. They had problems working with group distress, group splits and conflicts.

LESSONS LEARNED 'the hard way'

1. Learning structure and processes of their community
2. learning to accept and tolerate differences
3. Learning to be non-judgmental and accepting of others
4. Learned about themselves and their family development
5. Learning about the components of their culture and their identity

Performance in homogenous teams was satisfying to psychologists and satisfactory when assessed in evaluation. They provided professional and emotional support. Multidisciplinary teams have been observed in the Cellules d'Ecoute and specialized hospital centers (CHU). Functioning here is complicated by communication and language problems (Arabic for psychologists, French for medical staff). Administrative constraints limit the benefit from multidisciplinary teams.

Motivation for work: Stress and difficulties

Psychologists -junior and senior- are highly motivated for work for several reasons. Their motivation is the main force driving their interventions. This motivation has been assessed at several levels and found to be high and persistent even in difficult work situations. In sectors restricting or limiting the expression of their professional experience and creativity, motivation declines and burn-out sets in. Low pay has not been posed as a hindrance, but administrative problems, isolation, and poor communication were the main reasons cited in psychologists with moderate degrees of professional burn-out.

MOTIVATION FOR WORK

1. The need to find a job and escape from unemployment (high rates among university graduates in Algeria).
2. Concern and altruism to serve their people and country
3. Exposure and experience with the violence and psychosocial problems
4. The need for identity definition and social role

To avoid stagnation and burn-out some psychologists escape to NGOs, which compete with the public sector for experience and talent. Even though they are not paid more, they find more job satisfaction due to the release of limitations and chance to express creativity. Many psychologists with high experience immigrate to Western countries, leading to attrition in number of skilled professionals available for local public and NGO sectors.

With this versatile and patchy professional background, and with little support from the professional body or administration, psychologists find themselves in working in situation where they have to deal with complex clinical and psychosocial problems. They resort to utilizing skills available to them, to improvise, and to experiment with models and techniques. Learning through trial and error, and with little chance for feedback from seniors, they accumulate doubts and self-blame together with professional experience. Questions about the validity, efficacy, and relevance of their interventions haunt them and lead to feelings frustration and isolation.

Algerian psychologists are required to work in difficult conditions, with a minimum or resources and with children with posttraumatic and complex psychosocial problems. In doing that, they reported feeling anxious during interveiwes with patients and in role plays. The sources of stress as compiled from focus group data:

1. Defects basic university education
2. Sending them to the field with little preparation
3. Exposure to the similar events and situations as their clients
4. Administrative problems and obstacles:
 - a. discrepancy between professional demands and administrative demands and constraints
 - b. In teams, medical and administrative staff are unaware of the function of the psychologist

5. Complex psychosocial problems of children and families posing a challenge for their competence
6. Stressful working situations:
 - a. Working in places and situations that expose them to danger and violence
 - b. Sense of isolation in remote areas

The effects of stress observed include somatic, emotional and behavioral changes which the psychologists present with. Some psychologists complained of posttraumatic symptoms which affect their reactions and efficacy in intervention with traumatized children. In some psychologists, the stress reaches the limits of professional burnout. This was noted by the senior psychologists and observed in the field especially during the response to the May 2003 earthquake.

Needs and demands

There is a clear discrepancy between need and demand that is very interesting. This discrepancy has been studied by some NGOs and found that the increasing demands for technical and material support is correlated more with the feelings of insecurity and isolation than to real working needs. The trainees demand for specific techniques to deal with specific adversity (trauma) or specific disorder runs contradictory to current knowledge about the comorbidity and non-specificity of child mental health disturbances and treatment approaches.

In focus groups, young psychologists complained that they could not understand some of the training material and lectures given in French. They were embarrassed however to show that to the trainer, since Language is a marker of social status.

Demands by junior psychologists for training do not necessarily come from real educational needs, but from isolation and poor self-confidence. The same goes for their demands for psychological tests, which they do not use regularly. It reflects a need for reassurance and cover for a sense of incompetence. However, the continuous demand for training, equipment and material may reflect the psychologist's sense of insecurity, helplessness, isolation and their own posttraumatic symptoms. The demand comes translated in professional language as need for training and material support.

DEVELOPMENT OF THE NETWORK

1. Psychosocial phenomena on the individual and collective level raising public, professional and official concern
2. Public awareness of the need for and availability of mental health services as alternative -or parallel- to medicine and traditional healing
3. A network of MHW active in the field. They are self-reliant, have initiatives, communicate and coordinate with each other in parallel to the official public sectors.
4. A wide spectrum of psychologists with varying level of experience and competence from ill-prepared, burnt-out and helpless to well-trained and highly competent.
5. Algerian psychologists have gained experience in working with trauma, multiple trauma, and natural disasters. They developed capacity to self-organize and intervene in crisis situation.

Contributions

What is emerging as a result of interventions in repeated crises in the Algerian context is an informal network of professional mental health workers. In their struggle to develop themselves and their services, Algerian mental health

professionals have re-invented the wheel. Lessons learned from their interventions belong to the humanistic and systemic models. Only a few could refer to these models in their description of their interventions.

Conclusions

Algerian psychologists have been faced with a difficult task. The recurrent crises and disasters have posed great demands on them, and tested their preparation and competence in more than one way. In the struggle to fulfill their professional ambitions, while keeping respect to their values, mental health workers had to develop skills depending on their own experience in the field (Kohut, 1971). The mirroring they receive from their clients and their colleagues were the only source of self-esteem in the absence of supervision. Postgraduate training opportunities offer another source of knowledge, skills and self-esteem. However, such experience remains patchy and unintegrated within a model of child mental health. Psychologists usually find difficulties in applying skills and techniques in the field. Many of these obstacles can be attributed to language. Psychologists are educated in formal Arabic, the available references are usually in French, which many of them do not master well, while much of the accumulating experience in child mental health and trauma is written mostly in English.

The corpus of human resources comprising psychologists can be roughly divided into two strata. The first composed of new graduates and non-clinical psychologists whose main function would be counseling and orientation of children and families and are distributed widely over the different sectors. The second stratum is composed of clinical psychologists with training and experience whose main function would be dealing with severe psychopathology in a therapeutic framework. Those are mainly position in the health services at all its levels.

A systemic culturally-aware understanding is being formulated by young psychologists working in the field after several crises. It is presented in vague general terms but clearly forms a conceptual framework for their interventions. Language and communication difficulties prevent them from expressing the nature of the model. Many of them lack self-confidence, past experience and supervision which prevents this understanding from being documented and elaborated. Implications of these observations relate to the issue of supervision and capacity building beyond theoretical training. It also relates to the need to improve the pedagogical methods of training activities and to use AV tools in training (mirroring and self observation).

Outcome of the project activities

Better understanding of the context

One of the most critical factors in determining the outcome of a project is the context within which it is being implemented, and in particular the extent to which the project is coherent and relevant within that particular context. The relevance of this project to the context has been shown in its response to the need expressed by different mental health professionals and ministries for support in the care for children affected by terrorist violence. The wider context however developed progressively throughout the project history, and pointed out the complexity of issues related to mental health of children and adolescents extending from history, culture, family and community sources.

