



ACF MENTAL HEALTH AND CARE PRACTICES: STORIES FROM THE FIELD



**ACTION
AGAINST
HUNGER**



STATEMENT OF COPYRIGHT

© Action contre la Faim – France

Reproduction authorized, provided the source is credited, unless otherwise specified. If the reproduction or use of text and multi-media data (sound, images, software, etc.) are subject to prior authorization, this authorization will cancel the above-mentioned general authorization and shall clearly indicate all possible use restrictions.

DISCLAIMER OF RESPONSIBILITY

The current document aims to promote public access to information relative to the initiatives and policies of Action contre la Faim. Our goal is to provide accurate and up-to-date information. We will endeavor to correct the errors pointed out to us. However, ACF does not assume any responsibility for the information content of this present document.

This information:

- is exclusively of a general nature and does not target any particular person's or institution's situation;
- is not necessarily complete, exhaustive, accurate or up-to-date;
- sometimes refers to external documents or websites over which ACF has no control and for which ACF declines any responsibility;
- does not constitute legal advice

The present non-responsibility clause is not aimed at limiting ACF's responsibility contrary to requirements of applicable national legislation, or at denying responsibility in cases where this cannot be done in view of the same legislation.

Cover photo: © Damien Guerchois - Somalie

ACKNOWLEDGEMENTS

Contributors:

Joséphine Antoine-Milhomme; Alexandra Bataille; Brutus Bayard; Barbara Bobba; Mélanie Couvreur; Elaine Joyce Duaman; Egor Gavrilov; Charles Hunter; Jules Luckson; Valérie Piloti; Stephan Richard; Liana Rahmani.

Principal Authors:

Cécile Bizouerne; Alexandra David; Elisabetta Dozio; Maud Rivière.

ACF Mental Health and Care Practices team wishes to thank all the people who took part in carrying out this testimonial book: headquarters and field colleagues, national teams, beneficiaries and their families, as well as Translators without Borders.

We would like to particularly thank beneficiaries and their families the trust they put in us and all the things we could learn from them.

INITIALS AND ACRONYMS

ACF: Action contre la Faim

FSL: Food Security and Livelihoods

ICDDR-B: International Center for Diarrheal Disease Research, Bangladesh

IGA: Income-Generating Activities

MHCP: Mental Health and Care Practices

MPC: Mothers' Participation Center

MSF: Médecins Sans Frontières

NGO: Non-Governmental Organization

SAM: Severe Acute Malnutrition

TNC: Therapeutic Nutrition Center

UNHCR: United Nations High Commissioner for Refugees

WaSH: Water, Sanitation and Hygiene



TABLE OF CONTENTS

Statement of copyright	2
Disclaimer of responsibility	2
Acknowledgments	3
Initials and acronyms	3
Table of contents	4

1. INTRODUCTION 7

At the beginning of the programs....a field request	9
Conception of mental health and care practices within the contexts of ACF interventions	11
The conceptual framework of nutrition and malnutrition	11
The conception of child care practices	12
The integration of mental health and care practices actions in the treatment and prevention of malnutrition	13
Emergency preparedness and response in conflict or natural disaster situations...	16

2. MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN AFGHANISTAN (2002-2008) 19

Context	20
Programs	21
Narrative accounts and clinical observations	24
<i>Arsallah or how to unify two lines of descent</i>	25
<i>Infanticide as revenge, Leila's broken dreams</i>	26
<i>The story of Leeka and Kasia: a fight for survival</i>	29
Research and technical development: example of severe chronic malnutrition management among children under the age of 6 months	31

3. MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN BANGLADESH (2008-PRESENT) 35

Context	36
Programs	38
<i>Adoption and the family system's difficulties in welcoming a new child, their needs, and their feelings</i>	41
<i>What possible care between rejection and loss anxiety?</i>	42

4. MENTAL HEALTH AND CARE PRACTICE PROGRAMS IN MYANMAR (2006-PRESENT) 45

Context	46
Programs	47
<i>Yaminn, or the search for a parental imago</i>	50
<i>Rokha, or the endless search for answers</i>	52

Interview with Zawlal and Fozul, co-founders of the impromptu prevention center 54

5. MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN HAITI (2009-PRESENT) 57

Context and program	58
Psychosocial support in mother baby friendly tent program (2010–present)	61
<i>Elise’s story: Becoming suddenly the head of the family</i>	62
Holistic (economical and psychosocial) support program for teenage mothers in Gonaives (2010-2011)	66
<i>How to receive what is good, when you have never experienced it?</i>	68
Mental health and care practices program integrated with treatment of malnutrition program (2008-present)	70
<i>Robenson: Strengthening a father-son relationship</i>	70
Family support program Gonaives (2011)	71
<i>Marie, a story of loss</i>	73
<i>Johanne: from the perception of fate to positive control over her life</i>	74
Cholera victims support programs (2010- present)	76
<i>Ritha’s story: a family reconstruction</i>	77
Distressed people support program (2010-2011)	78

6. MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN CENTRAL AFRICAN REPUBLIC (2008-2010) 79

Context and programs	80
<i>While trying too hard to stand up, it’s our children who collapse</i>	82
Impairment and transmission anxiety	83
<i>Attached for protection</i>	84

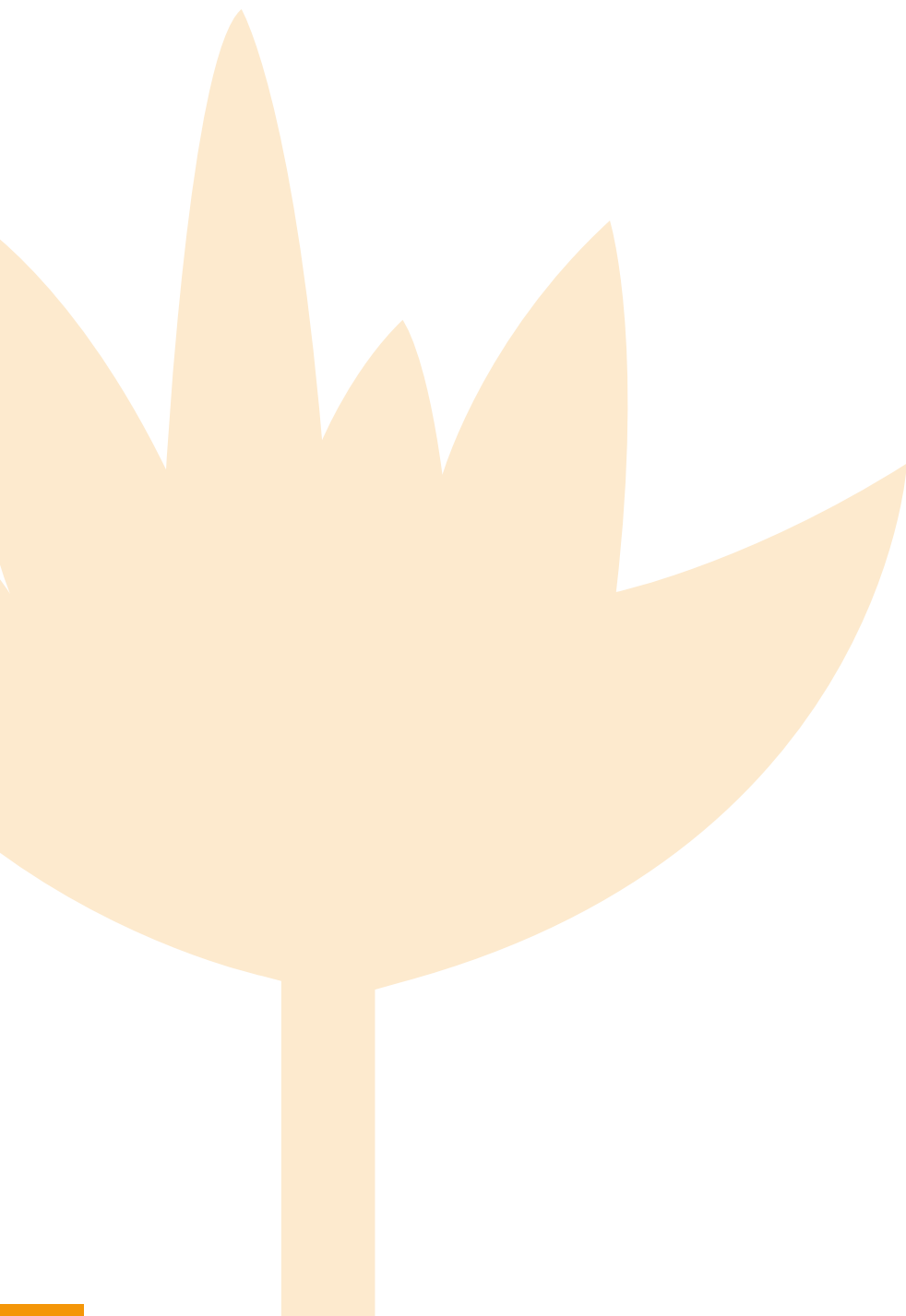
7. MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN SRI LANKA (2005-2007) 87

Context and programs	88
<i>Senuri’s Story: a child replacing...Gihan</i>	91
<i>Madushani’s story and the importance of rituals surrounding birth</i>	93
<i>Kumar’s curse. The story of a suicide foretold in Sri Lanka</i>	94

8. MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN CHAD (2007-PRESENT) 103

Context and programs	104
From humanitarian intervention to the human factor – transcultural perspectives	106
<i>Abbakar or the limits of traditional care</i>	106

9. CONCLUSION 111



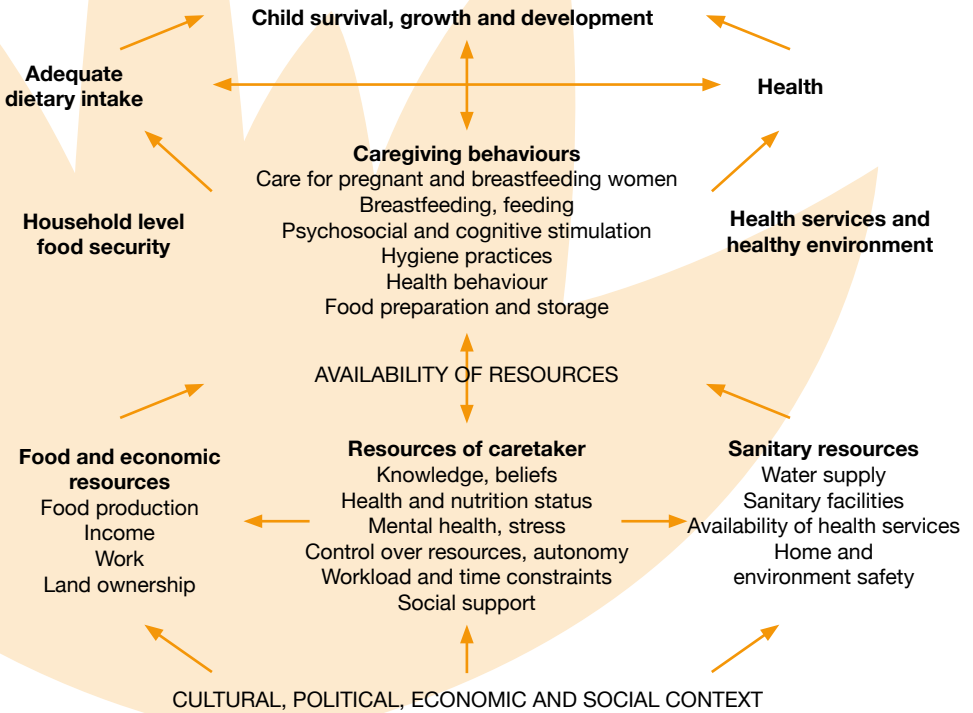
1 - INTRODUCTION



© Véronique Burger / Phallie - Libéria

ACF's mission consists of saving lives by eradicating hunger through prevention, detection and treatment of malnutrition, particularly during and after emergency situations, in the aftermath of conflict, war and/or natural disaster. From crisis to development, ACF tackles the underlying causes of malnutrition and its effects. By integrating its programs into local and national systems, and by using advocacy and research, ACF makes sure that short-term interventions become long-term solutions. ACF's general technical strategy is based on the conceptual frame of the causes of malnutrition adapted from the 1997 UNICEF extended health-care model (see Figure 1). It considers the immediate, underlying and fundamental causes that determine the nutritional status of individuals and populations.

Figure 1 – The extended care conceptual framework (Source: Engle¹)



¹ Engle, P. (1997). The care initiative: assessment, analysis, and action to improve care for nutrition. NY: UNICEF.

Various technical sectors (Nutrition and Health, Water, Sanitation and Hygiene, Food Security and Livelihoods) work together to better respond to the specific needs of populations within a given context and to fight malnutrition in an integrated manner. Since 2002, child care practices and mental health actions have been developed in line with the other existing technical sectors or through programs operated independently. ACF's policy for intervention in child care practices and mental health is in line with the overall ACF strategy and contributes to fighting hunger

AT THE BEGINNING OF THE PROGRAMS....A FIELD REQUEST!

1999, Congo – Brazzaville: ACF teams felt powerless when confronted to people coming out directly from the bush, where they had taken refuge for several days or weeks, in order to flee abuses. Hosted in nutritional centers because of their state of severe malnutrition, a large number of them were displaying behaviors of prostration, suicidal thoughts, and some were refusing to take the treatment. Others began telling what they had suffered or what they had witnessed. In this context, the medical-nutritional treatment was not sufficient and it appeared essential to offer something beyond the sheer medical-nutritional treatment. But, what?

During the 2000/2001 period, ACF reflected on a proper way to respond to this demand (collection of testimonials/protection and/or psychological support of traumatized people) and on how to set up and develop mental health care interventions for its beneficiaries.

The work carried out on the support of the populations suffering from psychological disorders related to difficult life experience was based on various observations and experiences: the willingness of ACF to improve the quality of its services, the experience of psycho-social programs brought by different NGOs in Eastern Europe in the 1990s, as well as the questioning of beneficiaries' needs at a psychological level. This process resulted in a double axis positioning for mental health and psycho-social dimension:

- a “contextual” axis based on the psycho-social specificities of ACF's intervention contexts (emergency, extreme poverty, discrimination...)
- a “thematic” axis based on the existing links between mental health, child development, and malnutrition through the prism of child care practices¹.

■ Contextual axis: the psycho-social specificities of ACF interventions

ACF's interventions are often carried out in situations of crises, social disintegration and/or political violence, which have an impact on the mental health of beneficiaries, national teams and expatriates, if only by the disruption of normal life and the loss of benchmarks that it entails. Thus, it seemed very important that ACF should take into account these aspects of populations' background in its daily work.

Facing with the psychological suffering of populations (who have been subjected to or have witnessed abuse, physical and/or social violence, who have had to abandon their homes, who do not know what has become of certain family members ...), ACF had to position itself on the responses it could bring. How to provide short-term support and help people to cope with daily life and meet their needs? How to prevent medium and long-term psychological consequences of a trauma? These questions raised the necessity to further improve services in the emergency phase, the post emergency period as well as during more chronic situations.

¹ Definition proposed by Engle (1997): “Behaviors and practices of caregivers (mothers, siblings, fathers, etc.) who provide food, healthcare, stimulation and emotional support necessary for the survival, development and adequate growth of the child. These practices turn food security and healthcare resources into well-being of the child. Not only the practices themselves, but also the ways in which they are conducted (in terms of affection and in being receptive to the needs of the child) are critical for the survival, growth and development of the child. It is impossible for the caregivers to bring this care without sufficient resources such as time and energy.”



■ The thematic axis based on the existing links between mental health, childhood development and malnutrition through the prism of child care practices.

Malnutrition often has a multi-factorial origin. Child care practices that is the way in which adults take care of the child and respond to their needs so that they will grow and develop well, constitutes one of these causes. Food availability or the existence of health services for example, are not enough; adults still must serve as go-betweens so that the child might have access to them. This often depends on parents' availability, time, flexibility or beliefs about what is good for the child. Besides, even if meeting their basic/vital needs is essential, it is long been known that in order to develop properly, the child also needs a special bond with one or more adults. In some situations, this emotional bond is inexistent, because the adult is not psychologically available in an overall manner (depression, trauma, survival situation, etc.) or specifically for a very child (unwanted child, child born out of rape, etc. ...). Without this bond, malnutrition can be part of a more global scenario of negligence, mistreatment or abuse; the child can also let himself die through lack of an emotional bond (hospitalism¹).

The episode of severe acute malnutrition in itself can be a trying experience for parents and their child. S/he is extremely sick, loses weight, becomes apathetic, and does not respond to solicitations. S/he comes very close to death, one does not know if s/he will live. It is hence critical to accompany families during this ordeal and to take into account its vital dimension.

As far as the admission in therapeutic nutrition centers goes, it was important to think about proper supporting measures, in order not to have any additional traumatic effect on people already in vulnerable condition. Indeed, despite the obvious urgency of bringing medical and nutritional care to children suffering from malnutrition, it is also essential to take into account the caregiver-patient relationship the quality of reception, as well as parents and children supporting methods...

Finally, an episode of malnutrition often leads to developmental delay and ACF was anxious about integrating activities that should limit or stem this phenomenon.



© Alicia Garcia - ACF Spain - Mauritania

¹ Affective disorder theorized by R. Spitz, describing a depressive state in the child when the infant is neglected by their mother during their first months of life, involving crying, then a loss of weight and eventually development arrest. This emotional deprivation can lead to death. Spitz, R.A. (1945). Hospitalism. In Spitz R.A. The Psychoanalytic study of the child, vol.1 New York: International Universities Press.

A mental health and care practice pilot project was defined in order to improve the mental health of children and adults admitted in therapeutic nutrition centers (TNCs). Thus, through this project, ACF was responding both to the population needs and to the requests coming from the field teams. The project was about taking individuals into account in a holistic manner, thinking beyond the “body/spirit” dichotomy, stimulating verbal expression, and listening to psychological distress... Its objective was to further improve the quality of all services proposed by ACF first within the nutrition centers and furthermore, within its global interventions.

These actions concerned all the TNC’s beneficiaries. Indeed, they all can be considered as distressed, vulnerable people, since underneath difficult and potentially traumatizing events they have experienced, their current malnutrition situation was requesting specific attention at both physical and psychological levels.

Furthermore the cultural and anthropological considerations that arose from the project have undeniably modified ACF missions’¹ set up and organization and thus the implementation and efficiency of its actions have increased.

Thanks to these observations and the preliminary work, it was admitted that mental health does not play a mere additional part, but an integral and essential role in ACF’s treatment of malnutrition, global fighting against hunger and emergency responses. The start-up of the pilot project took place during 2002 in the nutritional programs open in Kabul, Afghanistan and in Juba, Sudan. The new knowledge and tools developed within the framework of this pilot project have been gradually integrated into the programs of other countries, in Burma, Liberia, Sri Lanka, the North Caucasus ... and each new mission or new activity has enriched ACF reflection and brought new approaches adapted to the particular contexts and specific needs of each affected population.

CONCEPTION OF MENTAL HEALTH AND CARE PRACTICES WITHIN THE CONTEXTS OF ACF INTERVENTIONS

In 2001, Action contre la Faim made the choice to develop socio-psychological actions to support populations living in very difficult situations due to hunger and malnutrition and/or geo-political context.

The setting up of mental health and child care practices programs is driven by the following objectives:

- Improve the prevention of acute malnutrition by reinforcement of positive care practices as well as by training and change management of inadequate practices.
- Prevent the deterioration of child care practices during disruptions.
- Improve the treatment and limit the negative consequences of malnutrition on the child’s health.
- Insure psychological support to populations in case of natural disaster or conflicts².

To do so, ACF relies on a certain conception of nutrition and malnutrition, child care practices and mental health which we will detail below.

■ The conceptual framework of nutrition and malnutrition

Malnutrition is a complex phenomenon both in its causes and consequences on individuals, and for its treatment it is necessary to take into account the different factors having an influence on the nutritional status of the person.

In this sense, UNICEF proposed in 1992 a *conceptual framework for nutrition*³ underlining that nutrition allows growth, survival and development of the child, and highlighting that it constitutes only one

¹ Sometimes, in emergency situations, the extent of the human catastrophe might lead to setting up systematic programs, which do not take into account the experience and human reality they have to address.

² Two other objectives relate to the implementation of programs within ACF: the first aims to improve understanding of contexts of intervention by integrating the social and psychological impact to our analysis. This allows the adaptation of programs in the most appropriate way in order to strengthen the mechanisms of adaptation and to not further disrupt the social and family environment. The second objective consists of improving the quality of ACF programs.

³ See figure on page 8.



of the consequences of the contextual, environmental, familial factors ... but not the only one. Furthermore, malnutrition rarely results from a single cause but most often from a group of factors combined into a given context. A systematic approach of the problem is thus particularly pertinent to understand malnutrition (that is to say that a cause can have several effects and retroactively, an effect can modify the risk factors). Therefore, it appears essential that the analysis of causes leading to malnutrition should be not only adapted to each context, but be personalized in order to be able to bring the appropriate responses and advice. According to the identified needs and resources, the actions in mental health and care practices developed by ACF may target individuals, families, groups and/or the whole community.

In addition to food and health, the UNICEF figure also includes a third underlying factor in nutrition issues: care practices provided by parents to young children. Yet, these three conditions are necessary for the survival of the child. Whence ACF's decision to include specific work on care practices, which are the least known both at malnutrition explicative analysis level and at setting up programs designed for populations exposed to hunger. Indeed, interventions with malnourished children address most often exclusively medical and nutritional aspects, without adding a specific child care practices work (and/or mothering behaviors¹). The care practices, as described by UNICEF, concern breastfeeding and feeding of the young child, care directed towards women (because in most societies women are the children's caregivers), psycho-social and cognitive stimulation, preparation of meals, hygiene practices and home health practices. ACF programs in mental health and care practices attempt to integrate these different aspects into the actions which are brought to the field.