Another important contextual factor is the fact that the mental health services themselves have been devastated –in structure and capacity- by the violence. The objective of building the capacity for intervention with children exposed to terrorist violence falls in line with other needs in reconstructing and rehabilitating the whole health services in the country. Implications of this contextual influence can explain the findings that the support offered – training, material and equipment support- have been useful in addressing other general mental health needs for adults and children alike.

The rapid development and several consecutive social and political changes form another important contextual element. The project needed to adapt and adjust to these developments without losing focus or direction.

The difficulties encountered by professionals in dealing with the long-term effects of violence belong to two major classes of problems: 1) the ‘severe’ reactions with evident psychopathology on the individual level that calls for specialized psychiatric or psychotherapeutic interventions, and 2) the ‘complex’ after effects, usually on a collective level, where limits between psychopathology and adaptation are blurred, and where interventions should be directed to the community by multidisciplinary teams with a high degree of intersectorial coordination.

Although exposure to violence of all forms was found to be prevalent, only a fraction of children and adolescents have developed pathological reactions. Resilience of children in the face of adversities is remarkable (Garmezy, 1984).

Training and capacity building

A core group of trainers was formed early in the project. The group was selected by the multisectorial steering committee. The composition of the core group seems to have changed since the start.

The needs of mental health workers and of psychologists in particular have been screened in this report for evaluation purposes and from the perspective of project objectives. A deeper analysis of performance is needed to complement and validate the findings of this evaluation. Context analysis shows that the interveners with traumatized children have themselves been exposed to similar events and situations, have come from universities that were themselves devastated by the violence, have been thrown in the field with little preparation or supervision, and have been isolated, with little access to information, knowledge or integrated training programs. One

week training course on psychotrauma is hardly sufficient to answer all needs of mental health workers and provide them with necessary tools to intervene efficiently with traumatized children. Nevertheless, the formation trauma as it is called had far reaching impact on the situation of child mental health services and on mental health services in the country as a whole. The readiness of trainees to form and implement a crisis intervention during disasters (e.g. earthquake in May 2003) stands as an evidence of the outcome of this training. Other factors may have intervened including other training courses done in this area. In order to assess the impact of the training done in the framework of the project we assessed several training seminars in the country and tried to discern the additional impact the training contributed to the process.

Weaknesses in the training offered in the project framework

Certain patterns were observed in all training seminars:

1. The trainees need to define role and status in the system, their need to socialize, exchange and share experience, their need for supervision both personal and technical.
2. The trainers having to lower their objectives to accommodate a wide range of trainees with different educational backgrounds and levels of experience.
3. Language and communication problems: Arabic is the language of education for psychologists and other human sciences in Algeria but in training, French language is used by most trainers in the field of psychology and psychiatry.
4. Some trainers used highly abstract theoretical language that was hard to understand for trainees.
5. The content is oriented to disaster and emergency response while most trainees face demands for regular mental health and psychosocial problems.

Training evaluation was usually done at the end of training seminars. The degree of satisfaction is usually high regardless of the quality of the training. A few trainers have attempted to assess knowledge in a pre and post test.

Strengths

1. Compared to other training initiatives in this country, the training on child psychotrauma was structured and had clear goals.
2. It contributed to the development of professional identity in psychologists and the definition of their role and self-confidence and relieved the sense of guilt and helplessness
3. Correcting misperceptions about trauma and child mental health, and rehabilitating some of the defects in the undergraduate education of psychologists.
4. Reaching out, and connecting to the majority of psychologists in the field, and creating links between trainers and trainees that went beyond the training seminar
5. Contributed to the creation of a network of mental health professionals
6. It was free of charge

Until now, training has focused mainly on psychologists and psychiatrists. It is time to involve other professionals and paraprofessionals in this effort. Medical doctors stand at an earlier station in the help-seeking pathway, pediatricians also receive large

numbers of children that have been traumatized, teachers live daily with children in schools and have more time to observe and interact with them in a natural setting.

Technical and Material support for structures providing psychosocial care for children and adolescents

Due to lack of M&E in the ministries and NGOs, it is hard to assess the utility and effectiveness of this mode of support. Direct observation and interviews and focus groups indicate that the utilization of these items is partial, irregular and non-specific to project objectives. Analysis indicates that the response of UNICEF by providing material and equipment comes as a reaction to demands from the partner GO and NGOs. No systematic needs assessment has been done by either side.

Tracing the demand back to the psychologists in the field leads to two conclusions: First their actual needs for support, self-confidence and sharing which is translated as demands for equipment and material support. And second, their inability to use some of the material (tests) and equipment (computers) due to lack technical or operational skills.

Material and Equipment support came relevant and timely to the needs expressed by the professionals and institutions. However, the utilization of this component needs to be synchronized with the professionally assessed needs in the field and directed essentially to the service of the children affected by violence. Needs for material and equipment should be assessed in parallel to other needs within a comprehensive needs assessment protocol. Monitoring the utilization of material and equipment is one important source of information for future support. Some material could –and should have been- provided by the ministries, while UNICEF performed a catalyst role in conveying the demand from the field through the focal points. Recommendations from senior staff and trainers that these should be based on field based needs assessment. The benefit should be weighed against the utility of this mode of support for solving client problems, and not be based on demands from the institutions and staff.

Technical support has focused until now on the material aspects of the services. The overall framework of the service delivery system has not been addressed much. The organizational aspect of the services are critical for putting material, equipment and skills for good use.

Information, documentation and research studies

Algerian experts realize the importance of documentation and research for development of mental health services. Basic statistics on prevalence of mental health and psychosocial problems are lacking and impede effective planning for mental health services. The experience gained from application of models and techniques in the field risks being lost if not documented.

The pilot study⁵

In 1999, the national institute of public health (INSP) conducted a study in which a group of 348 school children and adolescents were interviewed to study the extent and

⁵ Etude sur l'ampleur et l'impact des événements traumatiques liés à la violence chez les enfants, INSP, 1999

effects of exposure to traumatic events. The pilot study aimed at testing the feasibility of conducting a large scale epidemiological research on the prevalence and effects of terrorist violence on children and adolescents. The results showed the wide prevalence of traumatic events, their multiplicity and their concentration in children coming from disadvantaged families. Results also showed the multiform reactions to traumatic events. Effects on children included emotional behavioral and somatic symptoms with a high incidence of dissociative reactions at the time of exposure.

The study on the prevalence of posttraumatic stress disorder in school children

Lessons from the pilot study were not taken into consideration while planning the major study. While the section on demography and exposure to traumatic events screened a wide scope of events and situations in the family and in the environment. The outcome section focuses exclusively on posttraumatic stress disorder, reflecting the medical ideology of the research team. The instrument used (CIDI-PTSD Section) screens for the core symptoms of the disorder, and excludes the developmental effects of trauma on children and adolescents. However, the prevalence of PTSD can be taken as an indicator of prevalence of traumatic reactions in this population. It should be utilized only as an indicator, keeping in mind three known facts: First, the prevalence of PTSD measured by research instruments –as compared to clinical assessment- does not reflect well the functional impairment and disability caused by the disorder. Second, that PTSD is usually associated with other disorders and disability beyond PTSD (Goenjian et al, 1995). Third, that the effects of trauma on children and adolescents are usually measured functionally, by the degree of functional impairment in family and school, rather than the degree of symptom severity.

Documentation of experience

Two problems prevented the experience from being well documented. First, the lack of monitoring data, both qualitative and quantitative, and second: the delay in functioning of the Information and Documentation Center, which could have been a forum where knowledge and experience converge. However, some attempts were successful like publishing the productions of local experts in the form of books. Two of these proved very useful. The Training booklet prepared by the core group and published under the title 'Pratiques de soins et psychotrauma : Manuel pour la prise en charge des enfants traumatisés' and the book by Houria Salhi 'Ecouteur de Rose'. Other experience has not been documented, like the experience of psychologists intervening in crises, and adapting their interventions to the situation, and the experience of some focal points in networking and coordination.

Promotion of an intersectorial vision and decentralization of activities

Child mental health risk and resiliency is a multifactorial issue. Genetic, biological, socio-cultural and service delivery factors all play important roles in the origins, incidence and prevalence, and 'cure' of child mental health problems. A multidisciplinary approach is logically needed and needs not be argued for any further. Organizationally, this is translated into a multisectorial approach, involving all sectors dealing with the issue. A misunderstanding over the meaning and operationalization of concepts like multisectoriality, decentralization and network has

been striking among partners. An interesting example: while psychologists have created a functional network around focal points in the several Wilayas, representatives of the public sector services were calling for 'installation of a network through creating a committee of coordination'. Another interesting example relates to decentralization: From the side of UNICEF, decentralization is understood in network terms, through supporting initiatives and activities in the different Wilayas, and supporting the function of focal points, while the central management of the project perceives decentralization in structural, policy and financial terms.

Focal points

In interviews and focus groups with focal points, there was a wide difference in understanding of their role and responsibilities in the framework of the project. While some were very active and competent to the degree of creating a local 'team' of mental health and other related fields. Others were complaining that they had no means to treat all affected children in their Wilaya given a small office and a computer. Obviously, the first group understood decentralization well, and acted upon that understanding achieved results. The second group, understood decentralization differently, and were waiting for their share of authority and control of resources which never came. Between these two extremes, the majority of focal points were not sure about their function. Their performance has not been monitored, so their achievement depends mainly on their personal motivation.

The criteria for selection and appointment of focal points are unclear. Some have been selected for their experience in the Wilaya, others were appointed because they were available. Several changes of focal points resulted in discontinuity of this component of the project and it seems that changes were sudden, with no handover of responsibility.

Future vision differed much among focal points. Those who were active, understood the task well, seemed to be satisfied with their function, realizing the difficulties and planning to address them. While a few were on the edge of burnout hoping to find a way out of the assignment. Obviously the stress implied in this type of work is great. Starting alone, with little support from the administration, and taking the responsibility for child mental health coordination at the level of a whole Wilaya takes a person who can function in ambiguity, has good connections and communications skills and a lot of patience.

Impact of the project

Being one of the very first in the field of care for children traumatized by terrorist violence, the project can claim a large share of the impact on the target population. The fruits of the project may not be ripe yet, but the effects are observable and measurable. It is unfortunate that monitoring and evaluation, as well as issues of sustainability were not given due priority value at the start. This was due to the emergency nature of the project.

It is also true to say that the receptivity and flexibility are not equal in all project partners, which caused some imbalance in the distribution of achievement successes.

What is not documented here is the experience of dialogue, negotiations and mediation efforts carried out by project pioneers in the initial and later phases, training minutes, coffee break and lunch-time discussions in training seminars and casual chats among professionals exchanging experience from remote parts of the country. As a participant observer the consultant was able to experience the

developmental outcome of such trivia on his image of country and project and translate that to indicators of success.

Qualitatively speaking, the accumulation of potential, ideas, questions, enquiries, and above all different views and thoughts make the conditions ripe for a quantum leap in the quality of MH services in general, and that for children in particular. What is needed is channels for exchange, and a forum for collaboration of thoughts and efforts.

Impact on policy

It is important to consider that at the early stages of the project, the country has been in the initial stages of forming a vision for mental health. The project has contributed to the emergence of this vision as well as its institutionalization in policies and structures.

- Contributing to the advocacy for bringing the issue of the psychosocial effects of terrorist violence on children and adolescents, thus opening the door for initiatives for treatment and prevention
- Raising public and official concern over the phenomena of violence and contributing to the emergence of a national mental health policy represented in The national mental health plan
- The project has invoked developmental changes in the public sector that led to emerging structures in the public sector addressing these issues
- Building momentum for the emergence of a child mental health policy in the country through bringing together efforts and interests of several governmental and non-governmental organizations.

Impact on mental health services

There has been an unforeseen, but nonetheless valuable impact of the project that prepared the stage for a qualitative change in child mental health services. Mental health services as a system is striving for balance on a higher level of organization. The driver behind this was the repeated crises striking the balance of the social system as a whole in Algeria, and the needs and resources created by the process. Several obstacles however prevent this natural evolution:

- Its dependence on crises as initiator and activator
- Organizational rigidity on the administrative level
- Lack of communication and coordination among the different partners

The project through its different components has facilitated this transformation

- Contributed to correcting the imbalance of distribution of qualified mental health workers over the different Wilayas
- Shifted the debate over theory and technique that split the mental health professionals to a practical context, thus subjecting this issue to serious experimentation and evaluation
- Facilitated the creation of a network of services and professionals around the issue of child mental health

Empowerment of psychologists and other mental health workers

Algerian mental health professionals realized that there is homework to be done before tackling the issues of community wide psychosocial problems they have started their own work on themselves. This part of the impact cannot be attributed exclusively to this project, however, the size of input that it has contributed to the process is remarkable. Training has reached a large proportion of psychologists, teachers, doctors early in the process and has participated in focusing knowledge about issues of child mental health and trauma.

The impact can be summarized in the following points:

- Correcting errors in knowledge and skills
- Contributing to role definition and professional development
- Creating links and opportunities for sharing and exchange
- Validating the experience gained in field work
- Realizing and promoting the development of a professional network
- Encouraging and promoting the emergence of local professional leadership with vision for the future (the core group of trainers, focal points, intermediary staff)

However, this positive would be greatly enhanced if:

- The emerging network is recognized and empowered by the decision makers in the public sector
- The professional leadership (partly represented by the core group of trainers) take a serious attempt to resolve differences and conflicts over theory and techniques through serious evaluation of field experiments
- The supervisory function is enhanced and extended to the field
- The academy and research become involved in documenting and consolidating the experience and redirecting the training of new psychologists, doctors and social workers

Impact on community and civil society

- Support in bringing the issue of traumatized children to public and official concern and creating a culture for mental health of traumatized children
- Empowering the NGO movement
- Promoting interest and awareness about child rights

Impact on children and adolescents

Although most critical, the question about the outcome of activities and their impact in improving the wellbeing of children traumatized by terrorist violence remains to be answered. In attempting to obtain information about the utilization of the supported services and resources from existing records:

- The quality of the existing records and registers
- Concepts, terms and categories are not constant and not clearly defined
- The majority of monitoring mechanisms are administrative and quantitative. They were not designed to address specific issues like trauma and violence

It is difficult to measure the impact on children in the span of 3 months with the absence of reliable baseline monitoring data. However, it can be deduced from cases seen during the period of evaluation, but cannot be generalized. Creating accessible and culturally sensitive mental health service functions within the public sector

structures and NGOs seems the most obvious impact indicators related directly to child well-being in the country. The utilization and efficacy of these structures and mechanisms need to be assessed more closely and on a longer term basis. Through development of the monitoring and evaluation component, it is hoped that the necessary indicators can be developed and used to measure outcome of interventions. Indicators should come from a vision for the future of children and adolescents in the country. They should serve as landmarks in their trajectory as happy and productive citizens and not only point to their 'cure' from past traumata and violence. Medical indicators are insufficient; all sectors concerned including children and youth should participate in creating a vision for the future. The role of the civil society represented by the NGOs, parents and teachers in developing this process cannot be overemphasized.