© ACF, Sandra Calligaro - Afghanistan

For example, a mother who lived through dramatic experiences (i.e. the death of her family during a conflict or a natural disaster) can encounter difficulties in taking care or perceiving the needs of a baby born after this event. Faced with such a situation, a program proposing for example only advice in nutrition or nutritional supplements for the child would prove to be insufficient. In parallel to these interventions, assistance aiming at taking in charge the emotional distress of the mother (depression, trauma symptoms ...) as well as actions allowing the strengthening of the mother/child relationship must be put in place. These interventions consist indeed in bringing to this mother the help she needs, and in assisting her so that she can re-adopt the appropriate care practices.

■ The conception of child care practices

Child care practices are considered by ACF both in terms of time spent with the child (effective availability) and of quality. That is to say the type, sensitivity and continuity of the responses brought to the needs of the child, the warmth of the exchanges, the affection, the commitment of the people taking care of them, the way of encouraging their autonomy, exploration and learning. These different elements interact and will develop through the relationship built between the maternal entourage and the child. The cultural context in which the child and their entourage live has certainly a major influence on the modalities of this relationship, and is taken into account within each program.

- In the field, ACF has developed an original approach which presents three strong features. First of all, it is a holistic approach which takes into account all aspects of care practices (in terms of quantity and quality) without being limited to one of them as is often the case in humanitarian contexts¹.

¹ Care practices are often reduced to the practices of breastfeeding and feeding of the young child.

- This approach is intended to be global as well, in the sense that it tackles the very practices but also identifies and addresses as much as possible the different factors (or resources) blocking or facilitating their operation.

For example, one can meet young couples who had to leave their village, their home and live in camps for displaced people. Because of isolation, estrangement or disappearance of their familial and emotional entourage, and because of the absence of their community environment, some of these parents can find themselves powerless when it comes to taking care of a newborn. In this type of context where the family distress is intense and the situation of the baby is at risk, one can imagine the organization of group activities in order to recreate a network of support and mutual aid on care practices to be brought to children. At the same time, individual support for these parents and their babies is proposed in order to respond in a personalized way to their specific needs.

- Finally, it is strongly based on the psychological and social dimensions which influence care practices in a major way: the specificity of the contexts of ACF interventions gives a special character to this approach since the populations concerned are usually experiencing periods of destabilization, insecurity, loss, extreme destitution leading to social and familial reorganization and affecting the mental health and psychological well-being of individuals (adults, children and babies).

In addition to these contextual aspects, the place of women within certain societies or even the high prevalence of postnatal depression very directly affects the quality of child care practices. This is why *particular attention is given to psychological (mental health), familial and social aspects, mainly the resources and skills of the child's motherly entourage and its autonomy.* These elements have a central place in the analysis of care practices and needs of the population as well as in the choice of methods of intervention. Based on this conceptual framework, actions in mental health and child care practices are developed according to two main axis of intervention: on one hand, the integration of mental health and care practices actions in the treatment and prevention of malnutrition, and on the other hand, the implementation of activities within the emergency preparedness and response plan.

■ **The integration of mental health and care practices actions in the treatment and prevention of malnutrition.**


Concerning the management of child severe acute malnutrition, one of the axes of ACF programs consists of **improving the reception of patients and the caregiver/patient relationships**. Indeed, this type of action is important in order to guarantee the well-being of patients and facilitate the observance of treatment. It is also about supporting them in the ordeals: the serious illness of a child can turn out to be for him as for his entourage extremely harrowing and can throw the family system out of balance. To be ready to listen to the family's concerns, supporting them in making the necessary adjustments must be an integral part of their management¹.

Another axis of these interventions consists of **supporting and stimulating the child**, directly and indirectly (through reinforcement of parental skills) in order to limit the developmental delay and environmental potential deficiencies.

The malnourished child is less responsive to the solicitations of their entourage, who in return will tend to less stimulate them, or their emotional investment in the child will slowly decline (while the child particularly needs it). This vicious circle can lead to a continuous degradation of the child's condition and to a certain carelessness of their needs. Specific assistance given to these families, on **how to support the parents and strengthen the parents-child relationship**, is needed in order to avoid deterioration of child's overall situation and health.

Malnutrition leads, in the medium and long term, to various consequences in child development, such as delays in development and/or an impact on the cognitive, intellectual, affective and social functions.

¹ Working with severe malnourished children may have a significant impact on the very care-giving teams. Sick children may have quite an impressive or disturbing physical appearance and the mortality rate can be quite high. Observations show that caregivers spend less time with a severe malnourished child than with children suffering from other diseases. This can partly be explained by the lack of response and interaction from malnourished children towards external stresses. Thus it is equally important to give attention and support to caregivers too, through stress management training and supervision.



Nevertheless it is possible to decrease¹ these consequences, notably by helping the caregivers in establishing a secure and gratifying relationship with the child and by helping them in providing to the child the appropriate stimulations that will positively contribute to his development.

Supporting parents of malnourished children during games sessions, simultaneously allows parents to enjoy interacting with their child, to play by themselves, and rely upon the benevolent gaze of the psycho-social expert team. Thanks to that, parents regain confidence in their parental skills and observe the progress of their child with the psycho-social team. This process allows the parent to feel himself “mothered”, to reinvest their position as a parent and progressively reinvest a better relationship with their child.

All these interventions aim at creating this dynamic between parents and the child. They strengthen the parents' participation, improve the treatment and reduce the negative consequences of malnutrition. They facilitate as a result the survival, health and development of the child.

More specifically, **training** can be provided on these topics to the teams working in therapeutic nutritional programs. It concerns basic training on precise points, intended for non-psychologist participants, which targets the caregiver/patient relationship (improvement in the reception of patients, sensitivity towards the suffering of parents and of the child faced with malnutrition...), the day to day assistance of parents/child (taking time to explain the treatment to parents and children, to help/advise parents for the administration of the treatment to the child, for the taking of food supplements...), and propose if possible a game and stimulation area for children with their parents (free game, massage activities for babies, time for bathing the child ... the idea being to start working on the parents/child relationship). Sometimes, a psychologist present in the program carries out the psychological management for parents and children and a team of psycho-social workers insures a psycho-social follow-up (individual and by group) of patients.

In terms of prevention of malnutrition, ACF tackles simultaneously direct and indirect determinants of malnutrition. According to the identified needs, interventions concern directly the improvement and strengthening of adequate child care practices but they also aim at creating the framework allowing an optimal implementation of these good care practices. **Thus, it is important to support and reinforce caregiver's resources, as to say their knowledge and beliefs, their health and nutrition condition, their mental health and level of stress, their control over resources and their autonomy concerning the implementation of care practices, their workload and their time constraints, the social support from which they benefit.**

Particular attention is given to the **mental health of caregivers**, especially mothers. Indeed, beyond the psychological consequences of difficult experiences undergone within emergency contexts, many studies² have shown that children whose mothers are depressed are more likely to be malnourished and to present growth delays; in these situations, the risk of child mortality increases as well. Thus, it appears essential to take into account the difficulties of mothers suffering from depression in order to bring necessary care to their young children. Yet, if around 30% of women suffer from depression during pregnancy or at the child's birth in developing countries, these rates increase even more in emergency situations³. Actions of prevention targeting families at risk are thus essential.

For example, programs addressed to pregnant women (in a group or in the framework of individual or familial monitoring) can allow the detection of future mothers having particular difficulty with their pregnancy and susceptible of poor future commitment to the coming child, and to propose to them an adapted psycho-social support.

In other contexts, mother's nutritional deficiency leads to tiredness, which can be the cause of a disinvestment in the housework and childcare, creating loss of balance and competition between both. It is important that the actions led on the field take into account the concrete components of childcare as well as the parent and child relationship. As stated previously it is primordial to take care

¹ Grantham-McGregor S and al. (2007). Development potential in the first 5 years for children in developing countries. *The Lancet*, Volume 369, Issue 9555, 60 - 70.

² These studies have been done essentially in Asia in developing countries, outside of emergency contexts.

³ WHO : Improving Maternal Health, 2008.

of mothers, of their health and of the level of difficulty of their everyday life so that they might be able to bring the necessary care to their child.

For example, we have been able to observe in Burma that many mothers of children admitted in the therapeutic nutritional centers expressed very strongly their needs to be themselves mothered before being in a position to be able to think about the needs of their young children. Their demand to be heard in their mothering needs, to have their emotions noticed, turn out to be elements absolutely fundamental to the accompaniment of these beneficiaries, whose maternal and nurturing function finds itself weakened because of extremely difficult events that they are experiencing.

In addition, social, familial and individual disruption experienced by the population ACF is working with, contributes to the degradation of care practices provided to children. **Yet, psychological and psycho-social interventions help to minimize the impact of these disruptions on individual and public health, and to contribute to efficient childcare practices.**



© ACF Sandra Calligaro - Afghanistan

When the crises contexts persist or interventions are late, it is important to consolidate or restore the individual/group resources to facilitate the establishment—or the re-establishment—of adequate practices.

For example, programs of familial support are developed to help populations living in conditions of widespread poverty. It concerns regular monitoring of each family by a psycho-social worker, aiming to facilitate the expression of feelings, a common reflection on the situation and the needs of the family, to restore self-confidence and reach solid objectives in order to respond to their needs. In cases where beneficiaries went through potentially traumatizing experiences, the symptoms shown disrupt their daily life, that of their children and family relationships, and affect their capacity to cope and mobilize their resources. Facing this type of difficulty, the confidence relationship built between beneficiaries and psychosocial workers is a crucial element in making these people able to reach out for external services, to re-mobilize their resources, to find more well-being and the capacity to improve their living conditions. This type of program is interesting in the sense that it can be adapted to a wide range of contexts, and integrates the particular social and cultural environment of each family. The solicitation and use of locally-existing services also allows their optimization or furthermore, their development and quality improvement (for example, the coordination among ACF teams and those of external services can bring about a common work for the targeted populations).

Finally, population exposed to hunger is likely to face psychological changes. Both adult and children can develop disabling behaviors that have negative consequences on their everyday life adaptation as well as in their social interactions. In these cases, it is essential to propose a psychological support to these populations suffering from hunger, in order to help them in improving or maintaining their mental health, and to treat the psychological disorder if there is any.

■ Emergency preparedness and response in conflict or natural disaster situations...

ACF intervenes amongst others in emergency situations, where people are made vulnerable because their life, social and family bonds are affected. In these situations, there is an important need of psychological support (trauma, depression, suicidal tendencies...)

Studies show that the percentages of people suffering from severe to moderate mental problems increase from 12% to 23-24% in the aftermath of a natural disaster. Moreover, it has been shown that 30% to 50% of the affected population is in psychological distress, which could also lead to decompensation^{1,2}. Over the course of the last twenty years, clear links have been established between factors associated with poverty and poor psychological health, showing the evidence of a cyclical relationship between the two³. The question of poverty should therefore be understood in terms of poverty of psychic resources, and not only in terms of economic resources. Regarding the understanding of mental health problems in these populations, ACF adopted a certain number of principles. First of all, post-traumatic stress is not the only psychological disorder that can emerge in the aftermath of a violent event or following natural disasters⁴. The expression of mental suffering can take on various forms and varies between cultures: multiple and recurring physical disorders in the absence of significant disease, a decrease of immunity, and increase of somatic diseases... The adoption of inappropriate behaviors like alcohol and drug consumption is also very frequent. It is thus the entire variety of these manifestations, behaviors and mental disorders that ACF takes into account in its interventions, without recourse to a systematic «model.» Sociocultural, economic, political and spiritual factors have a crucial influence on their progression (aggravation, chronification) or on their potential regression. Thus a comprehensive approach appears more appropriate, more attractive and more effective than a strictly psychiatric analysis grid.

On one hand, definitions of mental health, disorders and their symptomatic expressions are part of a particular cultural context, which utters the necessity to adopt an intercultural approach. Therefore, there is not a program or technique type that could be duplicated from one country to another and each program must be created in cooperation with the community for which it is designed.

In natural disaster or war situations, ACF evaluates the psychosocial needs in coordination with other concerned institutions and develops psychological support and counseling. The mental health approach is equally included in disaster risk reduction programs by training teams and relay people in the community, or by setting up natural disaster support networks or by developing referrals to in-house services.

For example, in Sri Lanka, in the camps for displaced people where ACF intervened following the 2004 tsunami, all pregnant and lactating women were approached in order to propose various support activities (discussion groups, individual or family psychological care, mother-baby activities...). As a matter of fact, the large majority of these women had lost several family members, including one or more children. The problematic issue of death was considerable and the grieving process particularly difficult and complicated, even impossible to carry out: since bodies of the missing people were rarely found, funeral rituals could not be performed, and this situation had a tendency to keep people in denial about the death or their loved ones. Various psychiatric disorders noted in connection with this disaster and had to be addressed: depression, anxiety, alcoholism, family violence, and traumatic symptoms... In such a context, counseling pregnant and lactating mothers was indispensable so as to prevent the risk of attachment disorders, mother-child relationship disorders, difficulties with nursing, and the risk of infant malnutrition.

Contexts of natural disasters, conflicts, extreme poverty and discrimination/violence lead to upheavals in social structures, to population displacements, loss of familiar landmarks, changes in family structure, individual psychological changes... Deprivation, material loss, present life conditions, and

¹ Decompensation might be defined as the psychological imbalance within an individual, following an extreme emotional situation which can potentially uncover underlying pathology and lead to multiple symptoms, such as phobias, depression, delirium, somatization, etc.

² WHO (2006). Mental Health and Psychosocial relief Efforts after the Tsunami in South-East Asia.

³ WHO. Mental Health, Poverty and Development.

⁴ On a strictly mental health level, depression and anxiety are the most common disorders and are often associated (co-morbidity).



© S. Hauenstein Swain, ACF UK - Tchad

relief assistance also have an impact at the social, group, family and individual levels. Whereas the frequency of psychiatric disorders increases in these contexts, the more the group is affected, the more the individual is at risk. This impact is taken into account in the context analysis and in the definition of the projects.

For example, if people are living in day to day survival conditions, it is inappropriate to ask them to project themselves into the future or

to or to set up think tanks. Or if people are living in fear, it is difficult to ask them to put themselves at risk by working... Up-stream actions should be conducted before addressing these issues.

Mental health activities can also be linked to other existing ACF programs (Food Security and Livelihoods; Nutrition and Health; Water, Sanitation and Hygiene).

Mental health and child care practices interventions are thus developed in various contexts, very different from one another. Taking into account the different factors already mentioned above have led us to imagine actions adapted to these very difficult contexts, in order to properly respond to the populations' needs.

After a natural disaster, we can observe an increase in the number of births in the affected populations, in particular among people having lost children during the event (this phenomenon is like a «post-disaster baby-boom»). The intensity of the grieving issues and the extent of parents' difficulties in dealing with their newborns (babies supposedly replacing deceased children, babies bearing the traumatic experience or supposedly comforting their parents...) show the essential need of being able to offer to grieving parents appropriate individual psychological care and support within the parent-child relationship (for more details, cf. Sri Lanka chapter).

ACF programs in mental health and care practices rely on the approach and methodology previously presented. Given the very wide variety of intervention contexts, the great number of countries in which ACF has set up these programs and the variety of needs of the people from one context to another, a large diversity of actions has been developed. Thus, projects implemented in Sri Lanka following the tsunami targeted pregnant and lactating women, but also elderly living in camps for displaced people. In Haiti after the January 2010 earthquake, our teams developed programs for individual psychological care, actions for family support, discussion groups and a holistic approach for pregnant, lactating women and their young children. Interventions were paired with other programs (nutritional programs, cholera prevention and treatment, implementation of income generating activities...). In Afghanistan a specific work was done around breastfeeding practices.

It is in order to reflect all the depth of this work, the diversity of these projects as well as their complexity that we wished to gather this testimony.

It was also important for us to report on beneficiaries' personal development and progress throughout ACF support actions and activities.

The stories stated come from the testimony of the field teams who have worked with the affected populations and try to highlight the complexity of their work.

Among the 18 countries where ACF implemented mental health and care practices programs, we



have chosen to present the work done in 7 countries: Afghanistan, Bangladesh, Myanmar, Haiti, Central African Republic, Sri Lanka, and Chad. These very different contexts seemed to us to be interesting examples, reflecting the diversity of our approaches, and of our programs while showing the richness of the work conducted.

We will illustrate the presentation of programs developed in each of these countries with clinical case thumbnails, for which we will propose a reading grid with reflection elements. The names in the clinic cases have all been changed.

BIBLIOGRAPHY

- **Engle, P., Lhostak, L. & Armstrong H.** (1997). *The Care Initiative - Assessment, Analysis and Action to improve care for nutrition*. New York: Unicef, Nutrition Section.
- **Grantham-McGregor S. and al.** (2007). *Development potential in the first 5 years for children in developing countries*. The Lancet , Volume 369, Issue 9555, 60 - 70.
- **Martin-Prevel, M.** (2002). «Soins» et nutrition publique [Care and Public Nutrition]. Cahiers Santé, 12, 1.
- **Spitz, R.A.** (1945). *Hospitalism*. In Spitz, R.A. *Psychoanalytic study of the child*, New-York: International Universities Press, Vol. 1.
- **World Health Organisation (WHO)**. (2006). *Mental Health and Psychosocial Relief Efforts after the Tsunami in South-East Asia*.
- **World Health Organisation (WHO)**. (2008). *Improving Maternal Health*.
- **World Health Organisation (WHO)**. (2012). *Mental Health, poverty and development*. http://www.who.int/mental_health/policy/development/en/index.html

2 - MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN AFGHANISTAN (2002-2008)



© ACF - Afghanistan



CONTEXT¹

Unlike a country facing a major but isolated event, Afghanistan has been through a long series of disasters that have profoundly affected the population's coping mechanisms and its culture and social bonds. Afghanistan has experienced more than 30 years of wars in the course of which losses, displacements and exiles have weakened a large segment of the population: loss of property, of references, lifestyle changes, separation of families, bombing, shootings, terror, etc. Insecurity was permanent, and so was the possible need to flee away. At the peak of the crisis, there were more than 6.2 million refugees in Pakistan and Iran², and displaced persons within the country. The successive fighting have reportedly killed more than one million people during the Soviet invasion. In 2012, the UNHCR counted 2.7 million refugees and 500,000 internally displaced persons (UNHCR, August 2012)³.

The Taliban came to power in 1996 and imposed a very strict Islamic regime in accordance with sharia law, sharply limiting individual liberties and forbidding cultural activities (music, dance, etc.). Women's rights considerably regressed. For example, they were forced to wear the burka and forbidden to work or go to school. Terror was pervasive: one could at any moment be arrested and detained by the employees of surveillance institutions such as the Vice and Virtue Ministry. Public stoning and hangings were frequent with both adults and children being encouraged to assist at these events...). Yet, at the same period, the frequency of fighting started to diminish, creating a paradoxical calm in the country.

In this context of serious danger, one can assume that families progressively isolated themselves. At the same time, laws were penetrating into homes and it was not unusual to see police representatives coming within the family houses to arrest people or to monitor accordance with rules. Obedience was a vital matter, while insubordination was subject to death penalty. Even when unconditionally complying, one was not certain to be spared.

For decades, daily life largely revolved around merely staying alive. While nowadays safety risks are relatively contained in the country, material living conditions remain extremely precarious. The difficulty of daily life and the fear of being unable to provide for one's family are issues that come up frequently in interviews with ACF beneficiaries, whether those returning from Pakistan or Iran or those who remained in the country. Beyond lack of comfort and material vulnerability, this instability results in permanent stress for families and severe instability that limits any possibility of rest or development of any project. It should be mentioned that life expectancy in 2005 was 43 years for men and 44 years for women...

Despite or, perhaps, thanks to this succession of upheavals and attacks upon social bonds, certain Afghan values seem to structure contemporary society, foremost religion and family. These strong anchors references are perhaps what have allowed people to survive and stand so much violence. Indeed, the extended family constitutes the fundamental social unit in Afghanistan and seems to have survived the recent tragic events. It is through the family that individuals interact with the wider sociocultural environment. The family's reputation is of extreme importance, and the power of negative rumors



¹ This introduction is largely based upon, and borrows passages from, Cécile Bizouerne's thesis (2008). *Insuffisance en lait maternel et souffrance psychologique en Afghanistan – approche psychologique clinique en situation humanitaire*, [Mother Milk Insufficiency and Psychological Suffering in Afghanistan – Clinical approach in humanitarian settings]. Université Bordeaux 2.

² UNHCR source: <http://www.unhcr.org/cgi-bin/textis/vtx/afghan?page=chrono>, accessed on Oct. 10 2007.

³ <http://www.unhcr.org/pages/49e486eb6.html>

or gossip within the community concerning the family unit or the behavior of one of its members is to be feared. Each member of the family is a representative of the family's honor, and his or her bearing can either raise or lower the family's status. The chastity and sexual purity of women in particular is a key issue in family honor – whence the need to control women and their bodies.

Women live under particularly intense pressure from the authority figures within the household: their husbands, the men of the house, and their mothers-in-law. Men's and mother-in-law's authority is exerted through decision-making power (women must request authorization to leave the house, to go to the doctor, etc.) and the distribution of domestic chores. It sometimes leads to verbal humiliation, through the refusal to recognize the needs or desires of the other, and to physical violence. Arranged marriages are the norm and are not always satisfactory to the spouses, between whom numerous conflicts may arise.

The “destiny” of the Afghan woman is to marry and bear children. Social and family recognition rest upon her fertility, as pregnancy attests to the woman's reproductive capacity and her husband's virility. Early pregnancy is common. Van Egmond and his colleagues conducted a study in Kabul and noted that 67% of women had given birth to their first child between the ages of 13 and 19 (van Egmond, Bosmans et al., 2004)¹.