Sustainability

Due to the post-crisis nature of the project sustainability was not considered an issue at the start. However, several sustainable features -as well as several others that threaten sustainability- are implicitly discernible from the project strategies. The partners are essentially able and willing to be handed over responsibility of project activities. The MSP, MJS and MOE, depending on the capacity of trainers trained in the first phase of the project, took their own initiatives in expanding the training to other areas and other professionals. The MOH trained more than 75 general practitioners with support from the WHO. The MOH took the responsibility for communication and coordination and the SDPSM is doing its best to coordinate though facing many problems doing that.

Criteria for sustainability have been assessed on several levels (Mancini and Marek, 1997). The development of skills and knowledge of human resources seems to be the largest impact of this project.

First: the emergence of a local vision for child mental health and human rights in the public sector and in NGOs.

Second: The project has been successful in achieving stated objectives to a large extent.

Third: the project has been successful in supporting the emergence of a network around the issue of child mental health and child rights. Although the network is informal, it is flexible and self-reliant and is developing with time.

Threats to sustainability

Sectorial division in management, centralization of the decision making mechanisms, lack of evaluation and monitoring, and the schism between technical and administrative managements seem to be the major factors behind project delays and obstacles. These problems are inherent to the administration in Algeria and are recognized by officials at all levels as facts they have to live with. Interviews with key persons in Ministry of Health and the Ministry of Education, and the Ministry of Youth and Sports and several NGOs gave strong indicators on the their recognition of these problems and their incessant efforts to find solution. No one expects these problems to be solved in the near future however.

Concepts like decentralization, coordination of services and networking are interpreted differently at the center and periphery, and across the different sectors. The partners, with the help of UNICEF should try to reach a common operational understanding of what is meant by these terms. This can be done in a multisectorial framework that includes all partner representatives. Its main aim should be reaching an agreement on concepts and strategies within the project framework and not to reach a consensus on terms and concepts in general.

Although the network of care is more structured and better organized in the MSP, it does not communicate well with other sectors and NGOs. Continuing this pattern risks to lose the momentum and input from the other sectors that quantitatively have larger elements and nearer contact with children and adolescents in their natural environment. We remind ourselves that only a minority of children and adolescents affected by violence will reach the attention of the health sector at any level, and usually at an end stage of a complex help-seeking pathway. We also note that especially to adolescents and young women, a medical setting is not as acceptable as a social or educational setting. Involvement, or more accurately recognition of the involvement of other sectors in the psychosocial care of children and adolescents is an important guarantee for future success of this project.

Conclusions, Lessons Learned and Recommendations

The project is proceeding persistently towards achieving its overall goals. Some components are moving faster than others. There is a need to synchronize the change among the different components. For example, the training and capacity building component is achieving its objectives well enough, but the difficulty in monitoring and evaluating the training in relation to desired outcome and impact prevents informed planning for the next step. The project has generated a lot of experience at all levels. Information however is spread over the field in raw form, not gathered and not shared. It was interesting to observe how professionals from remote areas consolidate their experience in focus groups and training sessions through intense comparison and contrast. Our input of experience generated from working with traumatized children in other countries served to validate their field experience.

Conceptualized as a system, psychosocial care for children can be graphically viewed as a set of three interleaved levels. The level of information, shared by a group of people with different disciplines and interests. The level of communication and coordination, where the different players share channels and procedures of interaction. And the level of cooperation, in which efforts and initiatives from the different players realize into actions in prevention and treatment for child psychosocial problems.

Lessons learned from the experience of the project

There is a need to complete the management cycle: planning, programming, implementation monitoring and evaluation. Each element could be detected in more or less all activities. The following lessons are important points to consider in the remaining period of the project:

1. *Discrepancy between need and demand and importance of initial and ongoing assessment of needs and resources:* a comprehensive situational analysis should be performed to build a clearer profile of what the project really is, and where it is heading. An old lesson in management is that demands usually hide several sets of real needs when professionally analyzed. This report can be the starting point of a deeper analysis. Responding to demands emerging from the field leads to a cycle of demand-response-nonsatisfaction-more demand, since the real needs have not been attended to. Integrating a monitoring mechanism with each activity, together with indicators of progress and achievement can objectively assess the developments in needs and resources.
2. *Psychosocial and mental health problems in children and adolescents are not static:* a dynamically changing picture of psychosocial effects of violence could be seen in the target population. While the focus was first on the immediate posttraumatic effects, a wider psychosocial picture developed through the project. A developmental perspective was implicit in the project implementation but not highlighted in the training. Intergenerational transmission of such phenomena is also a known dynamic. Adolescents, and later adults, traumatized as children have been seen to perpetuate such violence in a wider social circle. A preventive perspective is needed to circumvent such dynamic. A developmental perspective needs to be incorporated in the project planning process. Childhood is a highly dynamic and rapidly changing stage of life. Children are resilient and have resources to cope and accommodate to a wide range of life adversities.

3. *Importance of on-site follow up and field supervision:* Things are not usually what they seem to be, and reports –especially quantitative- may not represent what is going on in the field in the absence of agreement on concepts and application, categorizing outcomes under different titles is only confusing. Direct observation and exploration is much needed at this stage. The role of UNICEF project staff and the role of senior professional staff from the different sectors should be extended to reach out, see and feel the impact.
4. *Recognition and encouragement of local initiatives:* Several successful innovations and initiatives have been observed in the public sector and NGOs during this evaluation. From practices in interventions, intervision, cooperation and self-reflection in field staff to initiatives of community outreach and prevention in NGOs to culturally aware skills in intersectorial management and networking in project and ministry ‘intermediary level’ staff. Such innovations can be documented and disseminated through a ‘best practices’⁶ approach. A qualitative research methodology would be appropriate at this stage to describe the nature and dynamics of what goes on in the field of psychosocial interventions.
5. *Evaluation of results, outcome and impact:* Indicators should be defined early in the history of the project. Monitoring information should converge onto an analysis framework at the level of the project management that feeds into the planning and decision making mechanism. Failing to do that threatens loss of experience gained in the field and necessitates re-learning what could have been stored in the organization’s memory. This explains the ‘zero tendency’⁷ seen in several governmental and NGO programs. Training project and field staff on techniques of monitoring and evaluation is necessary.
6. *Research is not only collection of information:* in order to conduct research studies, several steps should have been accomplished. The baseline of research is the stock of knowledge accumulating about the phenomenon from different researchers in different parts of the world. The connection between traumatic events and PTSD for example has become folklore, not in need for replication by a large scale research. The nature and effectiveness of interventions as they are actually delivered, on the other hand is a road with few signs until now. Professionals are still feeling their way within the maze of techniques and theories with little evidence to guide them in the process. The research component should be integrated and harmonized with the psychosocial systemic and culturally-aware nature of the project. Psychiatrization of this component is an easy trap to fall in since psychiatry has more concrete criteria based operational tools than psychology and sociology.
7. *Bypassing the obstacles of culture, language and theoretical ideology:* Child mental health work is a serious business. It is not the property of any single model, theory or discipline. The first expert in child mental health is the mother inheriting the stock of traditional methods of child rearing practices. Algerian professionals –especially seniors- should seriously consider resolving