The pregnant woman acquires a special status: she is considered as a special, fragile being who must be protected, and at the same time she acquires great power from the fact that she is carrying a child. However, pregnancy is a high-risk period for both women and babies, and many women fear pregnancy and childbirth. Indeed, the child mortality rate is one of the highest in the world; in 2010, one out of six children did not reach the age of five, and 103 out of every 1000 newborns failed to reach their first birthday². Finally, more than 50% of children show delayed growth. The country holds the world record in maternal mortality, with a rate of 1600 deaths for every 100,000 live births.³

In addition, knowledge of the needs and abilities of young children has proven very limited. A baby is not considered a person or a participant in an interaction. As a result, it is very common to encounter newborns that receive no stimulation and have hardly any social life at all: they are never spoken to and are rarely caressed, carried, rocked, touched, etc. They are swaddled, most often placed in a cradle or on blankets in a corner of the room, sometimes covered with a blanket that leaves them in the dark all day long. These mothering behaviors frequently lead to development delays, revealed in the rare published studies on the development of young Afghan children.

PROGRAMS

In 1995, Action contre la Faim developed a severe acute malnutrition treatment program in Kabul due to the repatriation of Iran and Pakistan refugees during the Russian invasion. Different strategies were adapted for the treatment of severe acute malnutrition in order to respond in the most efficient way to the needs of the population, taking into account the severity of the child's pathology and difficulties linked to the culture and the context present in Kabul (limited mobility for women, pressure from husbands and mothers-in-law requiring that mothers spend as little time as possible outside the home, etc.).

In order to attain profound changes and improvements, ACF targeted not only child-caregiver pairs but also the entire family, particularly in a society in which responsibilities and power are in the hands of husbands and mothers-in-law.

¹ Van Egmond K., Bosmans M. & Nacem A.J. (2004). *Reproductive Health in Afghanistan: Results of a knowledge, attitudes and practices survey among Afghan women in Kabul*. *Disaster*, 28 (3).

² Source: UNICEF, 2010

³ Source: UNICEF, 2012



Three therapeutic feeding centers (TFC) were opened in collaboration with the Health Ministry. These centers were integrated into the city's pediatric hospitals and operated 24 hours a day. 15 day-care centers were also created, attached to health centers where severely malnourished children¹ and an adult caregiver could spend the day. Beneficiaries could be referred via screenings organized by ACF or other organizations/partners, or could come to the nutrition centers on their own. The average hospital stay in a TFC was of 30 days.

It is within this framework that ACF's first Mental Health and Care Practices pilot-project was implemented in 2002. The first step consisted of raising awareness of ACF staff within therapeutic nutrition centers about active listening, child development, and mother-child relationship.

A year later, a team of full-time psychosocial workers established "mental health" activities within the therapeutic nutrition centers. Their role consisted in welcoming mothers and proposing to listen if needed, leading mother-child play sessions, better explaining treatments to families, finding solutions to allow children to be treated, leading group health education activities, providing breastfeeding counseling to mothers, etc. In the three hospitals where TFCs were located, a play room was created, freely accessed by mothers and their severely malnourished children.

ACF's experience in Kabul demonstrated the added value of mother-child play sessions in stimulating the child and therefore his/her development, as well as in reinforcing mother-child bonds. The session is a time when mother and child concentrate on each other, the child goes off to explore his/her environment and takes pleasure in doing so, and the mother observes her child's progress, which gives her great satisfaction. Highlighting caregiver's abilities in the parental role and the child's abilities through playing, as well as the pleasure of being together and sharing experiences, promote the establishment and/or reinforcement of adequate care practices, an essential issue in child's survival and development as well as in the prevention of malnutrition.

Children admitted within the severe malnutrition program arrived in a critical condition. Families, often very worried about the child's survival, had to organize themselves to allow for the hospitalization of the child and an adult for at least three weeks. This implied complicated choices for the family, due to childcare needs for children remaining at home, loss of income, general housework management, in some cases support needed by a sick or elderly parent.... These concerns put additional pressure on the family, which in many cases was already in a precarious situation. Proper reception, guidance, and understanding of these problems were crucial in helping the family to find solutions and organize their daily lives. Precise information about malnutrition, its consequences, and the proposed treatment also had to be presented. It was in the course of casual exchanges that all of these topics were discussed, but they could also give rise to more formalized discussions: discussions with the mother, an invitation to family members when the mother did not receive authorization to stay or in the case of withdrawal during the treatment, in the case of specific events such as a funeral in which the family needed to participate, etc.

Each mother and her child also benefited from formal discussions with the psychosocial workers. They aimed for a better understanding of the family situation and the causes for the malnutrition, evaluating the mother's psychological health and the mother-child relationship, and providing support for the mother and her baby. Given women's extremely difficult situation in Afghanistan, what we proposed was often the first space for dialogue in which they could express themselves without fear of judgment. Very difficult, often intimate, past and present troubles were revealed there. The follow-up sessions were adapted depending on the mothers' issues and desire to commit to a therapeutic relationship. They proposed either: discussions with mother and child, discussions with the mother alone, family discussions, and/or conjugal discussions. Sometimes the work was centered on the relationship between mother and child, but sometimes it was necessary to take distance with this problematic in order to address the mother's own problems that interfered in her capacity to invest and care for her child.

¹ All children meeting severe acute malnutrition criteria— that is, children between 6 and 59 months of age presenting a weight/height index less than 70%, and/or edema and/or a brachial perimeter of less than 11 cm, according to the current national protocol, are admitted to ACF centers.



If considered necessary, the psychosocial team was able to assure the continuation in the follow-up after the end of the medical-nutritional treatment for the most severe cases (a child's relapse, a very young child, domestic violence, etc.)

Observation and stimulation of the child are key elements of the program. Indeed, the children being cared for, though very young (some just a few days old, all under five), have already been through difficult past experiences; they have suffered from

hunger, in some cases have been sick, were born in difficult childbirth situations, lost a twin or their mother, or in many cases were victims of neglect or other forms of child abuse. In these circumstances, it is essential to look after the child's well-being and to identify the causes of their suffering. There may be physical suffering first and foremost when the child is severely malnourished, when his/her body and the medical care being provided are painful, when being carried causes wounds. There may also be psychological suffering, going as far as depression or hospitalism, when the mother or her substitute is unresponsive or emotionally absent, when his/her crying are ignored, when his/her surroundings do not provide a holding environment. Attention is given to the child's well-being, to translating for the family and the medical team the signals that they send to their entourage and to revealing the child's abilities. Empathy thus plays a significant role in order to feel and then work with the family on this baby's experience and to provide appropriate responses. This support to the young child is offered through daily care and through medical treatment, but also within the context of play sessions, massages, or special interactions in which one of the objectives is to bring joy to the child and allow him/her to experience positive sensations in his/her body.

While many mothers and their children rapidly readjust their relationship in response to malnutrition and treatment and grasp each opportunity to be together and enjoy each other's company, some other relationships require stronger support, even going as far as mother-child psychotherapy. This can be the case if the child was not wanted, if the mother is too depressed and/or incapable of emotional investment, if the child is perceived as displeasing because they are handicapped, small and weak, or because it is a girl.... For these mothers and their babies, the psychosocial workers are an especially close and steady presence.

The (daily) play sessions and the massage sessions contribute to this global approach to the child and their mother. The malnourished child is apathetic, in retreat, easily fatigued. It is important to stimulate them progressively as recovery takes place, in order to help the child regain a certain appetite for life, to give them pleasure and limit developmental delays (which is, after the risk of death, the main consequence of malnutrition). In return, children help their own mothers, who discover their abilities, feel recognized as mothers within the group, regain a certain maternal pride and, strengthened by this recognition, raise their self-esteem and are consequently better able to provide quality care to their children.

Throughout this process, the group plays a significant role. Mothers support one another and find comfort and hope in the support of a neighbor or in observing the children nearing the end of treatment. The activities proposed to mothers, like sewing, toy making etc. also play an important role in their own enhancement and in creating interaction support.

Group training sessions on hygiene and medical and nutritional care are provided to caregivers in order to improve knowledge and care practices within families: treatment of diarrhea, different contraceptive methods, breastfeeding methods, etc.



Finally, withdrawals (those who leave ACF before the end of their treatment) are followed up thanks to home visits, in order to better understand their reasons for leaving and to motivate them to resume treatment.

In September 2004, the arrival of an expatriate psychologist made possible some daily technical guidance for the psychosocial team. At the same time, the medical management was strengthened, and a program component was established allowing for certain infants under the age of six months, without medical complications, to be treated at home. Results show that the recovery rate within the children admitted grew from an average of 70% to over 90%. Deaths dropped below 3%, and withdrawals from an average of 20% to less than 3%. The result improvement turned out to be sus-



© ACF - Afghanistan

tainable, as it continued through the end of 2006. We have noticed that the permanent presence of psychosocial workers in the centers has led to enormous progress in the perception of families, and relationships between the families and medical staff have changed considerably. Indeed, given that the psychosocial team was responsive to each family and to its challenges, the understanding of each situation and the interest in providing individual response was highlighted. This allowed the medical team to move beyond a strictly bodily approach toward a more holistic care approach which considers the patient as a whole. These transformations meant approaching the family as a partner in the treatment of their child and not as the passive object of all-powerful medical knowledge, leading to major progress in caregiver-patient relationships.

From 2005 through mid-2008, a handover was carried out with the Afghan teams in Kabul hospitals, and then the program was stopped for safety reasons, while a prevention project was ongoing.

In 2012, an assessment of mental health and care practice needs was conducted in the KIS (informal camps for displaced persons) within Kabul, and it highlighted the needs for mental health and care practices support for women and very young children living in these extremely precarious conditions. A new project has started in July 2012.

NARRATIVE ACCOUNTS AND CLINICAL OBSERVATIONS¹

In emergency situations, like those in Afghanistan, people are not confronted with one unique dramatic event but are victims of a succession of events which progressively erode mechanisms of protection and survival. When conducting interviews it is extremely difficult to construct a coherent case history.

In a day-care center I see a woman forcing her two-year-old child to drink the therapeutic milk. Her child refuses the milk; he has been crying non-stop since arriving at the center in the morning. According to the team this behavior occurs frequently. The mother looks sad. During our conversation she tells me that she has persistent headaches, that she is sleeping bad, has no appetite, faints occasionally and can cry for no reason for a day or two. When we try to reconstruct her history, she tells me first about her fear of dying during the Kabul bombings (this is at the end of 2002) and her

¹ This sub-chapter consists of excerpts from Cécile Bizouerne 's PhD.

permanent distress during the war. In trying to put together her story in order to find out when the symptoms began, we go back in time up to when she was 12 years old. One day when she was outside with her family she saw corpses all along the road. It was the first time that she had seen dead people. A group of armed men stopped the car and shut them into a room. Her father was beaten. The confinement lasted the whole day during which she thought that they were going to kill her father and maybe also the rest of her family.

This case is relatively atypical in the sense that the patient seems to be in a position to go back to an inaugural incident that triggered the symptoms she is suffering from. People accompanying the patients at the institute for mental health¹ systematically included the war and living conditions during that period as factors triggering pathologies in the patients. The most severe, such as schizophrenia or chronic pathologies, are stigmatized by families, society and professionals. One might wonder if this systematic reference to the war is not also a means for families to reassure themselves by thus attributing the origin of the mental illness to an external factor.


Arsallah or how to unify two lines of descent

Arsallah has been admitted to the Indira Gandhi hospital. At the age of three months he measures 53.5 centimeters and weighs 2.5kg. His mother says that he was small when he was born because she had no appetite during her pregnancy. She had to work very hard even though she was sick. During the first three days Arsallah was not breastfed, because her mother-in-law forbade it. Indeed she thought that his mother's milk was not clean but impure as long as she had not taken a bath, a ritual carried out three days after the birth. For the first ten days Arsallah was fed with zouf² and had stomach problems. The mother lived in a family of thirteen people and was busy from morning till night with domestic tasks. There is no cooperation among the members of the family and she does not have a good relationship with them. While his mother is attending to domestic activities, Arsallah is looked after by his grandmother. Every three quarters of an hour the mother comes to breastfeed her child for a short time because she is always behind time. She is under pressure to return to her work and «that's the reason why the child has always thrown-up after breast-feeding.»

I put this in inverted commas because this is a literal translation of the sentence written in the report. I don't know if this remark is a comment made by the mother or by the psychosocial worker who is interpreting the child's vomiting. In this case, the mother is not able to fulfill the domestic tasks assigned to her and feed her child. In her time management of, the two types of activity are in competition with each other. Not being able to juggle everything, she saves time where she can: in the time spent breastfeeding her child. The child is not fed on demand but instead according to the time his mother manages to free up in order to go and feed him, while she is obviously not calm nor at ease but thinking about the tasks she still has to do. This rush, this daily race is certainly sensed by the child who vomits after every meal. One might make various assumptions about this: the child is fed too quickly and does not manage to digest the milk; perhaps he drinks it greedily because he «knows» that time is limited and he has to take as much milk and as quickly as possible; perhaps he senses his mother's excitement and nervousness, he is infected by it and finds himself unable to digest the feelings and rejects them simultaneously with the milk; perhaps he cannot stand these stolen, excessive, moments, this absent mother who approaches him at a time chosen by her, feeds him and leaves him and he rejects this bad milk, this breast which is bad for him.

¹ The only hospital service in Afghanistan taking in people suffering from mental illness.

² A type of cereal with very poor nutritional value traditionally given to infants.



We cannot, however, rule out a physiological problem (a form of feeding unsuitable for a new-born resulting in stomach problems) upon which the issues related to psychic phantasms are added. Her milk was “unclean” and unfit for consumption according to her mother-in-law. Arsallah was fed with zouf. The question of the mother’s milk being «good» or «not good» for the child is therefore raised straight away by the mother-in-law. In this short account, we do not know the mother’s opinion about feeding her child at birth. It is likely that her views were not taken into consideration and that it falls to the mother-in-law to say what is good or not for the child. In this she is upholding an Afghan cultural tradition which dictates that colostrum is rarely given to children (above all in the provinces – and this family comes from Pakia, not from Kabul) and that the mother only wash herself three days after the birth. During these three days she remains with her baby but is dirty, impure. Her milk is dirty as well. The baby is fed with products coming from the paternal family because they are said to be better for him. According to the mother, they made the baby ill. What comes from the in-law-family, from the mother-in-law, was not good for him. We do not know what happens between the third day when the mother could in principle start breastfeeding her baby and the tenth day on which he is no longer given zouf. One might think that since the inflow of the milk had not been facilitated by putting the baby to the breast after birth, there would need to be a transition period, in which the child is breastfed and receives zouf as a supplement. This is a transition period in which the new-born receives food originating from both sides of the family. Finally, the child is looked after by the mother-in-law and fed by his mother but throws up just after the breastfeeding. Nothing is good for him anymore: the zouf produced stomach pains and the mother’s milk is rejected. These good or bad food issues occur within a conflicting relationship framework. The mother says that there is no cooperation between the members of the family. The child seems to be caught up in this game of conflict-ridden relationships, in this power struggle and one may wonder what might be good for him. Alone with his mother after birth the food suggested by his grandmother made him ill. Alone with his grandmother he cannot stand his mother’s milk. He seems to signify how impossible it is to unite the two branches of the family: his mother and the paternal line. And yet he is the product of both since he comes simultaneously from his father (and thus from his mother-in-law) and from his mother. What compromise can be found, how can these two antagonistic parties get reconciled? In this precise case the therapeutic milk constituted a third party, at least for a while. But how will the return home play out? With this example we can well understand how domestic activity is organized by the mother-in-law according to criteria which go beyond sharing out the burden of work and instead play on the tie she has established with her daughter-in-law, on the place she grants to the birth and the arrival of the new-born.

Infanticide as revenge, Leila’s broken dreams

In the small room of the day-care center the team introduces me to a grandmother and her grandson. The boy, aged three months, «does not want» to feed at the breast. He has already had jaundice and, since then, is covered by red patches between his legs, on his hands and in the folds of his neck. After several minutes of discussion the mother arrives and takes the crying child that her grandmother is holding out to her. She is young, has put glitter on her eyelids and is wearing a pretty velvet dress. We continue our discussion. The mother explains her child’s refusal to suckle. At our request she presents her breast to the child who shows all signs of being ready to suckle despite his mother’s poor positioning. After two or three minutes the mother covers up her breast again and rests the child next to her. He starts crying again. She leaves him beside her.

This is the story of Leila and her child as she recounted it to us during the interview we conducted in private with her: it all began about two years earlier when her uncle’s son, whom the family was living with, decided that it was no longer suitable for her to continue going to school. Despite her tears and protestations, her family made her return home. A short time afterwards an aunt’s son introduces her to a man looking for a wife. Leila does not wish to marry and does not feel ready, but she has no right give her opinion in the matter. The man who is introduced to them is young and lives most of the time in Pakistan because he works for an international NGO. He seems to be a good alliance and promises to soon construct a house for his new family. It is important for the family because Leila’s eldest sister was married to a poor man and now lives in very difficult circumstances. This

man seems to be able to offer a better future for their youngest.

They are engaged for two months during which they go for walks to the bazaar and buy jewelry and clothing as one normally would do during this period. Then comes the marriage. The married couple lives with the bride's mother¹ while they await the construction of the house. After three months, Leila falls pregnant. Roughly at the same time her husband has to return to Pakistan for several months (two or three at the most he says) in order to work. During a phone call he passes her to a woman who introduces herself as the first wife. Leila's family then discovers that Leila is his third wife.



On hearing this news Leila is in complete despair, she feels abandoned and deceived. She stops eating, sleeps bad, cries night and day and wants to be alone. She takes paracetamol in secret and carries heavy loads hoping to provoke a miscarriage. All in vain. Her husband's phone calls are more and more infrequent and the last one was six months ago.

She says how she felt nothing when she saw her child after the birth. On giving birth she received congratulations from her mother-in-law, her sisters-in-law, news from the other wives but nothing from her husband. She does not like feeding her child and wishes that he would disappear after which she would commit suicide. But as soon as he is ill, she is afraid. The other day for the first and only time she thought about her child and felt her heart quicken, took him in her arms and placed him next to her chest. She felt better. But most of the time her mother looks after the baby. She herself does not want to do it. She would also like her mother to take more care of her like she did when she was little.

The neighbors and the family laugh at her now, say that she was abandoned by her husband and that the situation is not acceptable. She also finds this situation unacceptable. She wants to go to Pakistan when her child will be better. She is prepared to accept the first wives and to forget the lies. Anything as long she would not live in her own family while she is married and has a child.

How can Leila's story be understood? Leila has not finished growing up. She wants to continue with school, she wants to continue learning. But her aunt's son does not share this view, he thinks she is too old to continue going to school; she is considered as a woman already and it is no longer appropriate for her to go to school. The fiancé they choose for her seems to help her accepting the idea of marriage: he is young; he says he earns a decent living, he lives in Pakistan, which is rather valued in Afghanistan; he is probably well educated since he works for an NGO. During the engagement period, the advantages related to her new situation as a woman seem to predominate: she has clothes and jewelry bought for her. This attire asserts her femininity and increases her seduction power. This period is described rather like a fairy tale: the young girl meets prince charming. For all these reasons, growing up and becoming a woman can be considered worthwhile in life. A short time after the marriage she finds herself pregnant. Along with this pregnancy arrives bad news and disenchantment. Her parents who wished the best for her, who had hoped for a better fate than that of her sister, have been deceived again. After having praised the qualities of this husband, Leila and her family have learned that he was already married twice and that Leila was his third wife.

Now that Leila is married, has lost her virginity and is expecting a child, the family no longer has any means of recourse. Certain signs could perhaps have warned them: despite tradition, the married couple did not go to live with the groom's family. Instead, he talked about building a house in Kabul

¹ As a general rule, the married couple goes to live with the groom's family.



for them. But at the same time, this man represented a good alliance, which reassured the parents by comparison with their other daughter. Furthermore, they considered as an explanation to this situation the fact that he was living in Pakistan. Leila herself feels betrayed, deceived by the adults. They forbade her to continue with school and chose a husband for her who proves to be a liar. She had believed in the prince charming and discovers that she is only his third wife. Because of this deception, she becomes highly depressed and anxious; she sleeps badly, no longer eats. In her belly a child is growing, the fruit of her union with this man who has deceived her. She does not want this baby; she rejects it and attempts to make it disappear. But her attempts fail and the child arrives. He is welcomed by her family and her in-laws but not by her father. Her husband does not even acknowledge her as a mother. The arrival of the child is psychologically unwanted by either parent. If he survives it is thanks to his maternal grandmother who looks after him, who mothers him. For his own mother he is a reminder of the betrayal. He also symbolizes her new status, that of mother, which she rejects because it situates her in the world of adults. Leila would like to become a little girl again, also mothered by her mother, a return to a carefree world of love.

Within this family dynamic the baby is the product of maternal projections: he refuses the breast. Our observation of the feed shows us the opposite: a child eager to establish physical contact with his mother, a child who drinks greedily at the breast until his mother can no longer stand this bodily contact and puts a stop to it. The baby reacts to the rejection of his mother with red patches that cover his body.¹ He cries, he calls, he is hungry but his mother does not respond to his needs. Leila does not like feeding her baby; she would like him to disappear as if to cancel out what has happened. This attitude is described in cases of neonaticide and death wishes about children in whom a regression to mechanisms of magical thinking is observed in an attempt to magically cancel out the pregnancy. The disappearance of the child could bring her back to her previous situation, as if none of this had ever happened. Or she could kill herself as well. Though, looking at her in her pretty dress, well made-up, I can see rather a young girl who is still a dreamer. One senses a fragile and tenuous connection to this child. She is afraid when he is ill, without doubt a fear that he will disappear, that her infanticide fantasy will become a reality. Between the indifference felt upon seeing her child at birth and the fear she has when he is ill, Leila has experienced something new, has felt a new sensation: for the first time, she thought about her son while feeling her heart quicken. She then sought contact with him, a contact for pleasure, and a contact of love. This moment, however fleeting, seems to have made her experience a new emotion, that of acceptance of her child.