⁶ ‘Best Practices’ here refer to most effective model strategies – as judged by an expert observer- currently implemented but not yet integrated fully into the program

⁷ We owe this term to an Algerian colleague with whom we tried to understand the repetition and duplication of programs over time and across sectors: failing to learn from experience necessitates restarting from zero.

or at least side-stepping their academic conflicts over theory and ideology in order to be useful for their trainees and clients. We have observed several instances where a young professional –psychologist or psychiatrist- have been triangulated in a conflict between two of his seniors, leading to frustration and paralysis of judgment in intervention with clients. Local idioms of distress and folk tales and actual case studies are easier to understand and integrate in training than Greek mythology.

8. *Language of the training*: If the trainer is unable to convey the information in simple understandable language then there is serious doubt about his mastery of such information. Trainees have complained several times about trainers parroting text in foreign language to trainees who do not master that language, and its mother culture. A summary in Arabic was usually a useful and welcome ‘extra’. The function of the trainer is not only conveying information, which can be done by a good book or article. The trainer’s function is to translate experience into language that the trainees can understand and integrate with their system of knowledge. Unintegrated, poorly conceptualized knowledge –e.g. the concept of ‘le cadre’⁸- stay as foreign bodies in the trainees experience dissociated from their real world performance, and fueling their sense of incompetence and guilt for not being able to realize them. We are not advocating Arabization of all training seminars, but cultural awareness and respect for trainees’ capabilities and limitations.
9. *Community participation in the project planning and decision making is feasible and should be encouraged* This is feasible in the framework of the emerging network and will help as a reflecting mirror for the project staff to assess the relevance and impact of their initiatives. This is not an easy task however. Trust of a community is hard to win. Lessons from the intervention during crisis taught us that it is at least possible to involve the community in provision of support. Experience of NGOs with fund raising through contributions of concerned citizens is another example. In the same area of participation we should involve children and adolescents in the design and evaluation of systems of care. Our focus should shift from pathology and illness to resilience and participation.
10. *Culture and context are defining factors for outcome and impact*: cultural issues have influenced the project progress. Contextual changes –even crises- offer risks and opportunities for project development. In this project, understanding context and culture is an ongoing implicit component even for local professionals who day-by-day build an image of their own culture and history. It may be wise to expose this process of learning and formalize it as a component in training, research and outreach. NGOs’ experience in this regard is a valuable source and starting point. In our Cambodian experience we included culture and history as modules in mental health training, research and management. The module was written and presented by Cambodian psychologists and sociologists.

⁸ Therapeutic frame [French, *psychoanalysis*] a concept that has been sanctified by psychoanalytically oriented teachers, but poorly formalized and never operationalized in the Algerian context.

Areas not addressed enough and priorities for future planning

This section lists a set of unfinished business that the partners should reflect upon and address as a priority before expanding to new areas or setting new targets.

The psychosocial problems of adolescents and youth

It is never too late to start remedying the wounds of adolescents. The wounds attained in early childhood can be healed through the care of parents, teachers and therapists. Even the neuronal changes that carry the pathological images and reminiscent of trauma can be modified by their caring interventions (Young et al, 1998). As children the youth of today were unfortunate, psychosocial preventive or therapeutic interventions did not exist, while parents and teachers were not fully available to care for them. The state today is investing in the education and preparation of youth, full of hope that they will carry Algeria into a bright and modern future. It is their right to make available for them all facilities that will help them cure their own wounds. Their rebelliousness, aggression, and at times outright delinquency should be understood as cries of pain carried from a frightening past and non-responsive present. (Article 12, CRC). Some adolescent girls have been raped or sexually exploited by terrorists, some of whom are today young women. The issue remains surrounded by layers of secrecy and denial. The few examples we could reach were living a miserable existence, disavowed by their own families. There should be an end to silence about the subject and serious exploration for solutions (Kadjar- Hamouda, 1996).

Incidents and media reports about adolescent suicide have raised a few discussions with psychologists during field visits. The conclusion is that there is at least a public concern over spreading violence and delinquency by adolescents. No firm conclusion can be drawn on the trend.

Several models for psychosocial rehabilitation of adolescents and youth exposed to extreme war or war-like trauma exist in the world. None has proved unique advantage over the others. Algerian experts should start consulting their colleagues in the world on the best ways to tackle this problem. Analysis of psychosocial problems presented by adolescents in the framework of this evaluation shows that they are mainly relational and related to culture, identity and role definition. It follows that these are the usual problems in every culture, the complex tragic nature this path takes maybe an adaptive strategy to an abnormal situation. It might also mean that what adolescents need is a model where they can find a role for themselves in constructing their own life and the in the reconstruction of their country, and provide them with role models to identify with and become 'normal adults' in a normal context. Or, we might take the medical model and consider them 'sick' and in need for 'therapy'. A role and a role-model are the key words in psychosocial care for adolescents.

Children and adolescents living in families with severe or complex psychosocial problems

They form a particular group at high risk not only for mental health problems but also for all other sorts of other medical psychiatric and social problems. Postwar social fragmentation and collapse of traditional support systems became known facts to social and mental health experts. The cascading downfall of loss of resources (Hobfoll, 1989) can result in awful images of street children, homeless families and *bidonville* creatures that mental health professionals are usually very reluctant to

work with. A case-management approach by a barefoot and determined social worker is a likely suggestion to start tackling this problem(s). Many such resource persons exist in Algeria under different names.

There is a need to consider this component in future interventions. It is not enough to treat the immediate consequences of violence, but to ensure the rehabilitation and reintegration of the child or adolescent into a healthy environment “which fosters the health, self-respect and dignity of the child” (Article 39, CRC). ‘Structural violence — bred by the unfair distribution of wealth, the political violence, and the economic and social violence that denies people access to education and health. To categorize such exploitation as expressions of violence is valid. The consequences of these violations are explicit, and can, at their most extreme, lead to death’ (Quoted from: World Vision International, 2001).

Mothers have their own problems too. In taking care of their children and in participating in their mental health care, mother’s ability is limited by her own problems and suffering (grief, poverty, marginalization, gender problems and posttraumatic stress disorders). In Algeria, the prevalence of PTSD and the level of general distress was significantly higher in women, especially widows, divorced and unaccompanied mothers (Elmasri, 2001).

Children, adolescents and their families should have a say in the type of care they receive

They usually prove helpful when they are not considered as passive recipients of ‘care’. All that is required here is an attitude that is accepting and appreciative of the children and families contributions in planning and decision making. Several levels of contribution have been identified for UNICEF (Hart, 1997, and Rajani, 2000). In this evaluation, an experiment of conveying the children and adolescents evaluation of the context and services provided, although shared in large by psychologists in the field, raised some anxiety at the professional leadership and decision making levels. Schools and youth reception cells (CIAJ, CEPJ) are the available contexts where child and adolescent participation should be sought and encouraged. A starting topic could be the education of children, adolescents and youth about their rights as children guaranteed by the CRC of which their government is a signatory.