I do not have enough information in the light of this single interview to understand how the maternal grandmother ensured a sufficient emotional scaffold for this child. From what I observed she had a good relationship with him but depended on her daughter for feeding him. One might assume that she must have equally felt a deep sense of guilt about not having managed to marry her youngest better and protect her. In seeing these two women and this baby I thought that if they had the choice they would have preferred to continue living together like this. It is the sarcastic comments from the family and neighbors which made continuing with that situation impossible: it was not acceptable for a young woman to live with her baby in her own parents' home. Certain authors assert the idea that the act of infanticide is equivalent to suicide. If we draw on concepts such as those of symbiotic relationships or projective identification, infanticide means, in



¹ «Eczema in children under two indicates a lack of tender and enveloping physical contact from the mother.» (Anzieu, 1985, p. 34). Anzieu takes into account Spitz's hesitation regarding the interpretation of eczema: is it an attempt of adaptation in which the child tries through eczema to encourage the mother to touch them more or a form of narcissistic withdrawal or a defensive reaction in which, through eczema, the child tries to procure stimuli their mother denies them?

a way, killing part of oneself. Transnational studies have shown a correlation between suicidal rate and infanticide one. On the other hand, infanticide has no statistically significant connection with the rate of homicide. The authors assume a common origin for the act of infanticide and that of suicide (Dayan, Andro & al., 2000)¹. For Leila, infanticide and suicide seem to be perceived as the means of removing herself from this situation, cancelling it out, the only means at her disposal for finding an escape.

Denial of the breast, real or imagined is sometimes the expression of a conscious or unconscious desire for infanticide. Reasons for infanticide are multiple, going from rejection of a new child to disappointment in having a little girl or the impossibility of accepting this child, symbol of a union between two familial lines one does not want to belong to, or a situation that one wishes to cancel out. It might also form part of a more global framework of «hostile deprivation behavior», a concept invented by Lachal (2000)² to describe mothers in Palestine who voluntarily deprive their babies of food so that they will die. War and deprivation imposed by Israel produces a violence which invades the familial sphere and mother-baby relationships. The baby becomes the enemy and is subjected to two forms of attack: food deprivation and being thrown into a well. These attacks are determined by cultural beliefs on the one hand and by the situation of conflict on the other. In Afghanistan as well, this denial of the breast suggests and/or brings with it an insufficiency of maternal milk which is acceptable not only socially but also probably psychologically. It expresses the mother's aggression towards her infant without bringing guilt with it.

However, certain situations highlight a certain vitality and extraordinary strength in attempting to rescue oneself.

The Story of Leeka and Kasia: The Fight for Survival³

Friday morning, Kabul, Maywand Hospital (June 2006):

A woman is sitting there staring at the ground, with an empty gaze. She arrived this evening. The psychosocial workers welcomed her and took care of her, then asked me to meet with her.

I introduce myself: my name is Melanie and, if she would like, if she would like, I would be willing to listen to her story – whatever she would like to tell me. But above all I would like to help her and her daughter, Kasia, the best I could.

Leeka is 21 years old; she has four children and lives in Kandahar. Her life comes straight out of a nightmare, which we have heard so many times, and which we encounter here all too frequently. Married at sixteen to a man twenty years her senior, Leeka is resigned to her situation – she knows this is the fate of many young Afghan girls.

A year later, she gives birth to a beautiful baby, a little boy named Noor. Very soon, however, she becomes pregnant again and she goes through a difficult pregnancy. Nevertheless, she gets up each morning at 4 am to make breakfast, clean the house, fetch water at the quarry...and the day is just beginning. She gives birth to a girl, then a second one, which her husband could hardly tolerate. Then, since she was getting older and less and less productive, he takes a second wife, younger, thinner, prettier, and not yet scarred by pregnancies and work.

And so begins her descent into hell: mistreatment of her and her daughters, malnutrition, excessive work and endless days, repeated rapes. Leeka gave birth to a third daughter six months ago. Her husband does not tolerate this situation. She knows that if she stays with him she will die. Stress and fear causes a rapid decrease in the amount of milk she can give to her new daughter. She watches her daughter as she gets thinner and she wants to save her. Picturing her daughter dead, Leeka gathers up all her courage, and, for the sake of her child, attempts the impossible.

She flees and, with infinite sadness, leaves behind her three older children and travels day and night until she gets to Kabul.

I'm listening as she is telling me the story of her life, so reminiscent of so many other women in this country. I am facing her; I listen without missing a single word, a single emotion, a single posture. I am there with her, but I don't know what I can say to help her. It is this feeling of powerlessness that

¹ Dayan J., Andro G. & al. (2003). *Psychopathologie de la périnatalité [Psychopathology of Perinatality]*. Paris : Masson.

² Lachal C. (2000). *Le comportement de privation hostile [The behavior of hostile privation]*. L'autre, Revue transculturelle. Ed. La Pensée Sauvage, n°1, Juin.

³ The following case is related by Melanie Couvreur.



one feels so often during these humanitarian missions – this feeling of wanting to erase everything, to give everything, and at the same time to forget oneself.

I place my hand on her shoulder and Leeka smiles at me and thanks me... Then a thought brightens my heart. I need some time to realize that the greatest help I can give her at that moment is to see her as a woman, a person with rights, with a name, and an identity which she had lost completely.

That day I cast a quick glance at Kasia, who is on the ground in a swaddling cloth, a hijab, her bones protruding and her mouth open. She seems so small, so fragile. I let them rest and leave with the strange sensation of having shared their burden a bit. I promise to return the next day.

Saturday Morning:

I rejoin my colleagues from Maywand Hospital, and together we go to see Leeka and her child. Kasia's eyes are open, tiny slits allowing a little light to pass through.

Her body is crushed under its own weight; her delicate limbs seem as though they weight a ton. Her joints are protruding, and this little body seems devoid of any life and strength. I observe very little spontaneous movement and her gestures are very slow. She is extremely fatigable.

I realize then that it will be necessary to proceed gently, even very gently, at their pace. Our primary objective, and a very ambitious one, will be to restore to this woman her sense of being a mother, to counsel her, and to help her regain some confidence in her capacity to be a good mother.

To accomplish that, the ability to breastfeed is important. And so, we use the “suckling technique”: with the mother's consent, our well trained team places a tube at the end of her breast, connected to a glass of milk. Then, when the infant is at the breast and begins to suck she gets milk. This method is remarkable, not only because the mother's body and mind are capable of producing milk again, but also because the child can get accustomed to the oral nature of the experience, the softness and warmth of the breast, rather than a probe or a metal spoon.

As for Kasia, the primary task will be to position her properly, to give her access to her body, to accommodate her gestures. We set up a cocoon made of sheets around her which supports her head, covers her up to her shoulders and which raises her knees gently in order to restore a naturally curled position.

During the first few days, she is so weak that we essentially promote her well-being: her mother sings to her while she is awake, touches her body gently, caresses her tenderly -- as much as Leeka is capable of giving without ever having actually received any of these things herself. Massages are a bit tricky since she is so fragile and her skin can crack at a touch.

Her mother looks at her with affection and despair, a look tainted by guilt. She also needs some shoring-up and support, some way of rediscovering her own energy after all these years, as well as her ability to make choices, to become again the woman she once was.

One week later:

Unfortunately, Leeka is not among those women able to produce milk again while breastfeeding. During this special moment, however, she feels her daughter next to her and realizes that she feels good, that both feel good.

Kasia has gained some weight. She seems more alive, her eyes sparkle; her body is showing some vitality. Suddenly Leeka feels reassured, she smiles, she is improving, even though she immediately feels sad whenever she thinks about her children in Kandahar, or about her future. We then begin some short play sessions, with the help of contrasting colored objects designed to attract her glance, to motivate her to move, to grasp, to play with her feet, to discover herself...her weight is still low and her psychomotor delay is such that she gets tired very easily and spends a lot of time sleeping in her cocoon, or in a makeshift hammock fashioned from her mother's hijab and strung between two beds. But she progresses step by step yet surprisingly, quite quickly. I already see a very different little girl from the one I first met, a little girl who is now alive.

3rd week:

This week we decide to prescribe mother-child group massage sessions to Kasia, who looks less fragile and more alert.

Massages are neither described nor taught, but they come instinctually based on the cultural gestures of the women. We are there simply to assist them and to bring out their potential. We choose some body oil with a specific fragrance in order to produce an aromatic environment for the child. The women willingly take part in these sessions.

We try to introduce, as much as possible, pressure on the entire body, we try to show them how to move the baby's pelvis during the changing of diapers, as well as various ways to handle the baby's body in order to get it back "on the road to recovery".

Women often take this role seriously because it makes them active participants in the healing of their child.

We encourage mothers to speak to their children, to envelop them in soft, comforting words. But far more important, it seems to me, we encourage them to adjust their tonicity and emotions to their child, to become their own reflection and mirror their sensations.

4th Week:

This week Kasia appears to become more and more alert, and so we begin some game sessions. Our goal here is to make her active, to encourage her to move, to search, to try to rediscover her life completely. We urge her, with the help of her mother, to move, to rediscover her energy, her appetite, her will and not just to allow herself to be in a passive state of well-being.

Along with her daughter, Leeka also regains her own life, learns to smile again, to rediscover how a child develops, and regains her skills with a great deal of astonishment and a strengthened bond with her child.

Toys come from the local market, or are made from objects salvaged recovered by my Afghan colleagues (huts made of cardboard, arch stroller toy, balls, scarves).

5th Week:

While we follow the healing and the progress that Kasia is rapidly making, we perceive sadness and emptiness coming over Leeka once again. We understand soon enough that the future holds nothing for this woman but darkness, uncertainty, fear and emptiness. What will she do? Where will she go? My Afghan colleagues mobilize to help her find solutions. They try together to find some family living in Kabul who would agree to welcome her. In the end, they find an aunt who lives very close to Bar i zanana (garden of women) who agrees to take her in and keep her for a while.

We are reassured but ambivalent in our feelings...we all know that the destiny of a single woman is not easy. We are all thinking about Leeka's children who are still in Kandahar; we all experience this ambivalence of joy and sadness without expressing it. It is in this context that we must say goodbye to Kasia and Leeka after they have spent almost seven weeks in Maywand's therapeutic feeding center.

Leeka's breastfeeding problems show us the extent to which this biological function is connected to the psychological state of the mother. Here is an insert which discusses the research conducted in this area and helps us gain a better understanding of the difficulties connected with breastfeeding.

RESEARCH AND TECHNICAL DEVELOPMENT: EXAMPLE OF SEVERE CHRONIC MALNUTRITION MANAGEMENT AMONG CHILDREN UNDER THE AGE OF 6 MONTHS

In 2002, more than 30% of children admitted to nutritional centers operated by ACF were less than six months old. Normally, breast-feeding is thought to "protect" nursing babies. Hence, they are most often excluded from nutritional surveys and are not always included in malnutrition detection campaigns. A diagnosis of malnutrition is difficult to ascertain for this age group. The admission criteria were: "mother lacks milk" and/or "child is too weak to suck", regardless of the child's nutritional status. These primary criteria were eliminated in June 2005, due to their lack of reliability. Indeed, the complaint about "lack of milk" is extremely common in Afghanistan; examination of the breast to judge the quantity of milk is very controversial and provides no guaranty because the result is variable according to when the examination

is done (before or after breastfeeding for example). In most of cases, the team did not even verify whether or not the mother had milk. Anthropometric criteria have been established over time based on the experiences acquired within the centers. It was difficult, under these conditions, to evaluate the scope of this phenomenon.

Furthermore, many questions arise regarding the treatment that should be provided. The main objective in managing this problem is to increase the production of breast milk so that the mother might be able to feed her baby without recourse to the treatment center, once the treatment has come to an end. To accomplish this, the “supplementary suckling technique” is used (cf. picture opposite). The infant takes therapeutic milk through a tube while sucking their mother’s breast. In this way it stimulates production of breast milk. The volume of the supplementary therapeutic milk is gradually reduced while mother’s milk production increases, until the child gains weight from breastfeeding alone for five consecutive days.

In the face of these difficulties encountered in the field, and in the absence of an internationally recognized protocol regarding the care of a child under the age of six months, ACF has developed a complete strategy for research and technical development related to this issue. It is composed of two stages:

- firstly, bringing out this issue within international nutrition fora in order to stimulate reflection and research on this subject and to elicit responses to operational questions which we encounter in the field,
- secondly, implementing studies and interventions, particularly in Afghanistan, in order to better understand the problem and respond to it.

These two stages complemented each other.



Relactation technique

■ Bringing out this issue on international agenda:

Through international nutrition experts, ACF added this issue to the WHO priority research agenda in 2004. In the same time, ACF became a member of the group ACF “Infant Feeding in Emergencies” This group is made up of field experts whose goal is to promote good feeding practices for infant in emergency situations as well as to stimulate reflection and research on this topic. This collaboration resulted in a project conducted jointly by the Emergency Nutrition Network (ENN), the University College of London (UCL), and ACF: the name of the project was “Management of Acute severely Malnourished Infants” (MAMI) ¹ in 2008/2010». This project presented the current state of issues relating to severely malnourished children under the age of six months throughout the world, thereby demonstrating that this problem went largely beyond Afghanistan borders and was often underestimated in countries of intervention. It also identified existing management strategies, highlighted the lack of consensus at international level, and proposed areas of research to be conducted for the prevention and treatment of severe malnutrition among children. In 2012, a second phase of the MAMI project has started which assets priority research areas and develops some of these projects. At the same time, several specific infant care training sessions have been set up for field staff, and in the organization’s headquarters; handbooks and manuals have been issued. Operational research has likewise been conducted, as described in the example below, in Afghanistan, or regarding the treatment efficacy by comparison between therapeutic and conventional milk (research conducted in Congo by Caroline Wilkinson for ACF).

■ Implementation of studies and interventions in Afghanistan

When mothers were asked why their children under the age of six months suffered from malnutrition they used to answer “because I have no milk.” Breast milk deficiency may appear under various circumstances: slow weight gain, weight loss, crying or agitation of the child, change in living patterns, perception of empty breasts, change in appearance of the milk, etc. In order to better understand this phenomenon, it helps to differentiate the three types of insufficiency of breast milk (Gremmo-Féber, 2003)²:

¹ <http://www.enonline.net/research/mami>

² Gremmo-Féber, G. (2003). *Allaitement maternel, l’insuffisance de lait est un mythe culturellement construit* [Breastfeeding, The Milk Insufficiency is a myth culturally constructed]. Spirale n°27.

- mother’s physiological inability to produce milk, or enough milk, as a result of physiological problems (surgery, hormonal issues, etc.). This is rare (less than 5% of mothers) and cannot account for the breast milk deficiency phenomenon in Afghanistan, even if the percentage were higher considering the chronic nutritional deficiencies of women¹.
- secondary insufficiency of milk caused by an inappropriate method of breastfeeding or insufficient demand on child side. Milk production is stimulated by sufficient number of breastfeeding sessions. Poor positioning during breastfeeding, irregular feeding etc., that may lead to a reduction in milk production.
- fear or perception of lack of milk can result from a confluence of factors (lack of confidence in her capacity to feed her child, child crying viewed as a manifestation of hunger, despite being fed).

As psychologists, we focus less on breast milk deficiency as such, but rather on what this phenomenon reveals and its meaning for women and concerned families. Breastfeeding is certainly a nurturing act, but it also a gift, an expression of love, a bonding between parent and child. It is an integral part of the global, real and imaginary relationship between mother and child. But it involves much more than an interpersonal relationship. Economic and social conditions, as well as symbolic aspects, help determine whether or not it is successful, (Maher, 1992).

It seemed to us that there was something else to understand behind this complaint about milk deficiency, and from this rose a new task: to better understand what happened to Afghan women and their babies. Several studies have been conducted: a nutritional survey among children in Kabul under age of 6 months, a comparative study of the care practices and mental health of mothers of malnourished and non-malnourished children, a collection of life stories, individual medical files in nutrition centers, etc. Each little progress in understanding our problematic helped us enriched the program and suggested new activities. In concrete terms, it soon became apparent that mothers, even if they encountered difficulties related to breastfeeding, continued to do it, while simultaneously incorporating complementary inappropriate food in child’s diet. It was, therefore, essential to intervene proactively whenever the mother gave an indication that milk was lacking, rather than wait until her child became malnourished in which case he/she was a risk due to the using of inadequate methods.

Work in the nutrition centers has been reinforced by hiring psychosocial workers who listened to the parents and support the parent-child relationship. Relationship between the care team and patients has been transformed into an alliance, rather than one of mutual mistrust. Knowledge about mothers’ life story and their babies allowed the team to offer more personalized support and help. The totality of this data has enabled us to formulate the hypothesis that the insufficiency of breast milk was often, for Afghan mothers, a culturally acceptable way to express their malaise: a malaise sometimes personal, sometimes related to the bond with their children. Thus, strong correlations have been observed between conflicts and violent episodes within the family and lack of milk, as well as between maternal depression and breast milk deficiency. Indeed, how is it possible to give life and to nourish when one has no desire to live? Beyond statistical trends there are the stories of each woman and each baby which underscore the extent to which the insufficiency of breast milk and malnutrition of that baby could have a meaning and could operate in conjunction with medical-nutritional treatment to (re)establish a bond or generate a feeling of well-being.

¹ This is a questionable argument, since ACF experience in emergency situations shows that breast milk deficiency with nutritionally deficient women remains extremely rare. Like during pregnancy, the body will mostly draw on its reserves to feed the fetus or to produce milk – species survival mechanism. Biology solely cannot account for this phenomenon.



BIBLIOGRAPHY

- **Anzieu, D.** (1985). *The Skin Ego*. Paris: Dunod.
- **Bizouerne, C.** (2008). *Insuffisance en lait maternel et souffrance psychologique en Afghanistan – approche psychologique clinique en situation humanitaire, [Mother Milk Insufficiency and Psychological Suffering in Afghanistan – Clinical approach in humanitarian settings]*. Unpublished Doctoral Dissertation in Clinical Psychology, Université Bordeaux 2.
- **Dayan, J., Andro, G. & al.** (2003). *Psychopathologie de la périnatalité [Psychopathology of Perinatality]*, Paris : Masson.
- **Gremmo-Féger, G.** (2003). *Allaitement maternel, l'insuffisance de lait est un mythe culturellement construit [Breastfeeding, The Milk Insufficiency is a myth culturally constructed]*. Spirale n°27.
- **Lachal, C.** (2000). *Le comportement de privation hostile, [The behavior of hostile privation]*. L'autre, Revue transculturelle. Ed. La Pensée Sauvage, n°1, Juin.
- **Lacoste-Dujardin, C.** (1996). *Des mères contre les femmes. Maternité et patriarcat au Maghreb, [Mothers against women. Motherhood and Patriarchy in Maghreb]*. Paris: La Découverte Poches.
- **Maher, V.** (1992). *Breastfeeding in Cross-cultural Perspectives: Paradoxes and Proposals*. In Maher, V. *The anthropology of breastfeeding*. Berg, Oxford Providence: 1-37.
- **UNICEF** (2012). Afghanistan. http://www.unicef.org/french/infobycountry/afghanistan_statistics.html, accessed on 5 septembre 2012.
- **UNHCR** (2012). UNHCR country operations profile – Afghanistan. <http://www.unhcr.org/pages/49e486eb6.html> accédé le 5 septembre 2012.
- **Van Egmond, K., Bosmans, M., Nacem, AJ and al.** (2004). *Reproductive Health in Afghanistan: Results of a knowledge, attitudes and practices survey among Afghan women in Kabul*. Disaster, 28, 3.

3 - MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN BANGLADESH (2008-PRESENT)



© ACF, Sadeque Rahman Saed - Bangladesh

CONTEXT

Humanitarian situation in Bangladesh has long been a cause of concern to the international community, since even before its independence in 1971, the country experienced political troubles even when it was still part of Pakistan.

Its population is one of the largest and densest on the planet. (Total population around 148 million inhabitants¹ within an area of 144,000 km²).

Bangladesh is also one of the world's poorest countries; 31.5% of the population lives below the poverty line². Bad administration, widespread corruption, a lack of institutions and a high level of illiteracy (only 56% of adults know how to read and write³) are the main long-standing problems.

Vulnerability of Bangladesh can also be explained by its geographical situation, which makes it a place particularly conducive for natural disasters like flooding and cyclones, without mentioning earthquakes.

High birth rate, high population density, chaotic urbanization and chronic seasonal unemployment in rural areas account as well for this real scourge which is malnutrition (national stunting rate : 43%; low birth weight: 41%; wasting: 17 %⁴). The prevalence of malnutrition in Bangladesh is among the highest in the world. This phenomenon is responsible for half of the child mortality in the country, most often by weakening the immune system of children, affecting no less than 500,000 of them in its severe acute form. Domestic capacity of diagnosis and treatment is insufficient.

Feeding practices of infants and young children also play an important part in this nutritional situation: exclusive breast-feeding is rare and food lacks diversity. Malnutrition can be explained also by poverty and food insecurity in a country counting 56 million of absolute poor.

Problems related to water, sanitation and hygiene in Bangladesh are also major concern issues. Water is accessible, but it has been contaminated all over the country by arsenic; there are few latrines; hygiene practices are insufficient.

Acton contre la Faim's (ACF) mission in Bangladesh started in 2007 to respond to an emergency situation caused by the Cyclone Sidr⁵.

ACF's first program in Mental Health and Care Practices was launched in 2009, in the South-East district of Cox's Bazar, more precisely in refugees' camps sheltering the Rohingyas⁶ who had fled the bordering country Burma.

Rohingyas began to cross the border to seek refuge in Bangladesh during the Second World War. This complex conflict takes its roots in the era of colonial occupation of Burma which mainly pitted Rakhines Buddhists against Rohingyas Muslim. This conflict was poisoned by Burma's nationalist ideology and upheld by Buddhist religious authorities. Victims of military persecutions, Rohingyas sought refuge in Bangladesh in three large waves: in 1948, the first ones arrived just after the declaration of independence of Burma; in 1978, 200,000 more refugees came, desiring to escape the repression they suffered in their home country; in 1991 and 1992, over 250,000 Rohingyas subject to forced labor in Burma fled away.

At the beginning Rohingyas were sheltered in 20 refugees camps in the district of Cox's Bazar. Although most of them were repatriated, two official camps still remain, with 30,000 refugees (January 2012): the Kutupalong camp in the sub-district (upazila) of Ukha and the Nayapara camp in the sub-district of Teknaf. These two official camps are operated by the Refugee Relief and Repatriation Commissioner (RRRC), which essentially oversees management of the camps, as well as their water

¹ Data: World Bank , 2010.

² Data: World Bank , 2010.

³ Data: UNICEF, 2010.

⁴ Data: UNICEF, 2010.

⁵ Tropical cyclone having caused 3,000 deaths.

⁶ Rohingyas form a minority group of about 850,000 people in the north of the State of Arakan (Burma), neighbouring Bangladesh. From an ethnic and religious point of view, they are related to the inhabitants of Chittagong in the south of Bangladesh; moreover, their language is similar to the Chittagong dialect spoken by a large percentage of the local population of Cox's Bazar. Burma's Law on Citizenship of 1982 denied them their legal status since they were not part of the 135 national races settled in the country before 1823, the year marking the start of British colonization of Arakan. As a religious and ethnic minority, Rohingyas have been victims of persecution and repression for decades.

supply, primary health care service and the maintenance of law and order. The UNHCR provides humanitarian aid to meet the primary needs and offers basic services (food, shelter, education, health care, water and sanitation).

Bangladeshi government granted refugee status only to Rohingyas who arrived from Burma prior to 1992, and who presently live in the official camps. Even if the waves of refugees continue to flow into Cox's Bazar, the government has refused to extend "refugee status" to new arrivals.



Clandestine refugees who arrived in Bangladesh after 1992 thus began to settle in villages or lived illegally in refugee camps. Despite the precariousness of living conditions¹, Rohingyas have continued to cross the border. The makeshift camp established in January 2008 next to the unofficial camp of Kutupalong has thus grown, and its population now exceeds that of the official camp next door. Furthermore, up to 13,000 clandestine Rohingyas live in the makeshift camp of Leda Bazar, next to the Nayapara camp, on land given by the government in 2008 after the displacement of another makeshift camp² (Tal Camp).

All in all, almost 200,000 non-registered refugees live in villages or precarious makeshift camps. The government of Bangladesh does not authorize NGOs to provide help for non-registered Rohingyas. The few international NGOs who succeeded in carrying out their most important activities in these two makeshift camps can thus only supply limited humanitarian aid. The fact that the Mahjees – the traditional community leaders, often accused of corruption, violence and other forms of mistreatment³ – have full power inside the unofficial camps does not help matters.

It should be noted that Cox's Bazar is part of the poorest, least developed and most dense areas of Bangladesh. The local population lives in precarious conditions, affected by severe malnutrition and unemployment. In a country with few sources of income, the indigene population must confront fierce competition from the Rohingyas, who agree on been paid less. This situation may account for Bangladeshis' hostility towards refugees. At the moment, no one knows how this ongoing conflict will end. International community foresees voluntary repatriation and relocation of registered refugees. The program is not yet in full swing⁴, but rumors on the matter are beginning to circulate in the camps and influence the manner in which refugees see their future: repatriation seems the best solution for most of them if conditions in Burma allow it.

¹ For example, each person disposes of 9 m² in the unofficial camps, a figure well below the norms of the SPHERE Project (a non-profit project of humanitarian organizations that have come together aiming at improving the quality of humanitarian aid provided at international level).

² The living conditions in the Leda makeshift camp are made all the more difficult by its location in a marshy area of the Raf river, greatly exposed to natural disasters (e.g., heavy rainfall and floods).

³ That was the case in the official camps as well, but the UNHCR abolished the Mahjees' system in 2007. Now, it is camp officials and elected community leaders who are in charge of daily management.

⁴ That was the case in the official camps as well, but the UNHCR abolished the Mahjees' system in 2007. Now, it is camp officials and elected community leaders who are in charge of daily management.



PROGRAMS

The fact that ACF has worked with the Rohingyas in Burma since 1994 (more precisely in the Northern State of Rakhine, at the border with Bangladesh) makes it a first choice partner in the refugee camps of Cox's Bazar.

An assessment of mental health conditions and care practices of the Rohingyas was conducted in Cox's Bazar in 2008. It was very quickly apparent that mental health and care practices support was needed. Indeed, critical events are detrimental to the mental health condition of refugees: the displacement of people, the process of emigration, discrimination, mistreatment and above all the stressful living conditions they experienced in the camp where existence is confined to day to day survival. Real tensions, frequency of violent incidents (mostly gender-specific), limited space in shelters, lack of work, limited economic resources and lack of social structure undermine individuals, families and communities. Passivity, dependence on humanitarian aid, apathy, depression, stress and deterioration of social solidarity are evident, and the implications numerous. People lacking autonomy have difficulty planning their future, and develop a "life on hold" mentality and a limited ability to face daily problems. A "survival system" is thus replacing a better way of life geared towards reconstruction and development.

In the absence of a sustainable and long-term solution for the Rohingyas refugees, this "life on hold" state of mind and its consequences have become the norm.



© ACF - Bangladesh

These data, which have pointed out the necessity of an intervention in Mental Health and Care Practices, also show that pregnant and lactating women, women taking care of infants and young children, as well as children under five, should be the principal beneficiary group to target in order to fight malnutrition in the camps. The physical and psychological health of mothers is getting worse in view of the vulnerable social role generally attributed to women in the Rohingya community. Traditionally perceived as

the main caregivers, women are supposed to spend all of their time at home providing care for their children and for the daily household tasks. They are totally enslaved to their husbands and to their in-laws, most of all if the mother-in-law is present. Deterioration of life traditional organization and scarcity of income sources are even more unsettling for the status of women.

Widespread practices like early and forced marriages, frequent pregnancies occurring at a young age, conjugal violence and powerlessness in the event of divorce, which undermine self-confidence and the ability to make decisions, also constitute aggravating factors in the mental health condition of women. As for problems related to sexual aggressions in families and to rape, they are unfortunately a common phenomenon in the camps.

In addition to assuming their usual role of main caregiver of the family, some women must provide for their needs if the husband is absent. Thus they must juggle with both child care activities and income generating activities for their family. These responsibilities are lived with so much more difficulty given that these women generally suffer from an overall lack of support from the community.

Religion is a major source of comfort for a large number of refugees. However, its interpretation can sometimes reinforce certain traditional beliefs and habits that can lead to inadequate infant and maternal care and/or practices harmful to the health of the mother and the child.

The precarious mental health of mothers and families often hampers their ability to overcome the difficulties of everyday life and to provide enough care for their children.

Therefore, the goal of the MHCP program is to maximize families' psychosocial resources in order to detect, treat and prevent children malnutrition and the harmful effects that result from it. The MHCP component was integrated in the Nutrition program along with FSL and WaSH components thus providing a holistic approach to the project. The MHCP program began in 2008 in the two official camps, Kutupalong and Nayapara, and in 2009, in the nutritional center of the unofficial Kutupalong camp (camp called EMOP) and in the unofficial Leda camp. In April 2010 intervention in the latter was halted and limited to the Kutupalong center. In the camps, the MHCP program was characterized most of all by an integrated psychosocial intervention aiming to improve the treatment of malnutrition and to limit its damage on health, well-being, physical and cognitive development of children.

Every month, volunteers from the Nutrition program are making sure that every child under five from the camp gets examined and that their anthropometric measurement is taken. Those who suffer from acute malnutrition are taken care of by the nutritional programs of ACF set up in all the camps. Three types of nutritional treatment services are provided in the official camps: an outpatient program for severe acute malnutrition management; a supplementary feeding program in cases of moderate acute malnutrition; and stabilization centers to perform appropriate follow-up for malnourished children suffering from medical complications, or for children less than six months old.

Nearby the makeshift camps of Kutupalong, ACF is offering an outpatient program for severe acute malnutrition (SAM) management. In this event, children suffering from complications are sent directly to the nearest MSF [Doctors without Borders] clinic, which can arrange their transfer to a local hospital if its staff does not have the means to treat them.

The Mental Health and Care Practices program offers activities and psychosocial support to children, mothers and care givers admitted to the ambulatory therapeutic care center and to the stabilization centers, as well as to the most vulnerable children in the supplementary feeding program (evaluated in accordance with strict vulnerability criteria). Mothers and/or care givers admitted for the first time into the Nutrition program are subject to an initial psychosocial assessment by a psychosocial counselor. The interview focuses on learning about the psychological difficulties within the family and on the relationship between the mother/care givers and her child, which may harm the care and development of the child. It also aims to establish with the caregiver the kind of activities and support that would be appropriate for her and her child. The psychosocial counselor can propose several possibilities: individual support to the caregiver focused on her needs, group discussions between mothers and/or care givers who are experiencing similar struggles, and play sessions as well as advice on breastfeeding practices and a balanced diet.

Discussion groups can accommodate up to ten mothers and/or care givers where they can share their emotions, their struggles, their experiences and their knowledge and find solutions together, to deal with everyday life problems and with the care of the child. The play sessions and infant massage sessions, as well as other activities for the development of social skills, are geared towards strengthening the bond between mother and child. It is a golden opportunity for the child and the caregiver to reach an emotional shared state of well-being.

Beneficiaries only leave the MHCP program if improvement in her/his mental health and health care status is ascertained. If the beneficiary leaves the Nutrition program but still follows her/his MHCP component, a psychosocial counselor will make home visits. Whenever possible, each beneficiary is seen by only one counselor in order to provide the most regular and coherent follow-up possible and facilitate the relationship, which is crucial in this sort of follow-up .



In the most difficult clinical cases, the psychosocial counselor works closely with the program manager and a psychologist who supervises technical aspects.

Since 2011, a new component has been added to the MHCP program in order to respond to the precise needs of the growing population of camps and prevent malnutrition: a psychosocial prevention project focused on a community based approach. The program is focused on pregnant and lactating women, their husbands and their mother-in-laws and endeavors to improve care practices provided the mother and her child during the first 1000 days (from the beginning of pregnancy through the child's second year).

The prevention component includes group discussions and home visits on regular basis, paid by psychosocial counselors, from the third month of pregnancy through the first six months of the infant's life in order to cover the period recommended for exclusive breastfeeding. As previously stated, group sessions give mothers the opportunity to share their problems and their own experiences. The sessions are also a way for the young mothers and those who are experiencing particular difficulties, to find the best means to provide positive care to their children and to favor their children's health, well-being and development (cognitive, motor, social and emotional). Moreover, the group activity, be it in the form of social support or group organization, contributes to creating and reinforcing bonds and social dynamics that sustain the community. As a matter of fact, community provides a limited social structure, resulting from the competition for resources and the mutual distancing of family members. In addition, regular group discussions and meetings in which husbands and mothers-in-law participate, encourage them to become more invested in care provided to the mother and child and to promote positive care practices. In-home family support is offered and provided to families with specific difficulties.

Currently (2012), 70% of pregnant women settled in the official camps are participating in the ACF prevention program. The community leaders and health professionals are also involved in the program by participating in meetings, workshops and group discussions in the field. These activities raise awareness amongst members of the community about care practices and improve access to resources to prevent malnutrition, while reinforcing social and community links.



Thanks to its community-based approach, the prevention component contributes to the promotion of social and individual well-being and the prevention of malnutrition in infants and young children. ACF now records these results by an in-depth evaluation with the Unity for Development of the Child of ICDDR,B, a research organization located in Bangladesh that has significant experience in nutritional and psychosocial programs. The goal of this study, currently in progress (2012), is to show the impact of this preventative psychosocial intervention at the

community level on the well-being of mothers, on their resources for care-giving to the child, and on the nutritional state of the child.

Adoption and the family system's difficulties in welcoming a new child, their needs, and their feelings

"Afsar came to the out-patient Nutritional Treatment Unit with her son Omor, a small boy aged 12 months, because the child found himself in a critical nutritional state. A nutrition volunteer gave her information about the Outpatient Treatment Program run by ACF as well as about the possibility of receiving psychological assistance through the Mental Health and Care Practices activities. During their meeting with the psychosocial worker, both mother and child appeared to be in a state of physical weakness. They were both clean. The mother made good eye contact and responded well to questions. She shared her worries about the health of her child and admitted that she feared being beaten by her husband if the child's state got worse.

Afsar told us that Omor was adopted, and that she had four girls approximately the same age as him. She didn't want to adopt him but gave in when her husband insisted. He wanted a boy and blamed his wife for not giving him one. He held her responsible for the child's malnourishment, even though the family wasn't receiving full food rations. Neither the husband nor the family was able to earn a sufficient income. Her husband reprimanded her when the boy didn't feel well, and blamed her for not taking enough care of him. As for Afsar, she complained that her husband didn't help her take care of their children nor their home. Neighbors also criticized her for not taking care of the boy, which made her neglect him even more. At home, Afsar seemed to be overloaded by her household duties and no longer managed to implement fundamental hygienic practices (this information was confirmed during the home visit).

Omor's father abandoned his family when his mother was still pregnant, and was later abandoned by his biological mother as well. Afsar mentioned throughout the interview that he had had digestive problems since he was adopted. He had been treated at the health center various times, but his condition had not improved."

■ Hypotheses

Afsar came to the center as a result of her son's severe malnutrition problem and asked, more or less directly, for assistance for her as well. In addition to her difficult living conditions and the family's insufficient economic resources, which make her feel guilty for not being able to provide sufficient care for the child, the way in which her peers view her also makes her ashamed of being unable to fulfill her role as a mother.

These emotions seemed amplified by her previous experiences: she felt guilty for not giving (or not being able to give) a son to her family, and ashamed for having difficulties accepting the adopted child. It quickly became very clear that we needed to work with her on the concept of motherhood, and on her relationship with Omor and the emotions related thereto.

Beyond her request for help regarding Omor, she also seemed to be asking us for help in improving her relationship with her husband: indeed, relationship both with the husband and Omor seemed structured around violence and fear. When her husband blamed her for not giving birth to a boy, she felt attacked both as a mother and as a woman.

The attention and the special care accorded to the family dynamic seem to be of crucial importance, and home visits along with family counseling can help to tackle these problems. The husband's participation and involvement are necessary in this psychosocial process. Omor's digestive problems, which require more in-depth medical investigation, could be a psychosomatic complaint, a way of expressing his feelings of abandonment after his birth and his refusal of what the current environment offers to him. His symptoms may be the metaphorical expression of having been rejected by his biological mother and, later, by his adoptive family.

The difficulty of accepting Omor and the difficulties Omor has in being accepted and finding his place in the new family overlap. We can assume that Omor is to his adoptive father, an object that allows him to compensate for the frustration and the sadness of not having had a son. As for his adoptive mother, Omor's presence has allowed her to rise above the guilt of not having produced a son and to thus also be more accepted socially. But where is Omor's place in this system and in this dynamic? How and where can Omor express his own needs and emotions? Currently, Omor seems to have little room.

Continuing with the same metaphor, we can presume that Omor is currently refusing (as he refuses food) the space that is allotted to him and the emotions of those around him. We can suggest that he must learn to ingest/digest not only food but also his status as an adopted child, as well as all the difficulties and refusals he has already experienced in the first 12 months of his life.

■ Case follow up and Results

Afsar attended seven individual sessions to work on her feelings and her difficulties in taking care of her child. Play sessions for mother and child were also offered, in an attempt to reinforce their interaction and create relaxing, agreeable moments between the two of them. Her knowledge on child care practices has improved along with her relationship to her adopted son, which became more energetic, engaged, and less stressed. Afsar showed interest and commitment when seeking assistance to improve her relationship with her child. She was encouraged by the psychosocial program team, and rewarded by the acknowledgment of her efforts. This helped her gain back her self-esteem as a mother and woman. The home visits contributed to her husband helping a bit more with domestic duties in order to reduce the pressure that weighed on Afsar.

It should be noted that her social links need to be reinforced, and thus it is necessary to motivate her to participate in group sessions.

Following this subtle improvement in the family dynamic, Omor began to gain weight. The principal concern regarding the psychosocial problem has evolved. With her entry into a therapeutic program and her participation therein, we were able to reach a more empowering phase: encouraging the mother to pursue actions to avoid a possible relapse, given that the family's financial situation remains precarious.

What possible care between rejection and loss anxiety?

“Farha, age 30, came to the Infant Growth and Development Screening Program to evaluate her child’s nutritional status. Her only son is named Zay and is 19 months old. He was suffering from severe acute malnutrition and was directed to the out-patient treatment program. The boy refused the Plumpy Nut®¹ @ treatment and caught chickenpox. He was then sent to the stabilization center in order to attend to his medical complications. Though Farha had explained that Zay had not previously had health problems, it nevertheless remains that according to medical files, we realized that this was the second time the child had been sent to the stabilization center. Based on preliminary observations, both mother and child appeared neglected, vulnerable, and weak. The mother’s speech during the first interview was rapid, disorganized, and barely clear. She was very anxious and feared losing her only child. When asked why the child was losing weight, she responded that it was Allah’s will. Information about the child’s father is unclear: during the interview Farha said she had married a man from the region and moved to one of the villages not far from the camp. But the husband left her a few days later and she had to return to the camp. Prior to his departure she had become pregnant. Her neighbors didn’t believe her story and they started to treat her like a pariah for having had illicit relations with a man, and for being pregnant while unmarried. She felt exposed to criticism, mockery, and collective indifference. She stated she had gone through tough moments as a result of this lack of support: she had had to sell her clothes and personal belongings, and was forced to beg and to serve as a housekeeper in order to meet her and her child’s needs. Farha currently lives at her brother’s house.

During individual follow-up sessions, Farha revealed she had already had another child, whom she lost due to the inaccessibility of medical care. It is for this reason that she now worries so much about Zay’s condition. She never leaves him and takes him everywhere. She carries him on her back while she begs in the streets and while she cleans houses. She swears that she does everything to meet his needs and prays to Allah for his well-being. She also states that she followed the advice of others regarding an appropriate treatment for Zay’s health, but that it never worked.”

¹ Ready-to-eat, peanut-based, energy-rich paste with a high nutritional content, distributed to malnourished children for consumption at home. It is a therapeutic food.

■ Hypotheses

The situation is very serious both for the child, whose life is at stake, and for the mother, who is in a state of profound distress. Zay's health gets worse day by day and has been precarious for too long (at less than two years of age, he has already been admitted twice to the nutritional center). The mother is greatly affected by her economic, relational, and psychological conditions: she does not have sufficient resources, her relationship with the child's father was a failure, and she is now rejected by her community. She is very anxious and terrified by her condition, and more so by that of her child. She does not want to go through the same experience she had with her previous child. She overprotects her son (she needs him to be with her throughout the day) in order to avoid reliving that tragedy, but at the same time she shows difficulties in meeting his needs: the anxiety of loss is very present and tarnishes their relationship, and the child lives under highly precarious conditions for both his health and his development.

Farha requires psychological assistance and support, since her psychological state influences her capacity as well as her ability to properly take care of her child. An important aspect to consider for analysis as well as for the assistance given to Farha and Zay is that Farha tries and desperately wants to be a "good" mother; this is an important element to rely on in their follow up. She wants to do everything for her child: protect him, be a good mother, and watch him grow up—but at times she is consumed by fatalism ("it's Allah's will", "all her efforts are for naught"), and she loses confidence in herself and in her means. This confidence issue needs to be tackled.

Her statements, her story, and her position at times seem ambivalent and incompatible with multiple break-downs. She seems to be simultaneously personally rejected (by her husband) as well as socially rejected (by the community) and we can even presume that she might interpret Zay's state as yet another rejection. At the same time, she is showing signs of mistrust towards others as well.