We should stress here again that this is not a naïve, grassroots democratic dream, but a serious professional prescription that would help solve many problems —e.g. adolescent peer groups turning into long arms for outreach to problem of boredom and delinquency amongst their friends- At least one instance of this ‘transformation’ was facilitated by a junior psychologist during the outreach after the May earthquake. Several other initiatives were accomplished by ‘educators’ in the CIAJ across the country.

Psychologists’ need for continuous personal and professional support

Many of today’s psychologists are devoted active young women and men who carry the same pain and memories as their clients. Assigning them the task of providing mental health care to others may relieve some of the pain through the gratifying sense of giving and helping, but may also overburden them with the pain and suffering of others.

As noted in the evaluation, the university education of these psychologists is at best modest. They were not given the skills of self-care and protection in the professional

sense. Their experimentation with models and techniques and their self-reliance and improvising adds a factor of doubt and guilt to the many stressors they endure.

Although hard to generalize, the observation that many young psychologists lack basic skills in interviewing and counseling raises serious concern. The ability to receive and engage the child and family is the most critical part of any intervention in any model. The majority of psychologists we interviewed were honest enough to expose this difficulty, and relate to their education in the university. However, many projects jump to training in specific techniques in trauma and therapy, while ignoring this basic need. The lack of supervision and follow up led to the continuation of this problem undiscovered.

The typical answer from psychologists on the question about supervision is that it does not exist in Algeria, but many of them could recite a name of a more experienced person, a *cheikh*⁹ who they consult and learn from. This is usually done in informal casual way, but assessed as very useful. Another model identified during this evaluation was intervision. Studying these models, elaborating them, and formalizing the relationship may be the answer.

Systematically stated functions of supervision are: *Monitoring and evaluation, Instructing and advising, Modeling, Consulting, Supporting and sharing* (Holloway, 1995). While the tasks of the supervisor are to support the trainee in developing counseling skills, case conceptualization, professional role, emotional awareness and self-evaluation (ibid). In the psychosocial world there are several ways in which this can be done. Professional supervision is one way, but coaching, modeling or *parrainage*¹⁰ could do the task equally well. We say that because only a few senior psychologists considered themselves fit (physically or professionally) for the task of supervision and considering the cost and time needed to develop this function over a wide geographical area.

NEEDS OF PSYCHOLOGISTS AS ASSESSED IN THIS EVALUATION

1. In service training and supervision: a multi-level continuous education and rehabilitation based on systematic and individual assessment of needs and resources
2. Ongoing monitoring and evaluation of their performance
3. Identify and formalize modes of communication and coordination among psychologists, and between psychologists and other medical and administrative staff.
4. Resolving administrative problems and regulations related to role and status and impeding the efficacy of their interventions
5. Providing easy and free access to information, literature and developments in the world

Planning, monitoring and evaluation: completing the management cycle

Monitoring and evaluation are the nervous system and brain of a project. Monitoring records and documentation of experience are their physical memory. Achievements in installing a monitoring system in the area of child mental health have been partially successful until now.

⁹ A teacher, in Algerian dialect equivalent of *kruu* for Khmer which Cambodian mental health workers used in the same sense. It is also used to refer to university professors.

¹⁰ Sponsor or Godparent [French]

Consolidation of professional experience in the field seems necessary condition for starting monitoring and evaluation. Until now, psychologists have doubts about what they are doing, and professional leadership (senior psychologists and psychiatrists) have little access to information about actual modes of service delivery. Most of the experience of psychologists and other professionals comes from their own trial-and-error attempts to deal with a diversity of clinical and social situations. There is little consensus on concepts and terminology.

There is no stable classification system for mental health and psychosocial problems and disorders, but a blend of French psychiatric classification system, DSM and donor reporting requirements. Reviewing a sample of monitoring reports in the framework of the project shows that the children were categorized according to the type of violent situation they suffered.

A developmental strategy should be adopted. Imposing a monitoring and evaluation system at this stage will raise suspiciousness and resistance from professionals who already doubt the efficacy of their interventions. In a previous mission, we have installed a monitoring system bottom-up through raising professional's interest in knowing the nature and results of their interventions and creating involving them in creating the indicators and forms. The rest followed naturally – but not spontaneously. Algerian professionals have a unique thirst and search for knowledge, the stage is set for action. Better monitoring and evaluation would improve implementation of capacity building and community mobilization, as well as make it possible to measure progress more accurately.

Steps in development of a monitoring system

- Consolidate the experience of professionals through continuous in-service training and supervision
- Identify indicators through direct observation of interventions – couple indicators with objectives
- Install and train on a simple classification system
- Create forms and report formats with ample space for narrative data
- Install a mechanism for data recording and collection

Research between service needs and academic interest

Research is the outreach for information. Many young university students bare their feet collecting huge piles of data for theses with bad methodology and purely academic purposes. Nearly all studies remain stacked on shelves in the university archives with little or no use. Evaluating the research component reveals the scarcity of competent researches. Here, there is an expressed need for international expertise on the subject to train local researchers. Cultural differences are hardly an obstacle in empirical research methodology and procedures can be adapted by local field researchers. An epidemiological research on the prevalence of psychiatric disorders and distress in

Most pressing research questions

- The complexity and dynamics of violence against children and its effects from a multidisciplinary perspective
- Nature and efficacy of community-based interventions with children traumatized by violence
- Help-seeking behavior, service utilization and traditional methods of helping and healing

adults provided useful information on how this can be done in Algeria (Elmasri, 2001).

Research questions should arise from the enquiries of the professionals in the field and should be relevant to one or more of the project objectives like needs and resource assessment or measuring effectiveness of classical and innovated interventions. One serious and critical question in this regard is about the nature, relevance and effectiveness of interventions in the field. Research teams should include expertise from the different disciplines involved in the provision of psychosocial care for children traumatized by violence. Qualitative research is necessary at this stage to describe the context and dynamics of interventions in the psychosocial field.

A lesson re-learned: Imposing new structures to overcome problems of information access, communication and coordination

Solving local – non project related- problems of communication and coordination by erecting committees and structures only leads to creating new problem sources. Well equipped and externally funded structures feed the competition which is usually associated with communication and coordination stalemates. It is not because people do not understand or do not know how to speak, it is because people either do not speak to each other or do not listen or both.

The story of the Trauma Information and Documentation Center is relevant in this regard. Although a clever and well calculated well-intentioned solution, it remains an experiment in linear thinking to deal with a complex problem. The competition over resources and territory led to an impasse in the development of this component. A change of strategy may be needed in this regard. Stated simply: people

COMMUNICATION & COORDINATION

- Reactivate the intersectorial coordination in a new frame
- Avoid the blame-game
- Involve community and NGOs in the process
- Clearly define rules of membership and roles for participants
- Identify blocks in communication ‘attention to language and cultural issues, and institutional affiliation’
- Identify interests of all partners in collaboration
- Set clear realistic goals to be achieved in a preset timeframe
- Monitor and evaluate the process and feedback to partners
- Encourage exchange and communication with experts and programs in other parts of the world

cannot cooperate without coordinating their efforts, they cannot coordinate without communicating, and they do not communicate if they do not have the intention to do so. However, young Algerian mental health workers have taught us a valuable lesson. With a minimum of resources available they formed an informal but functional network of communication, coordination and exchange among themselves. Maybe, again, we need to study their initiatives and elaborate on them.