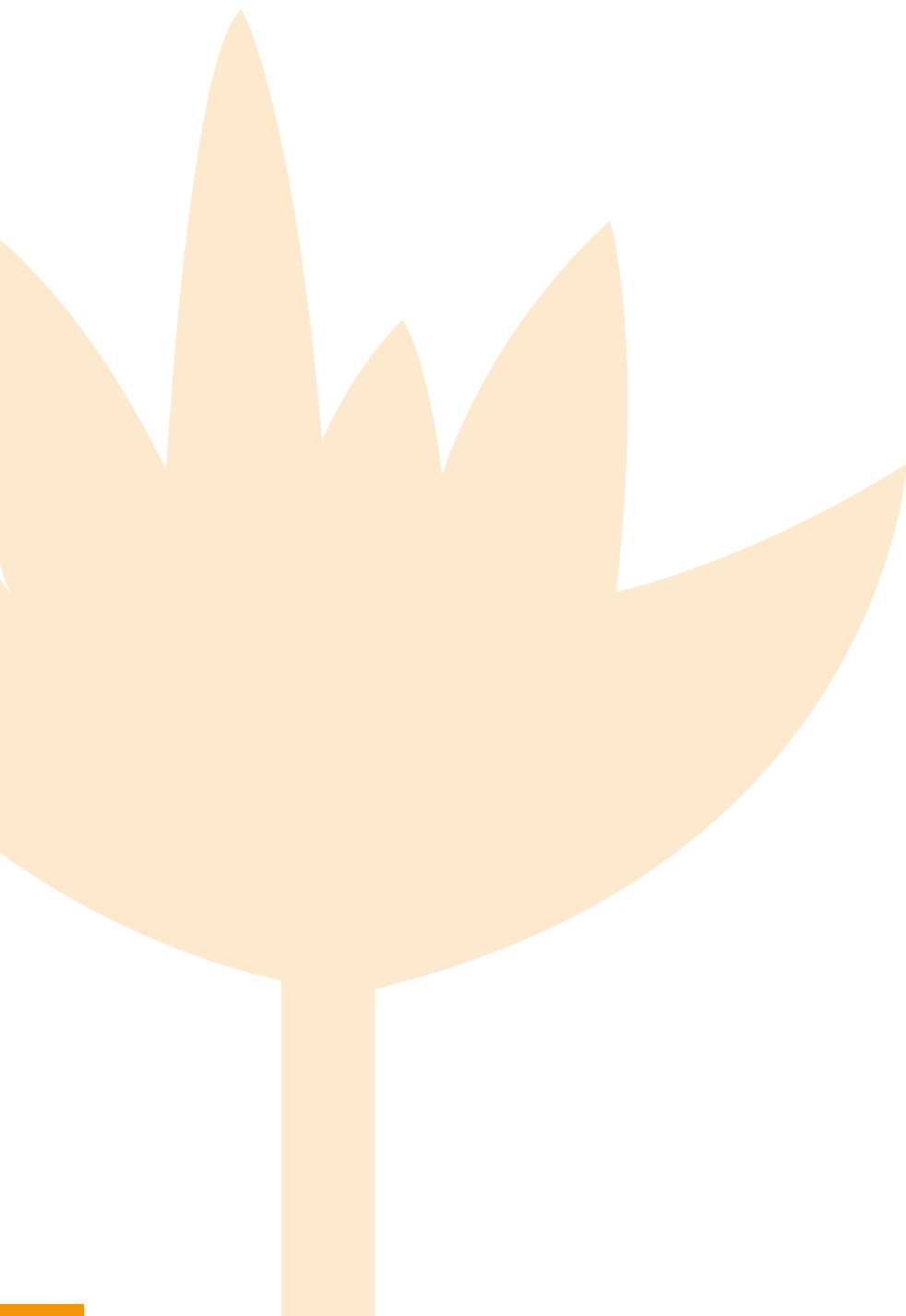
For this reason, she needs to undertake individual sessions with the social worker and, as soon as her condition improves, she should be involved in group activities to help her engage in new and rich social relationships. Zay plays an important role in this situation. His precarious health condition and his difficulties in getting better may be seen by the mother as a new rejection of herself and of her protection. The relationship between Zay and Farha exists and is engaged in both directions, but needs to be taken care of in order to reduce the anxiety and the refusal associated thereto, and to become once again a real resource for both Zay and Farha.

In parallel to Farha's follow-up, massage and play sessions will be offered to reinforce the relationship between Zay and Farha, and to instill it with pleasure, bonding, and tranquility.

■ Case Follow up

Farha started off with individual follow up then moved to group sessions. She showed a great interest in participating in the group discussions about child care. Her knowledge of basic care practices (such as interaction with her child, especially during feeding, as a form of motivation as well as the implementation of better nutritional practices) and hygiene habits improved considerably during her treatment. Zay's health condition improved and he was transferred fairly quickly to a complementary nutritional program. The same psychosocial worker and his child followed with him throughout his treatment.

The primary objective of this psychosocial support can be summed up as follows: to work towards the mother's acceptance of being treated by ACF and, in so doing, reinforce her confidence in her own capacity to intervene in the situation in a positive manner, so that her son may be taken care of. On the other hand, the child and his well-being may become, for the mother, a reward for her personal involvement.



4 - MENTAL HEALTH AND CARE PRACTICE PROGRAMS IN MYANMAR (2006-PRESENT)



© ACF - Birmanie



CONTEXT¹

Living conditions of the people in the State of Arakan (region in the extreme North-West of Myanmar, at the border of Bangladesh) are particularly difficult and complex.

In fact, this predominantly Muslim community of more than 800,000 inhabitants (Rohingyas) has been living under the control of the military junta for 60 years. These people have suffered from general rejection by the Burmese authorities for centuries, and especially since 1948, when Arakan was annexed to Myanmar and was subject to severe military oppression. Thus, in 1977, the government expelled the Rohingyas from this region to Bangladesh in such a violent manner that a complaint was filed to the UN; the return of these people to Myanmar was subsequently overseen by the UN High Commissioner for Refugees (UNHCR). In 1982, the status of this population became even more difficult due to a law that identified three classes of citizens: “full rights” (i.e., belonging to one of the eight so-called “superior” races), “naturalized” or “invited” citizens. Since very few of them have been able to submit the necessary documents for naturalization, nowadays the majority of Rohingyas are considered to be stateless, without a Burmese identity card or any other nationality. They remain under house arrest in their village, unable to travel within the country and are the target of violence. The language of the Rohingyas is similar to Bangladeshi, though unrecognized because there is no written form; the people differs from the majority of Myanmar citizens both in their physical appearance (98% of them belong to a minority of Aryan origin) and in their religious belief.



future and considering prospects that could improve their living conditions.

Political and governmental pressures have exposed these people to repeated experiences of violence, loss and restrictions in terms of their movements, work, access to education, health, etc. Such pressures have a socio-economic impact with a high level of unemployment and illiteracy, and also lead to the phenomena of discrimination against women and social isolation. These experiences affect the people’s self-esteem and produce strong feelings of insecurity, instability, loneliness and incomprehension. This very difficult situation keeps these people in survival mode, which prevents them from even minimally projecting themselves in the

88% of the women are illiterate. Many get married early (mostly upon decision of their parents), only 20% use any contraception and most of them suffer from a significant lack of autonomy (the decision-making power is attributed to men in the family and mothers-in-law).

Added to this is the frequency of natural disasters in this area (floods, cyclones, earthquakes). These sudden and unforeseeable events represent another source of chronic stress for the inhabitants, and reinforce their feeling of powerlessness and dependence on external forces. Thus, these people cannot even consider mechanisms to protect themselves against natural disasters. Our teams also observed that mothers explain the causes of malnutrition (or other problems) and attribute the condition of their child and their recovery only to the will of Allah.

These various factors and the continued oppression of this ethnic minority negatively influence the

¹ This introduction is based on Barbara Bobba’s text and Valérie Piloti’s research paper.

ability of individuals to plan their future, affect their wellbeing and mental health, the social structure and dynamics as well as the population's capacity for resilience. Families are becoming poorer over time, family and social ties are eroding and solidarity or mutual assistance is gradually disappearing... apathy and depression seem to have taken over the lives of these people.

Therefore Rohingyas live in a situation where they are confronted not by a specific "disaster", but rather by a series of disasters that accumulate in the long term, exposing this population to critical, even traumatic situations that deeply affect their coping mechanisms that they should use for everyday problems.

In this context, a reaction of withdrawal can be observed among this people struggling to preserve as much of their traditional beliefs as possible. These beliefs, which express a certain interpretation of Islam, are strongly linked to practices, convictions and an identity. At the administrative level, this leads for example to confusion and so the following might be specified on official documents: "Race: Muslim".


No clear data exist on the mental health and psychosocial conditions of the people living in Arakan. However, a mental health evaluation carried out by ACF in 2005 on women with a malnourished child being treated in one ACF center shows that more than half of them suffer from generalized anxiety disorder, and that an overwhelming majority (90%) feels constantly worried. The assessment also revealed that all mothers of severely malnourished children display great emotional suffering with depressive symptoms. The majority of these women say that they have had these symptoms for years. Moreover, clinical observations of the teams on the field indicate that more than half of the physical problems that prompted a visit to a doctor have psychosomatic causes (this last point concerns men and women alike).

A second survey carried out by ACF in January 2008, both on mothers with a malnourished child and on the general population, confirmed these results.

PROGRAMS

ACF has been present in Myanmar since 1994, with initial interventions in water, sanitation and food security. Assessments of the nutritional condition of children under five performed in this region in 2000 and in 2003 revealed a high prevalence of malnutrition. For this reason, an important program for treating moderate and severe malnutrition was set up in two towns of Arakan (Maungdaw and Buthidaung) in 2003 and 2004. Currently (2012), ACF manages 12 outpatient nutritional sites for treating severe and moderate malnutrition. Children come once a week to receive treatment in these structures, where their nutritional and medical condition is followed-up, and the treatment for the week to come is handed over to the mother. In addition, two therapeutic nutritional centers provide 24/7 care to malnourished children with medical complications as well as to infants under six months. Hospitalization services are necessary for both these categories of children, because their health condition poses a vital risk. In the event of a particularly serious situation, the child is taken to the hospital in the city and the travel (transport and access to the hospital) is facilitated by the ACF team. The teams handling these programs have noticed over time that while mortality among malnourished children declined sharply, the general rate of malnutrition remained stable despite ACF programs. This phenomenon is in all likelihood due to multiple external factors that affect the population and create conditions leading to malnutrition: discrimination, experiences of violence, insecurity, economic hardship, limited access to clean drinking water and adequate sanitation facilities...

In 2006, following the mental health and childcare practices evaluation of beneficiaries in the nutritional centers, a mental health and childcare practices program was launched in close cooperation and integration with the nutritional programs. A team of psychosocial workers intervened in the centers where severely malnourished children were being treated - the idea was to work with children suf-



fering from the most serious nutritional conditions. The team organized treatment and care for the children and their mothers based on various types of activities:

- a preliminary individual session to identify the actual condition of the child and family as well as child's specific needs;
- strengthening the mother-child relationship through play and massage sessions;
- support and discussion groups on various topics concerning childcare (breastfeeding, hygiene...);
- individual psychological support session.

Between 2006 and 2009, teams from the nutritional centers observed that between 15 to 21% of the children welcomed in the program had not gained sufficient weight at the end of two months despite the absence of any medical problem. Different hypotheses were set forth to explain this phenomenon: could the parents be distributing (or selling) the nutritional supplements to family members? Were the mothers perhaps (consciously or unconsciously) keeping the children on the verge of malnutrition in order to continue benefiting from the ACF program? Could other factors linked to care practices at home be involved? What other actions should be considered in order to help these families and children?

Such questions made the teams realize the need for monitoring these children and their families more closely. Two Mothers' Participation Centers (MPC) were opened in 2009 and they were managed entirely by psychosocial workers. The setting up of MPCs is a pilot project for ACF in the Burmese context, tailored to the needs of the beneficiaries in the particular context of this community in Myanmar.

Thus, when a child being cared for in the nutritional program does not gain adequate weight (or if the weight remains static after several consecutive readings) in spite of providing treatment and if no medical problem is reported, the family is referred to and treated at the MPC. Mothers (or the caregiver: father, aunt, grandmother...) and children are received all day long here, three to five times a week for several weeks (on average 3 weeks). Mothers provide nutritional treatment to the child during the day and various activities are proposed based on individual needs. Apart from offering psychological support and strengthening the mother-child relationship, the center's aim is also to enable beneficiaries to (re)form social ties, benefit from a space for dialogue with other mothers, be able to talk about feelings and difficulties being faced, and more broadly, be able to find support within the group.

All topics are covered here and provide a space for dialogue in order to express painful feelings and share one's experiences with others (e.g. approximately 38% of these women have already lost a child in the past due to malnutrition or a medical problem). The purpose of the MPC activities is to primarily support these mothers so that they can reduce their stress and go about creating a certain mental space in which to accommodate the child and establish their relationship. Child massage activities are especially interesting because they allow mothers to rely on old traditional practices to (re) establish a relationship with the child using physical, non-verbal communication, which satisfies the very early relational needs of the latter. This activity shows mothers that they can provide wellbeing to their malnourished child, who is now more relaxed, sleeps better and improves their appetite... The effect of these practices on the mothers' sense of confidence in their maternal capabilities and self-confidence, combined with the effect on the child's wellbeing, which as a result seems more "rewarding" to his mother, leads to an improvement in the mother-child relationship (read little Abdul-lah's story below).

Whenever possible, home visits are carried out for the families of MPC beneficiaries in order to take into account the specific features of each situation and the needs of each beneficiary. A follow-up in the family's home can be offered.

Before the family is discharged from the MPC, a debriefing is scheduled to assess the need for further follow-up through home visits, if such an option is feasible (families sometimes come from afar and home visits cannot be easily provided).

The results obtained in the MPC are very positive, both in terms of response to nutritional treatment and in terms of changes in the mother-child relationship, attitude and knowledge about childcare practices, needs and development of the child. With an average stay of a little over 15 days, mothers begin to get acquainted with games and massages as a means of communication/relationship/support for the child and they express the desire to use these means at home too. They have learned a lot about preparing the child's meal and hygiene too and they show a willingness to implement these practices in their homes¹.



From 2008 onwards, a mental health and care practices prevention program was developed to strengthen family and community resources around the problem of malnutrition and childcare practices. It was combined with interventions from other ACF technical sectors.

Beneficiaries of the program were selected from among those who were the most vulnerable and “at risk” of being exposed to malnutrition². A few “key” and influential people of the village such as traditional midwives were also invited to participate in the group activities and special trainings to promote certain changes within the community through their professional practices³. In parallel, training on childcare practices and their links to malnutrition was introduced for medical teams from the Health Ministry working for the local health system.

Group activities with mother and infant include facilitating discussions on the experiences, practices, emotions and problems being faced by the villagers, and the strategies that they use to deal with these difficulties. The idea is also to help them find common solutions to their common problems, in order to strengthen ties and social support in the village. Various activities are provided: thematic group discussions (hygienic practices, causes and consequences of malnutrition, principles of a balanced diet, needs of the mother and the fetus during pregnancy, birth control, setting up vegetable gardens... infant stimulation, support for breastfeeding and weaning).

Home visits make it possible to help families change their habits if necessary (or find alternative practices), and provide individual psychosocial support to them. During these home-based interventions, there have been regular requests for psychological support. For example, one of the beneficiaries showed concern about some important psychiatric illnesses (delirium, hallucinations, fears of losing control and acting out violently...). It is remarkable that this man and his wife, instead of simply linking these phenomena to the influence of external factors, are able to seek the help of a psychologist - and not just resort to a traditional healer.

Villagers' participation in community work was particularly significant (90% attendance rate), reflecting their need to receive such support and to (re)create communication and social ties within the community. Changes in attitude were observed in terms of hygiene and diet, exclusive breastfeeding, access to health care during and after delivery, with increased use of birth control methods, and greater attention to the child and his needs. Moreover, a new dynamic has emerged in the village, with more links between families, mutual assistance and expressions of solidarity, as testified by the village leaders.

¹ They go from a score of 0 or 1: very little knowledge; to a score of 7 or 8: good knowledge and desire to put it into practice.

² 200 pregnant and/or lactating women and 250 men were targeted at the beginning of the program - these quantitative objectives have in fact been largely exceeded: 220 women regularly attended our support groups and more than 800 fathers took part in care practice discussion sessions.

³ More than 50 traditional midwives have been trained and are currently supervised on a regular basis by our team.



© ACF - Birmanie

Following the implementation of this first prevention center/network in the village of Ay Tah Lya, a similar discussion and support group was set up informally in a neighboring village, at the initiative of a psychosocial worker and a nutritional center agent who live there (this initiative was developed following the death of the latter's child). This observation clearly demonstrates the need to strengthen community support and rediscover a space for dialogue and discussion in such contexts. The ACF team has offered

to provide technical support to the participants, without however interfering in the process or dynamics of the group and without any financial or logistic contribution. This is a good example of community intervention that is well-integrated and shared by the population and is, for this reason, effective and sustainable. A discussion with the “founders” of this spontaneous prevention center/network is transcribed below.

Yaminn, or the Search for a Parental Imago¹

“When I ask Yaminn to talk to me about her daughter Phyu, she answers that she suffered from a cough and a fever during the last five months of her pregnancy. Phyu was sixteen days old when she was admitted to the stabilization center, the week before the interview.

“Yaminn immediately adds that in order for children to be well fed, the mothers should receive food that is tasty as well as nutritious. She is often ill and the center’s meals aggravate her case. Breast-feeding mothers must eat fresh fish and vegetables so that their milk production increases, she tells me; when the mother’s stomach is full, this has a positive impact on her milk.

“When I ask her to explain to me how this works, Yaminn tells me that some foods are good for breastfeeding mothers and that their meals must be varied.’ When our milk contains these foods, our appetite increases and we can eat as much as we want.’ If their milk contains dried fish, their appetite decreases and they lose weight because dried fish is less tasty and nutritious. At home, they get priority at mealtimes, they eat dried fish—but large fish—green-fish, vegetables and meat. However, at the center it is different, she adds. She had more milk before arriving at the center than now, when they are always hungry but have no appetite.

“When I ask her to explain how Phyu became malnourished, Yaminn answers that she was very sick during her pregnancy. She could not get medical treatment due to her family’s poverty. As she was unable to eat, the child could not receive the right nutrients. She realized this after the birth, when she saw that her child was small and weak.

“She got better after the delivery thanks to vegetables, but Phyu’s condition started improving only after coming to the center. Yaminn has two other children who were normal at birth. ‘The children “She would like to leave the center because of the food that is too plain and that everyone complains about. I tell her that I will try to change the menus, and we part.”

At the time of this interview, women admitted to the nutritional centers were complaining constantly about the quality of the food offered at mealtimes. Yaminn takes on the role of spokesperson for the women in the center and complains about the lack of attention from Action contre la Faim, which,

¹ Narrated and commented on by Valérie Piloti.

according to the women, treats them worse than do their families back home. In fact, in Rohingya families, women eat last, but it appears that during breastfeeding, this practice reverses and the family pays special attention to the parturient woman's menu. Yaminn's discourse reveals bitterness at not receiving the special care that she would have benefited from had she stayed at home.

In giving them food that is "too plain," ACF is not taking into account their status as extraordinary women who need special attention and care. This lack of recognition constitutes a brake in their ability to provide adequate childcare because their status as lactating women seems denied.

The situation therefore appeared as a missed opportunity: the ACF teams have not figured out how to understand the symbolic and cultural importance entailed by the beneficiaries' complaints about the menus. The teams took these complaints as persecution and rejection, with the beneficiaries always asking for more while the teams already had the impression that they were doing a lot and enduring difficult experiences in confronting themselves to the challenges of the beneficiaries' situation, to suffering and sometimes to death. The complaints surrounding the meals became part of a vicious cycle of mistreatment/violence/lack of gratitude/dependence and signaled a mutual cultural incomprehension. By doing so, the NGO "is not good enough" to allow mothers to draw on their resources in order to be available for their children. Before asking for food for the production of mother's milk, they ask for food for their own stomachs because if their stomachs are not full, they will not be able to fill up their children's stomachs.

It is therefore a question of double mothering. In order for Yaminn to be able to breastfeed, it is first necessary to take care of the baby inside her; someone must take care of her feeding in her place and give it special attention. If this does not occur, there is a rivalry between the baby within herself and her actual own baby, and consequently an inability to give permission to the latter to draw on the reserves of the starving baby inside her.

Through the insufficient attention given to the menus at the center, ACF has exacerbated this rivalry and thus it is possible to understand the decrease in breast milk production since her arrival at the center. The maternal wrapping around Phyu's mother is not strong enough for her to allow self-devotion to her baby.

The expression "full stomach" holds my attention in the sense that it may also be a question of filling the loss of the round stomach of pregnancy. Paying attention to the parturient woman's diet also serves to diminish the feeling of emptiness. In order to breastfeed, it is necessary to feel alive and full, and to desire to eat. The notion of pleasure is central in Yaminn's discourse, like a call for someone to satisfy her pleasure so she can satisfy her child's pleasure. The wrapping around the young mother and her baby is also there to help her fight depression and emptiness.

Are we talking about nostalgia for the round stomach or a preexisting feeling of internal emptiness that is intensified by the act of giving birth? What does Yaminn's feeling of lack tell us about her past? Or maybe about the way in which she was fed?

Here the pact of welcoming the child may be stated this way: "In order for me to take care of you, someone must take care of me first." Milk therefore takes on a specific status as transmitter of life and pleasure to the mother herself. Does the "we" Yaminn uses throughout the interview refer to the women of the center or to herself and her child?

It is interesting to note that the mother's body is not evoked in terms of digestion. When she discusses her appetite, Yaminn systematically refers to the power her milk has over her, not to what she ingests or to what her digestive system contains, as if it truly were her milk that nourishes her.

Yaminn's speech is talking to us about a cycle that applies only to her: "eat well in order to have good milk in order to eat well."

Also heard is an immense disappointment at not receiving costly food. In fact, the foods that Phyu's mother demands from Action contre la Faim are products that are extremely expensive in the markets, products that she probably would not have received at home either.

The lists of foods give an image of an ideal of profusion of which she hoped to be a beneficiary, as if she had projected onto Western NGOs the absence of shortage in favor of opulence and luxury, which are denied to her and which she demands.

It is difficult to say if her position as breastfeeding mother is what provoked this, but it seems that Yaminn is desperately seeking a maternal figure that is characterized by abundance and capable of filling. It may be possible to draw a parallel, albeit distant in culture and time, with the patient Freud (1892-1893)¹ treated for her inability to breastfeed. Schneider comments on Freud's therapeutic strategy saying that he tried to place on the axis of generational succession the oppositional structure of a patient who desired to breast-feed but could not: "Freud thus addresses what in his patient corresponds to her position as a girl, not a mother... Becoming a mother would imply her acceptance of being orphaned from her mother insofar as it is precisely this maternal position that is being occupied, a situation that implies a change of position."²

One may wonder if it is in fact here where all the importance of mothering by the familial and social body is at stake. The generational change implies the need to find one's new place, and this is exactly what Yaminn seems to be having difficulty doing.

I cannot help but make a connection with this ethnic group's situation of statelessness, and wonder if the extent of this request to ACF is linked to the need to be recognized, to give her some solidity in the absence of the recognition that her country should have given her.

In not being sufficiently concerned about its menus, the ACF centers, on which a representation of profusion of quality care seems to have been projected, have incited an intolerable feeling of being rejected and disliked, and one may wonder if the anger this has provoked in the mothers of the children present has also served to manifest anger felt toward the ungrateful homeland by which they were shut out.

Rokha, or the Endless Search for Answers³

Rokha, aged four and a half, was admitted to the ACF nutrition program with his mother on the advice of neighbors (he was not eating enough and he cried constantly). The child was monitored by the ACF outpatient nutritional center, which then referred him to the therapeutic feeding center because of edemas and steady weight loss. Rokha was transferred to the Mothers' Participation Center (CPM) because he kept on losing weight, despite the treatment.

We met Rokha at the beginning of 2012, on the recommendation of the center's team. Since his admission, his weight had dropped from 9.1 kg to 8.4 kg.

The first time we met him, Rokha was wrapped in a dirty blanket in his mother's arms. She was wearing unclean clothing and seemed tired, depressed and hopeless. While his mother spoke to us, the little boy vacillated between states of wakefulness and sleep, and he sometimes tried to talk.

The mother explained that the child is handicapped. He is the fifth of sixth children (two boys and four girls); Rokha's youngest sister, who is seven months old, is healthy and with her mother at the Nutritional Therapeutic Center so she can continue to receive care. Apparently, the other brothers and sisters were not suffering from nutritional problem.

One year earlier, Rokha was a healthy little boy with no nutrition problem. Following a serious infection accompanied by high fever and convulsions, the family visited a traditional healer, who inserted a needle into the child's neck⁴. It was at this time that he lost the ability to move and speak. However, he began to visibly lose weight after his younger sister's birth, when his mother needed to take care of the baby.

¹ Freud, S. (1892-1893). *Ein Fall Von Hypnotischer Heilung Nebst Bemerkungen über Die Entstehung Hysterischer Symptome Durch Den «Gegenwillen»*. Gesammelte Schriften. [section 3 of On the Psychological Mechanism of Hysterical Phenomena: Preliminary Communication.] Vienna: Internationaler Psychoanalytischer Verlag, 258-72.

² Schneider, M. (2002). *Freud et le rapport féminin à la négation. [Freud and the female relation to negation]* In *Fatalités Du Féminin*. Paris: Presses Universitaires De France, 75.

³ Case study written by Barbara Fulva Bobba.

⁴ The healer probably did some sort of drain. It is possible that the child was suffering from encephalitis.

The mother agreed to come with us to a more private room so she could speak more freely and so we could better observe her son. We spent a lot of time with the mother and child, listening to her thoughts, feelings, hopes and distresses. She asked many questions, wondering if it was possible to get her child admitted to a hospital in Bangladesh—she had heard about handicapped children who could be treated there. She requested medicine or any treatment to save her son. She kept taking Rokha in her arms like a ‘little parcel that she would move from one place to another, and she never looked the team members in the eye.

During this interview, we could see that Rokha was able to slightly move his right hand and that he reacted with a sound when we called him. He also seemed sensitive to relationships and to physical contact (he would stop crying when someone would touch or speak to him). We assumed that the difficulties were connected to the child’s neurological state as well as to the environment’s ‘paralysis’ and the relationships the illness created within the family.

We showed the mother how giving massage to her child can create intimate moments that could lead to a better affectionate relationship between them. We also suggested that she avoid wrapping him for long periods in a blanket, and to talk to him as much as possible. The mother listened to us but her face was apathetic and her eyes were sad.”

One week later

The mother came to greet us as soon as we arrived. She was smiling and she looked us in the eyes. Speaking in her language, she explained that she woke up at 4 a.m. every day in order to give massage to her son, and she could see he was doing better. Showing us the weight records, the psychosocial worker told us that indeed the child had greatly progressed in one week: Rokha was more active, he no longer slept all day and he had gained weight (9.3 kg).

During lunch, Rokha’s father came to the center to meet us, pleased to see his son’s progress, and asked us if it was possible to have him X-rayed in Bangladesh. While she stayed at the MPC Rokha’s mother participated in individual psychological support sessions, support discussion groups and group massage sessions.

After two weeks of monitoring at the center

The target weight had been reached, Rokha weighed 9.9 kg. The mother asked us if, once she returned home, she could give her son the milk she received at the center. We then realized that the child had only rice and sugar to eat before coming to the center. The psychosocial team explained to the mother the different types of inexpensive and accessible food that would enable her to give her child (and the rest of the family) a more balanced diet. The mother was visibly interested and told us she would make an effort at home. She also showed us a small bottle of massage oil for children that her husband had bought at the market. We emphasized the importance of her maternal abilities in Rokha’s progress, beyond this oil’s attributes.

In conclusion, we began to discuss with her the moment when she would leave the center, stressing the importance of also paying attention to her other children, not only to her handicapped son.

Right away, we see that this mother and her small child are not doing well: she looks dirty and tired, with sad eyes. The boy reacts very little, and each day he loses more weight. She no longer knows what to do with him, and carries him around like a «parcel»... or maybe like a child already dead, already long gone. Her need of help is obvious, and has already been expressed by the parents to many people. They want to understand what’s happening to their child and how to heal him. They are ready to follow any advice.



Rokha's disability exceeds ACF's skills; however, we can help them by strengthening a parents/child relationship that seems rigid and unchanged since the accident.

We get the impression that Rokha's paralysis has also gotten the family stuck in its relationship to him: little interaction, little hope, and little stimulation. By his attitude, Rokha also expresses these relationship difficulties. The younger sister's arrival has exacerbated these issues, because the parents have also had to find time and energy for this new family member. How can they find time and an appropriate way to re-create the bond with Rokha, and how can they give him back his love of life by re-establishing a rich and solid relationship?

Immediately, the team sees that the child needs to physically «feel» this relationship and his family's love. His parents need to be reassured about their abilities to relate to him and to observe his progress. That is why the team immediately thought of suggesting the mother some massage sessions. Indeed, massage allows her to regain confidence in her maternal and mothering abilities; lets her work on the child-adult relationship through the body by touching something very emotional, affective and immediate; and it is a perfect method with the child, who shows cognitive, motor and relational difficulties. In addition, massage is a simple and fun approach in which a mother does not feel judged for her performance and can be free to express her love and care for her child. This solution will prove to be appropriate, if the immediate positive result is any indication.

The team is careful to leave the mother enough space to express her difficulties, her feelings, and her disappointments, by bringing her into psychological support sessions with individual follow-up. This mother and woman needs to be heard, accepted in her distress and in her child's distress, and revealed in her abilities as a mother, abilities derailed by the accident, which must have created feelings of guilt, shame and fear. The mother is doing better, and she shows us this through her appearance (better dressed, neater look...), her smile, and her response to us. She appears to believe in herself once again; through massage, she is able to make her child feel better; in fact he is gaining weight and being more responsive. Guilt is giving way to hope. The child becomes an individual (once again), with whom one can interact, and with his limited means, he shows it: he is sleeping less, gaining weight and moving more. The father feels involved; he makes the effort to thank us personally for the results, and shows us how much he wants to solve the child's problems by making a request for medical aid (no longer via traditional healers).

The familial paralysis seems to be making way for movement: less guilt and shame, more action and care!

A virtuous cycle has been created, and the family can continue to provide this care all by itself. The mother knows how to make Rokha feels better, the child knows how to value his mother and involve his father. A new energy is born in the family. A new investment in Rokha is created.

Interview with Zawlal and Fozul, co-founders of the impromptu prevention center created in a village in Buthidaung.

Q: Why and when did you decide to open up a prevention center?

We opened the Prevention Center in September 2011, because between July and August 2011, four children died in this village from accidents in the pond. One of those children was the only son of one of us. He was two years old and was playing in the pond with other children. The grandmother was watching him, but she fell asleep, and when she was awoken by another child, she realized that the little boy had died. It is impossible to express the pain we felt. The child was very well known in the village, because he was very active and healthy. We wanted to make sure that no such terrible experience would happen again.

In July, we received training in psychosocial support given by ACF, and we realized that conflicts and jealousy in the community had limited good relations within our families. The context of the State of Arakan is not easy, and it is hard to explain to someone who comes from the outside world how internal conflicts have impacted our ability to create positive links in the community. So we decided it was time to do something to change that - for us, for our children and for our community.

Because of traditional customs and culture, husbands do not allow women to leave the house. Women do the domestic work, and their needs are not heard. The mothers of our children feel they are under pressure, and it is not easy for them to have relationships outside the family. Women depend on their husbands; husbands depend on others who can in some way help them... The impression is that most people are not prepared to deal with their own lives.

Often, children will do casual work: they mind the cows or are sent to the mountain to cut wood for their family. In addition, it is unfortunately common to see children being abused in their families: many times, the only method used by parents to be respected is to use violence. The only way to get the children's attention is to use Arabic (Koranic) school and public schools. Ultimately, children are growing up in an extreme violent environment, and violence becomes the «norm» for them and within the community.

What's more, malnutrition is a common problem in our village, and the perception of this disease is that it's Allah's will.

Q: What is the objective you wanted to reach when you decided to open this prevention center?

The idea was and is extremely ambitious: we wanted to create a better environment, prevent child mortality and malnutrition, promote the rights of children and women, improve self-confidence and relationships, and develop children's education through play. The goal is to improve women's and children's quality of life, through the development of women's and men's education as well, by creating easier access to formal and informal education with participatory discussions.

Q: What steps did you take to open the center?

We thought we could address the issues we'd identified by using dialogue within the community, with families and key individuals. These discussions were the starting points for the activities. After these sessions, the community asked for a weekly meeting to think about their children, health and preventive behaviors.

The community-based prevention campaign began in September. After many discussions, the administrative officer of the village (village chief) gave his approval for the «Prevention Center» to open, and activities could begin.

Q: How did you organize the meetings?

Meetings were (and still are) organized house by house and children who like to take part in the play sessions are welcome to the Koranic school. Other people in the village, who had previously worked in various NGOs, volunteered to help us, and we organized a small village committee. Those parents who are interested in joining us must pay a small monthly admission fee (which is used to build a shelter for the children's lessons) based on their income. The poorest families pay nothing.

We support the teacher in the method he uses to teach the Koran to the children; violence is not allowed in school, because we want the children to learn for the joy of it, not because they are being beaten and/or forced.

Parents meet (groups of men and groups of women) during the weekend, with our help. We talk about how to minimize stress in the family and how to educate children without beating them. With the men, we did some sessions on toy manufacturing without any money, but we also organized discussions on how to prevent malnutrition, how to save money, and how to practice family planning. Women are also welcome to discuss hygiene, breastfeeding and health-care practices in general.

They come once a week. They are increasingly motivated. The children are cleaner, and the women who come to the sessions are more smiling than before. The weekly meetings had become a must in the village. Now, the people in this group are «ready» to spread what they have learned, and they want this project to be larger and to involve more people. We are going to support them as they open other centers like this one, on their own.



BIBLIOGRAPHY

- **Freud, S.** (1892-1893). *Ein Fall von hypnotischer Heilung nebst Bemerkungen über die Entstehung hysterischer Symptome durch den «Gegenwille»*, [section 3 of *On the Psychical Mechanism of Hysterical Phenomena: Preliminary Communication*,] G.W. I.
- **Schneider, M.** (2002). *Freud et le rapport féminin à la négation*, [Freud and the the female rration to negation]. In *Fatalités du féminin*, PUF.

5 - MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN HAITI (2009-PRESENT)



© ACF, Elisabetta Dozio - Haiti



CONTEXTS AND PROGRAMS

ACF has been present in Haiti since 1989 through various activities in Food Security and Disaster Risk Management (disaster preparedness). These programs were essentially developed in the region of Artibonite (Gonaïves town and a rural area) and in Port de Paix, a zone that was badly affected by two hurricanes, Jeanne in 2004 and Hanna in 2008. During the latter, a mudflow ravaged the Gonaïves region, sweeping aside everything in its path, destroying infrastructure and houses... Our teams observed that the inhabitants, severely affected by this series of natural disasters, started appearing depressed, adopting a posture of great passivity and expressing deep discouragement. It should be mentioned that according to Haitian beliefs, a major hurricane is supposed to hit the island only once every fifty years; yet, this chain of cataclysms contradicted the belief and the population experienced difficulties in organizing the reconstruction process.

In April 2009, a first assessment for mental health and infant care practices has been conducted in order to provide a better understanding of the difficulties encountered by the population. The results showed the interlinking of contextual problems faced by the population over the years (mainly natural disasters and political troubles), with structural issues that explained a global psychosocial vulnerability. The study also highlighted particularly worrying situations in the country. For example, teenage mothers represented a group particularly at risk: they were often isolated, suffering from social exclusion and facing great difficulties in taking care of their children, thereby exposing them to critical situations (high level of malnutrition and high mortality).

An initial project was set up in Gonaïves, in collaboration with the Food Security program that had developed canteens for children under five and their mothers, in order to provide access to an appropriate diet. Discussion groups, individual interviews, support for breastfeeding and mother-infant workshops were first put in place for beneficiaries of these canteens. With the onset of the hurricane season, fears of new possible disasters became apparent, and the memories of the loss and destruction of the previous years resurfaced in an overwhelming way. A prevention program - including group and individual activities and home visits - was developed to support the local population. During the second half of 2009, actions in mental health and child care practices were integrated into existing therapeutic nutritional centers in the Gonaïves hospitals. Various activities were proposed in terms of psychological support and parent-child relationship assistance for malnourished beneficiaries.

The 2010 January 12th earthquake led to the setting up of various new programs aiming to respond as much as possible to the, huge extent, diversity and complexity of the affected population's needs. Indeed, it is generally estimated that more than 2 million people have been affected by the earthquake (230,000 people allegedly died, 300,000 were injured, 1.2 million people became homeless). The effects of this disaster on the country (poverty increase) and on its people (psychological and physical impact of the earthquake) worsen the already existent extreme poverty experienced by a large number of Haitians, while people, with good life conditions prior to the earthquake, have now plunged into poverty as well.

In this crisis context in Gonaïves, ACF ensured the continuity of existing programs while adding new ones in order to support the people in facing earthquake's consequences (massive arrivals of displaced people, no more money sent by family members who were working in Port-au-Prince, mourning, traumatism). At the same time, specific programs in Mental Health and Care Practices began in Port-au-Prince.

The situation in the capital city was tragic, with buildings and infrastructure largely destroyed, and the general situation was highly disorganized. The landscape consisted of destroyed buildings, piles of rocky debris, with camps scattered all over the place, to shelter people who had lost everything in the cataclysm. In Gonaïves the situation was different, since the earthquake did not directly strike



the town. Nevertheless, people who had lost their work and their property during the 2008 and 2009 hurricanes were mixed up with current earthquake victims who had taken refuge in Gonaïves, where there was not enough aid available since the principal humanitarian actors were concentrated in Port-au-Prince.

By working with the populations of both regions, we observed that the general problematic of mourning and other psychological difficulties related to the seismic event (symptoms of trauma, psychosomatic troubles, depression, anxiety, consumption of alcohol, violence...) were linked to significant economic difficulties. The latter often figured in the forefront of demands for help expressed by the population. Thus the work of ACF team of psycho-social workers and psychologists also included referring people to the existing programs, and allowing the expression of problems or symptoms beyond these material demands. This was difficult since people are not used to seeing psychologists and they wanted immediate material aid. Responding to vital it is obviously crucial and should come

first, before being able to tackle other issues. Yet, requests of material help may be indicative of a deep feeling of powerlessness, of an inability to make choices and to control one's life and future, of exhaustion and discouragement in the face of adversity. Such issues could be tackled during therapeutic interviews to mobilize personal resources and energy, to take back control of one's life.

ACF teams encountered many people on the field who mentioned difficulties pre-existing to the earthquake, recounting life-stories punctuated with violence, experiences of abuse, abandonment, rupture, bereavement, and extreme economic insecurity. The earthquake, hurricanes or any other disasters therefore often severely aggravated a situation that was already complex and hard to endure for these people. Repeated natural disasters in the country have brought repeated mourning, loss of houses barely rebuilt, displacements to new zones... This instability and this series of traumatizing experiences has often kept affected people in a survival behavior, has affected their resilience ability and capacity to maintain confidence in themselves and faith in the future, and has frequently generated a strong sentiment of abandonment and isolation. The suffering of beneficiaries was most often expressed in the form of somatic symptoms, the most common of which were headaches, vertigo, and tachycardia, as well as problems of insomnia, loss of appetite and other anxiety and depressive disorders.

Finally, it is estimated that more than half of the beneficiaries were presenting problems linked to the mourning process: denial of the loved ones' death, incapacity to elaborate a bereavement process, idealization of the deceased. The fact that the bodies of the deceased often could not be found and that funerary rituals could not be performed¹, further complicated the mourning process and prevented people from assimilating the loss of those close to them, from investing gradually in the future, and from starting new projects.

In Haiti, where voodoo is very present, victims often interpret a string of natural cataclysms as the effect of actions did by an evil spirit, or the fact of being possessed by one. Confronted to this type of interpretations, ACF interventions have sometimes proved particularly complex...

¹ Dead bodies often cannot be found after a natural disaster. In addition, municipalities were charged with recuperating victims of cholera and burying bodies in common graves.



Along with the impact of the earthquake and cyclones, teams have noticed the great number of pregnant teenagers who were rejected by their families and were living alone with their babies, abandoned by their partners (often either the father is already married or he doubts the baby's paternity before leaving his girlfriend). The situation of young children's health, nutritional state and psycho-affective needs in such a context has proved particularly worrying. Moreover, many pregnant teenagers or mothers were living isolated in situations of great deprivation, and some of them had resorted to prostitution to try to meet their basic needs and those of their child(ren).

In this context, mental health and care practices interventions requested setting up of original and varied projects in order to respond to multiple needs. Some of these projects were associated with other ACF programs (integration of activities into programs for the treatment and prevention of malnutrition and cholera, the establishment of tents for mothers and child, family assistance linked with a program of food vouchers, psychological follow-ups in rural areas linked with an agricultural program, a joint program of incoming generating activities and support for young single mothers). Others were developed in an independent way (support to distressed people and psychological support and prevention in schools, participation in the elaboration of a mental health policy in the country). Faced with the important extent of the needs and the lack of access to psychological care, consultations with local psychologists were offered. Workers of other programs could thus refer intense psychological distressed beneficiaries to these psychologists. Thus, local psychologists insure individual follow-up, work on expression of feelings, on putting them into words, on listening to psychological distress, and offer for the implementation of concrete actions aiming to improve their situation (to define a project and the various steps needed for its completion, to support the capacities required to perform such procedures, etc.). Putting feelings into words and relying on the concrete elements indispensable to the improvement of daily life respond to the immediacy of beneficiaries' needs and is also part of a psychological support strategy. Indeed, by accompanying these persons so that they might take these steps and realize that they are capable of actually improving their daily life and answering their own needs, psychologists work on feelings of self-confidence and awareness of capacity for change. This process also allows beneficiaries to adopt a new dynamic and to get out of the shock/ immediacy which traumatic experiences and/or great poverty has kept them in. It also facilitates the mourning process, makes easier interpersonal communication and new exchanges within the family, and it brings a sentiment of general well-being.

This type of approach is particularly adapted to the context of Haiti, where the great majority of psychologists use cognitive and behavioral approaches. It should be noted that relationship between parents and children always stands for the very core of interventions in mental health and care practices.

Relaxation exercises (deep respiration, exercises reinforcing presence of self, or awareness of feelings, visualization exercises...) are very frequently used by teams in order to bring to beneficiaries techniques that can be easily used in daily life, allowing them to better manage their emotions and their stress, to recover confidence in themselves, in their perceptions, to realize their potential and to mobilize their energy around concrete actions. Focusing on their own physical distress is effective for reducing invasive thoughts of recurrent ideas or images (after a trauma, for example), and for re-centering on oneself instead of concentrating on outside environment and finding oneself "invaded" by an oppressive reality. Becoming aware of their capacities to feel/recover bodily well-being seems essential to these people, particularly after the very difficult experiences they have lived through, and also due to their frequent difficulty in getting access to – or being aware of the existence of – their personal resources. Repetition of these exercises during the sessions allows them to integrate these techniques and facilitates their practice. Patients state that these relaxation exercises (or just deep breathing) have greatly helped them in their daily life.

The expatriate psychologists who ensure the training of local teams have testified to the great efficacy of these exercises, with some beneficiaries showing spectacular changes of attitude after just one or two sessions... While the impact of therapeutic relationship, of listening and paying attention to them and the general support they experience during interviews are all fundamentally important, the regressive and motherly aspect of these techniques also accounts for their very positive impact. Considering the great diversity of programs set up in Haiti, we have chosen to give a more detailed account of 6 programs, illustrated with stories of beneficiaries monitored within this work.

PSYCHOSOCIAL SUPPORT IN MOTHER BABY FRIENDLY TENT PROGRAM (2010–PRESENT)

The baby-friendly tents program was developed in Gonaives, then in Port-au-Prince a few days after the January 2010 earthquake.

The goal of the baby-friendly tents program is to support mothers, their children and the parent-child relationship, but also to prevent morbidity and mortality among children under two. Even before the earthquake, the maternal and child health situation was not very good; there were significant levels of chronic malnutrition and micronutrient deficiency. In this crisis situation, vulnerable people - particularly very young children and



© ACF, Lucile Grosjean - Haiti

pregnant or lactating women - were increasingly at risk, for emotional, psychological and material reasons. Many families found themselves in difficulty with their infants: they had lost their property and were overcrowding under tents with difficult access to water and hygiene. Women were often alone; some of them were in a state of shock and were having difficulties to provide adequate care to their children, whose general health was deteriorating.

The program targets mothers and infant first and foremost, but also welcomes all child caregiver. We will therefore use the term “mother,” but this should be understood as the person providing care to the child.

In the baby-friendly tent, our team offered mothers and their children a place where they could “take their breath” and feel at ease, where they could receive attention and psychological support, and where a relationship of trust could be built with the teams. A tremendous amount of work was done in supporting and listening to these mothers, taking their feelings and beliefs into account.