There seems to be a variable degree of tension between center and periphery in all the sectors assessed. This is a healthy sign, and in the process of development points to the emergence of new attractors for a better functioning system. UNICEF has been triangulated in some areas, and found a way out by responding to the demands

expressed by professionals in the field. We should remember that development is a slow process that needs and takes its time. The temptation to find easy solutions and shortcuts should be resisted. A proposed framework for dealing with the problem of coordination and communication, given the above analysis of the situation, is to adopt a conflict resolution approach. The problem lies not in the absence of mechanisms, committees or channels, but in the competing interests and attitudes and paradigms among and across the different sectors. Review of past conflicts and problems shows that they have either been avoided through compromise, or solved through arbitration of a higher authority.

Addressing culture and context: time, patience and wisdom

Cultures cope with community wide trauma by creating shared meaning of the events. Such meaning becomes institutionalized as structures and mechanisms to repair the tears and prevent the recurrence of trauma. The meaning being created among children and especially adolescents is alarming. Our discussions with adolescents indicate the loss of trust and respect for parent and authority figures, a sense of alienation and being unwanted, and anger that drives many to consider immigrating as soon as the chance comes. Adolescents and youth have a clearly different version of the story of violence, terrorism and the current crises. Such versions should be heard and tolerated by parents and authority, and taken for what they really mean before attempting to correct them. If mental health services plan to implement a community based approach and mobilize community resources it will be necessary to address issues of history, culture and context and understand the in which direction, and by whom, the community is being mobilized.

Psychosocial projects offer a new dimension in the meaning of violence. One of the striking developments of the 20th century is the spread of the western culture's medical and psychological explanations of the world, a power once dominated by religion (Summerfield, 1996). In eastern countries, words like victimization, stress and trauma are hard to translate and if translated, had to conceptualize. Oppression, suffering, loss and misfortune are common to all languages and easy to understand. What is referred to the psychologists and psychiatrists in the west is still managed by family, teachers, healers and religious people in large parts of this country. The stories we hear from our patients are framed in cultural, religious, political and social terms, not by psychological jargon. In summary, what psychosocial projects may be unintentionally doing is a cultural change in the conceptualization and management of suffering, oppression and misfortune. Great wisdom is advised in this direction and a good question may be posed here. On the background of this evaluation of needs and resources and in the frame of community approach and participation: Do we need to teach the culture about its psychologists, or do we need to teach our psychologists about their culture?

Homework for psychosocial workers

- Assess community needs and resources
- Understand your own culture
- Understand traditional support and healing mechanisms
- Understand the local 'language of suffering'
- Participate wisely in creating a 'shared meaning' of what happened

The first step would be a documented assessment of community needs and resources. This should be followed by opening and maintaining channels with the community. Opening these channels aim at involving the community in planning and decision making. Experience in the world shows that this is a very tedious task, that registers itself in long-term community development initiatives rather than immediate relief.

Moving from crisis response to development

In the same vein runs the project’s steady movement towards supporting the development of capacity, structures, models and policies. It is clear that disaster mental health interventions are different from business as usual. In the transition from a disaster response to regular business many things have to be settled or changed, most important of which is a change from the mentality of a rescuer to that of a builder. The number and quality of mental health staff, management procedures and rules, and above all an orientation towards promotion of prevention and development.

The following table shows the road signs along this approach, and how far the project has reached in that direction. The argument is that this project has initiated changes in the direction of development of capacities, services and policies since its start. The question –phrased as such- becomes irrelevant.

First:	A policy for child mental health in the country		This project has pioneered the first steps in this regard
Second:	Legislations to reinforce this policy		Negotiations and consultations are underway...
Third:	Service models and practices that implement this policy or integrating the policy within existing services directed at children		Several initiatives and innovations have been supported by the project
Fourth:	Development of capacity of front line interveners in outreach, reception and management of child mental health and psychosocial problems.		What already started through the training and capacity building component, is being developed into a long-term more holistic approach and prevention

A more valid phrasing would be: should we continue what we have started? Obviously a long road, but children have the right, as stated in the CRC.

Role of UNICEF in the project

Catalyst for positive change

A major change was already underway in the official and professional systems towards the issue of children traumatized by terrorist violence. During the project planning phase, UNICEF has communicated with all potential partners and created a committee of coordination through which the essential needs were assessed.

Identifying the emergence of a professional network around the issue of child mental health, UNICEF has supported the functioning through

Innovation

Several innovations have been introduced by UNICEF and been welcome by other partners. The first was the adoption of a training-for-trainers approach in which trainers from different disciplines were trained by international experts. A usual pattern in the reaction to innovations was noticed: an initial skepticism on the part of the public sector representatives is followed by attempts of experimentation and testing. Success of the innovation was soon followed by adoption of the method or strategy. Because the project is still in progress, we can see several levels of satisfaction where new innovations are still received with skeptic criticism (e.g. multisectorial approach, decentralization) while older successful models have been handed over and owned by partners (training). The role of intermediary level staff both in UNICEF and public sectors in this dialogue as mediators and facilitators is a lesson to learn.

Partner, not substitute

All through the project, and with a few exceptions, the role of UNICEF was that of a full partner in coordination and collaboration with government sectors and NGOs. The lack of coordination in the public sector pushed UNICEF to take charge of the process in a few instances where it deemed necessary to change strategy and accommodate contextual changes. This triangulation, however, was usually short lived and UNICEF staff could withdraw and maintain a partner role.

Role model for local organizations

UNICEF provided models in strategic planning, monitoring and evaluation, project management and multisectorial approach, all are areas where local expertise is lacking or still in the beginning.

Contextual changes: that the project has to adapt to the following changes

Context		1998	2003
Violence	Forms and scope	Terrorism	Terrorist violence receding Community violence raising concern Successive natural disasters
	Effects	Acute crisis	Long-term effects Repeated crisis situations
Target population	Definition	Children and adolescents traumatized by terrorist violence	Adolescents and youth New generation of children Mothers and family
Resources	Interveners	Lacunae in competence	Competence improved Network of professionals active Focal points in place
	Trainers	No trainers in the area of child trauma	Core group of trainers in place
	Supervisors	Supervision is not established	A few trainers candidates for the role of supervisors

Services	Structure	Devastated by Violence	Partially rehabilitated
	Management	Centralized management	'Intermediary level' structures and staff
	Material & Equip.	Material Shortages	Partially covered
	Coordination	Poor coordination among sectors	Several attempts in progress
	M&E	Plans to initiate M&E functions	Slow development
	Services for children	No specialized services	New services for children in public sector
Policy	National outcomes	No Mental Health Policy	National Mental Health policy
	Specific	None	Child Mental Health policy in the making
Community	Concern and reaction	Shock, passive	Community initiatives Community awareness
	Culture	Cultural expression thwarted	Cultural expression and revival Media and modernization
	Resources	unidentified	NGOs active and inventoried Traditional resources being identified

References

- Barclay, A. H. *et al.* (1979) *The Development Impact of Private Voluntary Organisations: Kenya and Niger*. Report to the Office of Private and Voluntary Cooperation, Contract AIDS/otr-C-1383, Work Order No.39.
- Boswell, G., *Violent Victims: The Prevalence of Abuse and Loss in the Lives of Section 53 Offenders*, The Prince's Trust, London, 1995.
- Cohen DJ (1998). The mental health systems for children and adolescents: Issues in the definition and evaluation of treatment and services. In: Young JG and Ferrari P (Eds.) *Mental Health Services and Systems for Children and Adolescents: A shrewd investment*. Philadelphia: Brunner/Mazel.
- Callor, S., Betts, S. C., Carter, R., & Marczak, M. S. (1997). State strengthening evaluation guide. Tucson, AZ: USDA/CSREES & The University of Arizona.
- Cooper, C. R., & Denner, J. (1998). Theories linking culture and psychopathology: Universal and community-specific processes. *Annual Review of Psychology*, 49, 559–584.
- Costello EJ, Burns BJ, Angold A, Leaf PJ (1993) How can epidemiology improve mental health services for children and adolescents? *Journal of the American Academy for Child and Adolescent Psychiatry*, 32(6), 1106-1117.
- Cuffe, SP, Addy, CL, Garrison, CZ, Waller, JL, Jackson, KL, McKeown, RE, and Chilappagari, S. Prevalence of PTSD in a community sample of older adolescents. *J.Am.Acad.Child Adolesc.Psychiatry* 37[2], 147-154. 1998.
- Davidson, R. T., & Fairbank, J. A. (1993). The epidemiology of posttraumatic stress disorder. In A. Urquiza, G. Wyatt, & E. B. Foa (Eds.), *Post-traumatic stress disorder: DSM-IV and beyond* (pp. 147-169). Washington, DC: American Psychiatric Press.
- Diagnostic and statistical manual of mental disorders. 4th ed. (DSM-IV). Washington DC: American Psychiatric Association, 1994.
- Elmasri MA (2001) Prévalence de Stress Psychologique et des Troubles Psychiques en Algérie . *Psychologie*, No 9 (2001). Revue Annuelle, Société Algérienne de Recherche en Psychologie (SARP)
- Finkelhor, D. and Dziuba-Leatherman, J., 'Children as Victims of Violence: A National Survey', *Pediatrics*, 94(4), October 1994, pp. 413–420.
- Garnezy, N., Masten, A.S., & Tellegen, A. (1984). The Study of Stress and Competence in Children: A Building Block for Developmental Psychopathology. *Child Development*, 55, 97-111.
- Glaser, B., and A.L. Strauss (1967), *The Discovery of Grounded Theory: Strategies for Qualitative Research*, New York: Aldine de Gruyter.
- Glaser BG. (1998). *Doing Grounded Theory: Issues and Discussions*. Sociology Press
- Goenjian AK, Pynoos RS, Steinberg AM, Majarian LM, Asarnow JR, Karayan I, Ghurabi M, Fairbanks AL (1995) Psychiatric comorbidity in children after the

- 1998 earthquake in Armenia. *J Am Acad Child Adolesc Psychiatry*, 34, 9: 1174-1184.
- Hart, Roger. 1997. *Children's Participation: The Theory and Practice of Involving Young Citizens in Community Development and Environmental Care*. London: UNICEF/Earthscan.
- Hobfoll SE (1989) Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist*. 44: 3, 513-524
- Holloway EL (1995). *Clinical supervision: a systems approach*. California: SAGE. 25-40.
- Jacobs, F. H. (1988). The five-tiered approach to evaluation: Context and implementation. In H. Weiss, & F. Jacobs (Eds.), *Evaluating family programs*. NY: Aldine de Gruyter.
- Kadjar-Hamouda, E., (1996) *An End to Silence: A Preliminary Study on Sexual Violence, Abuse and Exploitation of Children Affected by Armed Conflict*, International Federation Terre des Holmes, Laesione, 1996.
- Kepel G (2000) Algérie: les Années FIS. In Kepel G. (Author) *Expansion et déclin de l'Islamisme*. Paris : Gallimard. 166-182
- Kohut H (1971) *The analysis of the self*. New York: International Universities Press.
- Lira E., Becker, D., & Catillo, M. I. (1998). *Psychotherapy with victims of political repression in Chile: A therapeutic and political challenge*. Paper presented in at the Latin American Institute of Mental Health and Human Rights, Santiago, Chile
- Miles MB, Huberman M (1984). *Qualitative Data Analysis*. Newbury Park, Calif.: Sage.
- Miles MB, and Huberman AM (1994). *Qualitative Data Analysis*, 2nd Ed. Newbury Park, CA: Sage.
- Miller T, Elmasri M, Allodi F, Qouta S (1999). Emotional and Behavioural Problems and Trauma Exposure of School-age Palestinian Children in Gaza: Some Preliminary Findings. *MEDICINE, CONFLICT AND SURVIVAL*, VOL.15, 368-378.
- National Mental Health Plan**, The Democratic and Popular Republic of Algeria, 2001
- Offord DR (1995). Child psychiatric epidemiology: Current status and future prospective. *Canadian Journal of Psychiatry*, 40, 284-288.
- Patton, M. Q. (1987). How to use qualitative methods in evaluation. Newbury Park, CA: Sage.
- Rajani, Rakesh. 1999 (December). Promoting Strategic Adolescent Participation: a discussion paper for UNICEF. Unpublished mimeo. New York: UNICEF. Quoted in : Evaluation Technical Notes : No 1. UNICEF Evaluation Office, April 2002.
- Rutter M (1989) Isle of Wight revisited: Twenty five years of child psychiatric epidemiology, *Journal of the American Academy for Child and Adolescent Psychiatry*, 28, 633-653.

- Salhi HC (2003) *L'Ecouteur de Rosée: Manuel guide de prise en charge des psycho-traumatismes des enfant et adolescents. Réaliser avec l'appui financier de l'UNICEF.* Alger.
- Shooter M (1997). The impact of death, divorce and disaster on young people. *Current Opinion in Psychiatry.* 10, 268-274
- Spatz Widom, C., 'The Cycle of Violence', US National Institute of Justice Study, *Research in Brief*, US Department of Justice, September 1992.
- Summerfield D (1996). The impact of war and atrocities on civilian populations: Basic principles for NGO interventions and critique of psychosocial projects. Relief and Rehabilitation Network. Network paper 14.
- Terr, L. (1991) Childhood traumas: an outline and overview. *American Journal of Psychiatry* 148, 1-20.
- UNICEF (1997) *Innocenti Digest No 2 - Children and Violence.*
- UNICEF (1998) *Psychological Rehabilitation of Traumatized Children.* UNICEF Algeria.
- World Vision International (2001) *A Safe World for Children: Ending abuse violence and exploitation.*
- Young JG, Ferrari P (1998). Designing mental health services for children and adolescents: Observations and recommendations. In: Young JG and Ferrari P (Eds.) *Mental Health Services and Systems for Children and Adolescents: A shrewd investment.* Philadelphia: Brunner/Mazel.
- Mancini, J., & Marek, L. (1997, February). Keys to sustainability. Paper presented at the Youth, families and communities: Arizona team training on sustaining programs and supporting families, Laughlin, NV.