To accomplish this, beneficiaries were offered individual mother-child psychological support, as well as group psycho-education on a variety of topics, such as pre- and post-natal care, care for pregnant and lactating women, breastfeeding, and food diversification. Significant work was done in the area of mothers’ beliefs. For example, a certain number of mothers thought that they no longer had any milk after the earthquake because the milk had risen into their brains, which explained why they felt sad or why people in the community sometimes considered them as “crazy”. Because of this belief, they stopped breastfeeding, thinking that indeed they could not produce any more milk. These



women felt stigmatized because they were “sad,” and it was important to explain to them the normal signs that are likely to emerge in response to a catastrophe or an “abnormal” situation (crying, suffering, sadness, anger, agitation, despair, etc.). Another local belief requires that at birth babies should be given a blend of herbs to drink. Since the water was not drinkable, infants with low birth weights could quickly become malnourished. The team therefore explained to beneficiaries, beyond that belief, the benefits of colostrum ingestion and breastfeeding for the child, offering support to mothers in infant care practices. Mothers were gradually able to talk about their wor-

ries, their concerns and their beliefs without fear of judgment. They reacted positively to the listening and advice provided to them.

These group sessions were gradually extended to other types of participants, and we implemented discussion groups for men and elderly women in order to reinforce our actions by raising awareness within the community on the issues of malnutrition, child care, maternal care and parent-child relationships.

Elise's story: Becoming suddenly the head of the family¹

“We met Elise in July 2010. She came along with other victims of the earthquake to ask for support from a psychologist with the ACF team. Initially, Elise was very reluctant to talk about her situation and express the difficulties she was facing. To help her do so, the psychologist mentioned that he had heard her talking to other beneficiaries before her personal session. The other people in the group were commenting on their situation, saying that “nothing will ever be the same” and that “there is nothing more to be done, because it’s all over.” Elise then spoke up, saying that in her opinion, “although nothing is the same, it isn’t all over. Even if someone has lost everything, they still have a chance to rebuild some things, and above all to rebuild themselves.” The psychologist praised this attitude, highlighting her optimism and the difficulty she had to overcome in order to assert herself that way among other people who all agree on an opposite point of view. Elise’s attitude in the session changed after that comment, and she was able to begin to tell her story.

She was able to talk about her children’s father, who died during the earthquake, as well as about her tremendous economic difficulties and her inability to meet her basic needs and those of her children. She was able to express the intense suffering she has been experiencing due to this situation (she rated her suffering on a 7 point-scale out of 10). Faced with the economic emergency, Elise asked that priority should be given to working on her financial autonomy issues. The psychologist proposed to move forward step by step, suggesting first working on her emotions, and then identifying her personal, family and community resources in order to identify a goal and marshal her resources to achieve it.

Elise agreed to come for personal sessions once a week, for at least one month. Before ending this first session, the psychologist suggested that, in preparation for the next session, she think back on how she felt when she found out the father of her children died, about how she lived through that difficult experience, both emotionally and in terms of her physical feelings and her behavior. This way,

¹ Case reported by Bayard Brutus in Gonaïves.

the psychologist wanted to work on what the deceased person meant to her and to assess where Elise was in the grieving process. The psychologist began the second session with a relaxation exercise, aiming to help Elise listen to her feelings and her needs, while being less overwhelmed by the thoughts and practical concerns of her daily emergency situation.


Next, Elise spoke of the circumstances of her children's father's death. After the earthquake, she went looking for him. When she arrived at his house, she found that it was halfway collapsed, and she heard him talking from under the rubble; he was saying that he was not dead, and he asked for water. When she heard him, she alternated between reactions of paralysis and agitation. She experienced sensations in her stomach, as though "something was gnawing at her insides." The father of her children was eventually given water. Then, there was another tremor and Elise no longer heard his voice. At that moment, she tried to enter what was left of the house to get him out of the rubble, despite the danger this put her in. Other people who were there held her back. She remembered that she was crying, that she was saying the father of her children was not yet dead and that they needed to get him out of the rubble to bring him to the hospital and take care of him. She felt extremely powerless in the face of these events. Later on, she long wondered why all of this happened to her and what she had done to deserve such a fate. These questions were constantly on her mind, and she had the impression that "everything was muddled in her head." She could no longer sleep, and she had headaches and pains throughout her body. She also had a lot of difficulties eating. She expressed how she had been overwhelmed with grief and explained that she had remained in a state of prostration for several days.

Subsequently, she was able to work with the psychologist on what the father of her children represented for her. She explained that she did not live with him; he was married and lived with his wife. Elise had a business that provided her with income, but he helped her financially so that she could take care of the children and meet her own needs. It is these means of meeting her needs and those of her two children that she considered to be missing the most. Through her precarious situation, she felt herself becoming a burden on her own mother, and felt very devalued. Those with whom she had spoken about her situation had advised her to quickly meet another man who would be able to help her financially. Despite her economic situation, Elise had reservations about that idea. She was afraid of becoming the mistress of a married man or of being exploited.

At the end of that session, the psychologist proposed that, at their next meeting, they work on the resources (of all types, not exclusively financial ones) available to her. In the meantime, he invited her to reflect on her abilities and on what she likes or would like to do in order to get an income, and to identify people who might be able to support her.

The third session started again with a relaxation exercise (identical to the first one). Since the previous session, Elise had thought about the things the psychologist had suggested to her, had taken stock of some of her resources and had started to put her energy towards a plan for a job. She thus foreseen starting to work again (she had unskilled labor and business experience) in order to regain financial autonomy. She was able to talk about the support her family (mother, sister and brother) gave her and the comfort they brought her. However, her psychological distress remained significant, and Elise realized that she had to stop being idle in order to do better. She seemed more eager to invest herself in an income-generating activity. To support her in this effort, the psychologist offered her a visualization exercise on this activity (imagining what she might do in practical terms, the changes this would bring for her and her children, her feelings, etc.). He then worked with her on practical steps to be taken to make her project happen; particularly identifying people likely to provide her with financial and moral support (Elise chose to develop a small rice business).

The psychologist suggested roleplaying to Elise in order to help her gain confidence to achieve these steps. She left the session with fewer worries and feeling visibly better.



As during the previous sessions, the fourth one started with a relaxation exercise. Elise then related that she had been able to contact people around her who can support her in her project and presented her rice business idea to them. She received promises of loans as well as several expressions of support (the grandfather of her children offered to take care of his grandchildren's education and to give her a bit of money, several friends promised to lend her a sum of money, a cousin in Port-au-Prince offered to help her find a job there, etc.). These promises far exceeded Elise's hopes, and she expressed a great deal of joy and confidence in making her project happens. The psychologist highlighted and praised the fact that she was able to get so much done in one week. It was decided that, while she waited to receive the money she had been promised, she would identify additional resources and work on the possibility of getting a job, because she felt it would be possible to run her business while handling another job. She also talked about a close friend who motivates her and provides her with moral support, and whom she considers to be a particularly precious human resource. Over the next week, Elise planned to identify additional resources and to take steps to get a job. She left the session confident and visibly optimistic.

Elise arrived late to the fifth session. Her daughter had suddenly fallen seriously ill, and Elise had been very afraid for her. A member of her family had consulted a "houngan"¹ » who had said that the child's father had come to get her. Then, the priest carried out a ritual to prevent the deceased from approaching the child. The child was currently doing better; she was eating and playing with her brother and the other children. Elise said she felt relieved, even though she said she needed time before she could chase completely away the anxiety she experienced.

Next, she explained that she had been able to get a job, but that she had eventually turned down the position. Indeed, she had been offered a team leader position in the construction of gabions (panniers or cages used in the building industry), but Elise had learned that there were snakes on the site, and she is very afraid of those animals. However, that difficulty did not affect her determination and she was busy finalizing the paperwork to be sent to her cousin in Port-au-Prince so that he could help her find a job. Elise told us she was certain that these efforts would bear fruit and expressed greater confidence in the future. Although the father of her children was still on her mind, Elise was gradually learning to live without him. The community support she was able to find around her provided her great help. She stated that she now had confidence in her ability to improve her situation by herself. "I moved from darkness into the light," she said. She was currently convinced that she made the right choice when she refused to enter into a relationship with a married man or a man who would have viewed her as no more than a sexual object. Elise stated that she thought she no longer needed the sessions because she felt she was doing much better. She rated her suffering on a 5 point-scale out of 10, because she is aware that she still has progress to make. She imagined that her suffering might decrease to a 2 or even a 1 over the next few weeks, when she expected to have been able to start concretely setting up her professional project.

Elise left this last session smiling and expressing her gratitude towards the team: "You have given me more than money; I will use what we have done together to overcome other challenges."

We can notice that this psychological support was brief but led to very positive results. Elise was undoubtedly "ready" to begin the mourning process and to be invested in a change process (as illustrated by the optimism she expressed at the first meeting - which accounts for an important position in mobilizing resilience abilities). Perhaps Elise is also one of those people who could adopt coping mechanisms (for example, due to an experience of extreme poverty) and among whom we very often observe very rapid development and progress when psychological support is offered to them. Such

¹ Vodoo priest.

people strongly invest the relationship with the psychologist (or the psychosocial worker) because the psychological support responded to fundamental needs: due to their hard life conditions, punctuated by disruption, violence, loss, etc., this population has never had the opportunity of expressing their feelings (our teams working in Haiti have noticed emotional blunting and extremely difficult expression of feelings with beneficiaries having experienced grieving and loss, which are typical elements of traumatic impact). Everyday life consisting of trying to meet one's basic needs and responding to emergency, does not allow stepping back and taking time to take stock on one's situation, to assess one's needs nor to trigger a change process.

The disrupted sense of time¹ (and sometimes also the impact of traumatic events they experienced) prevents these people from thinking ahead and from planning actions (even simple ones) they might take to improve their situation.

They live in real times with no anticipation, sometimes in repetition mechanisms. Meeting with a professional (psychologist, psychosocial worker, etc.) who listens to them and helps them to identify their needs, to express and work on their emotions, leads them to gain the perspective needed to begin a chance process that will improve their situation. Of course, the professionals' attitude towards them, faith in their abilities, lack of judgment, and so on, are critical elements that help beneficiaries to develop self-esteem and confidence in their future.



Elise's story also illustrates the importance of focusing on concrete steps and suggesting actions that improve the person's real situation, when the person lived through a tragic event, is experiencing intense suffering and has developed various somatic symptoms following that event. This process aims to support the person and enable them to rally their energy to focus on a project. The therapist, by being there and listening, is a witness to the actions that the person is capable of concretely affecting. In this way, the therapist leads them to become aware of their abilities and to realize the results they are able to achieve. This process enables a transition from a static position, a state of shock and/or of prostration towards a more active state. The change from passivity, dependence and helplessness to an active, independent position reinforces their sense of being an individual who is capable of decision-making, action and change.

This example shows the extent to which work to strengthen social networks can effectively fight isolation, act on a depressive experience, secure daily support, improve self-confidence and overcome feelings of inferiority.

The issue of mourning, which is central to this case, seems to be illustrated in a very interesting manner through Elise's daughter's illness, caused by the presence of the deceased in the family. Recourse to cultural resources to protect against it through the intervention of the houngan enables delineation between the spaces inhabited by the living and the dead; the ritual holds that the deceased father concretely moves away from the family—which could be understood, from a Western perspective, as a distancing from the uncontrollable presence of the trauma in the individual's mind and the initiation

¹ Observations gathered from family support programs in Asia, among populations living in extreme poverty have shown an ability to plan the future on a three or four days basis.



of the grieving process. The voodoo ritual serves to protect the family from invasion by the deceased/ death—and from the danger that it/he might remain present (as is the traumatic representation), invading daily life and keeping the family in the immediacy of the traumatic scene, with time suspended, frozen. Following the ritual, the deceased and the living people have been separated and the former can no longer invade the space of the latter. It can be noted that Elise’s daughter fell ill after Elise



© ACF - Haiti

had been able to reconstruct a supportive social network (in addition to the psychologist’s support) and concretely realize that she is not isolated and that connections are possible.

Did the presence of the living eventually replace the occurrence of death? Elise herself stated that she had “moved from darkness into the light.” This evokes a “return to life”, which implies action, (renewed) investment and thinking ahead, after being overwhelmed by death and trauma, which is immobilizing. ACF workers in Haiti have told us how beneficiaries were affected by talking about their deceased loved ones, and thus beginning the mourning process. They often say that the ghosts of these people become less present, less intrusive in daily life, and gradually interfere less in the life of the living. Beneficiaries then develop means of better defending themselves from the presence of the dead (generally through traditional or religious resources, as in Elise’s case) and are able to better handle the emergency situations they encounter daily. This shows the need to have programs work

in harmony with existing cultural belief systems, not against them.

Although Elise raised the question of guilt regarding the death of her children’s father, her psychologist did not deal directly with this issue but rather from an implicit manner, when Elise evoked the deceased.

We noticed that at the time when Elise is taking distance with the deceased by investing new social relations and new projects, her daughter is falling sick. Is it the “return” of the deceased an expression of feeling of guilt because Elise is doing new projects while she is invested in a mourning process...?

HOLISTIC (ECONOMICAL AND PSYCHOSOCIAL) SUPPORT PROGRAM FOR TEENAGE MOTHERS¹ IN GONAIVES (2010-2011)

This program aims to reinforce the resilience capacity of teenage mothers who have been socially excluded and are living in deprived areas in Gonaives, through personalized individual and/or group support and through material and technical assistance for the development of the income generating activities.

After the 2004 and 2008 hurricanes, which seriously hit the town of Gonaives, the economic activities were strongly affected. Indeed, the town was flooded and 80 % of its area buried under mud which resulted in a loss of mainly all inhabitants’ capital and supplies. A large proportion of the population lost their economic activities, leading them to be dependent from external help (donations, begging and money transfers) and increasing their precariousness.

¹ IGA/PSY program = Income Generating Activities/ Psychological Support Program.

In various surveys and interviews conducted by ACF staff several months after the disasters, it was brought out that an important proportion of the families had still not been able to start an economic activity and was forced to destructive survival strategies (debt, prostitution, begging, migration...). Migrations from Nord Artibonite and in particular from Gonaives to Port-au-Prince have been important for several years and motivated by various factors: fleeing from Gonaives natural disasters since 2004, job shortage, lack of academic education, rural areas structurally deficient at food and health levels, etc.

After the 2010 January 12th earthquake, people who migrated to Port-au-Prince returned to their origin region and in particular towards Artibonite region. In a context of economic breakdown such as the one in Gonaives, the capacity of the hosting families to absorb additional inactive people was obviously limited. This population displacement towards Gonaives and its surroundings only intensified the already existing major problems as well as the risk of impoverishment and urban violence. It should be noted that the unemployment of the youth (under the age of 26) is particularly important and that the work of women has been more affected than the work of men.

After the various hurricanes and the 2010 January 12th earthquake, a part of the population of Gonaives had to seek refuge with relatives for months, which created familial separations, tensions and disruption of social network. People lost their familiar landmarks and social resilience was hindered in the crucial times of recovering and events' ritualization.

According to the EMMUS IV¹, children in rank 1² are particularly exposed to child mortality. An important vulnerability factor is the age of their mother: the children of teenage mothers are particularly at risk. This vulnerability criterion is confirmed by the national staff of various NGOs specialized in the treatment of malnutrition (ACF, Concern). Those mothers are particularly unable to provide care to their children as they lack knowledge about the needs of their children.

In Gonaives, it is the national ACF staff in charge of the programs "cash for work" as well as the representatives of women associations that have drawn attention on this population. Indeed, according to them, these young girls are vulnerable at several levels. Teenage pregnancies carry great stigma and girls are very quickly taken out of school and potentially rejected by their families and communities. They then fall into critically precarious situation and resort to dangerous survival mechanisms (looking for a partner to ensure food or official prostitution), which exposes them to many risks: HIV, other pregnancies, discrimination and a still greater stigmatization and exclusion...


During an assessment conducted in 2009 by ACF on the needs in mental health and care practices, discussion groups with these young girls were organized to question them on their economic and psychosocial situations, as well as on child mortality issues.

Discussions highlighted their particularly difficult psychosocial situation as shown by their testimony:

- one teenage girl out of two voiced suicidal ideas. Teenage girls generally had a very poor self-esteem and felt ostracized and discriminated.
- socially speaking, some of these teenage girls did not actually have any familial support and could only count on some neighbors. Some others were living with members of their extended family or with their parents - but these welcoming people seemed very vulnerable (one member of the family being disabled, nobody in the family works...). Cohabitation is most of the time very badly lived.
- one teenage girl out of three had experienced death of an infant; it was brought to the fore that the causes of the death were mainly due to inadequate child care practices due to lack of appropriate knowledge.

¹ Survey on mortality, morbidity and use of services undertaken in 2005/2006 by the l'Institut Haïtien de l'Enfance.

² From rank 5 on, children would be at high risk. Another criteria of vulnerability is the time between each pregnancy: the shorter it is, the higher the risk of mortality.

- 
- these teenage girls were generally deprived of social abilities; for example, few of them dared getting out of the neighborhood by fear of rejection.
 - work possibilities for these teenage girls were very reduced and precarious; those who did not resort to prostitution were working at neighbors' cleaning some houses damaged by the hurricanes, they had no idea or plan for the future.

These interviews confirmed the vulnerability of this population and the risk of mortality of their children, mainly because of inappropriate child care and malnutrition.

Within the framework of individual clinical interviews, it was identified that these young women are concerned with survival at such extent and are in such a despair state that they neglect their own emotional needs. Anyway they have little option for a constructive expression of the latter, nor the means to answer them. Anyway, they cannot even receive a minimum of mothering to support them in their own process of maternity, nor identify themselves to a positive and structuring motherly representation. Thus the possibility they have to identify with their own children and their ability to develop satisfying affectionate relationships with them are seriously limited. They enter in parallel in a process of “self-exclusion”¹ which leads them to isolation and prevents them of benefiting or using services to which they could have access by thinking that, because of their situation, they are not entitled to them.

Considering the social and economic situation of Gonaives and the extreme vulnerability of these teenage mothers who were in both social and family rupture, the program aimed to reduce mortality and morbidity of children under five, with an economic and psychosocial program for the young teenage mothers.

This program wants mainly to support the development of capacity to project oneself, to set up a project or even to picture oneself within a social and family network through the reinforcement of individual and collective resources, and resilience abilities. The intervention does not aim only at triggering an economic activity, but also at accompanying a population towards economic and social integration and to a personal reconstruction in a holistic approach.

Three centers have been opened for those teenage mothers, offering nursery activities, group activities and training as well as psychological counseling. A medical care system was also developed for these mothers and their child/ren.

This service was created on the belief that these women were might be suffering from medical problems. The reality proved that their medical state more catastrophic than expected (for example, most of them were suffering from anemia, urinary infection, vaginal infections, various sexually transmissible diseases...).

Trainings aimed at teaching the teenage mothers the basic principles for setting up and sustaining incomes generating activities. Individual psychological follow-ups aimed at supporting the emergence of a personal development plan by working on individual difficulties (suicidal ideas, depression, self-esteem, bereavement, difficulties in thinking about the future, mother-baby relationships, etc.) and strengthening defense and resilience mechanisms.

How to receive what is good, when you have never experienced it?

Gladys, 19 years old and her 2 years old daughter Sofia, spent three months in the ACF center. Gladys took part in developing income generating activities training sessions, as well as psychosocial activities, aiming at reinforcing her self-esteem, her individual abilities and strengthening the mother-child bond.

During the medical assistance provided at the health center, we learned that Gladys and her daughter had syphilis (a proper treatment was given to them).

Gladys was quickly referred to the Haitian psychologist of the program, because she was in conflict with the other teenage mothers, she appeared aggressive, was often absent and seemed to have difficulties in the relationship with her daughter and the cares provided to her. In fact, the body

¹ Cf. Furtos' writings.

hygiene of the child was often neglected, Gladys did not answer adequately to Sofia's requests and needs, the exchanges between the two of them were rare and Gladys often answered to her daughter in an aggressive or violent manner. Gladys lost her mother as a child and when she got pregnant her father threw her out. She survived through occasional prostitution or thanks to irregular small jobs (laundry washing or housekeeping), by stealing and/or thanks to the generosity of some people in the neighborhood. She did not keep contact with the father of the child. She lived in a small room with her daughter and had to take every day her neighbors' insults.



During the psychological care, Gladys was able to explain her aggressiveness towards the others. The attention and the interests shown to her in the center seemed to have overwhelmed her. As she was getting aware of this situation, her behavior tested the limits of this kindness shown to her. The team suggested that she did activities (such as drawing) to allow her to express herself and represent her feelings. This way of expressing herself helped her to be less aggressive and enter in relation with others around her. Little by little, Gladys attitude in the center seemed to improve even if at times, she was missing or still clashed with other beneficiaries, trainers or psychosocial workers. As for Sofia, following the treatment against syphilis, the wounds and scabs on her face disappeared and she interacted more with the other children. At first, the little girl tended to stay behind, the other children were laughing at her and she was answering either aggressively or in withdrawing into herself. Sofia did not speak and like most of the children in the center, had important delays in her psychomotor and cognitive development. Activities in the nursery accelerated the development of this child who had been little stimulated until then. Some psychological assistance sessions took place with both the mother and the child. With the support of the psychologist, Gladys tried to talk, to explain things to Sofia. The relationships between mother and child improved greatly and even if Gladys still communicated at times with aggressiveness and/or violence with her daughter, once she was calmed down, she has taken the habit of putting words on her attitude and excusing herself to her daughter, thus making her feel less guilty.

One month before the end of the program, Gladys told us she was pregnant. She said she was delighted by the news for her new boyfriend would not leave her then. The latter, she said, treated her well as well as her daughter. However, she was worried about how she would be able to provide for the needs of another child. A few days later, when the psychologist arrived at the center, Gladys got near with a big smile; she had sanitary pads in her hand. She explained that she was in "perdisyon". According to Haitian belief, "perdisyon" is the temporary stopping of the development of the fetus and thus of the pregnancy. The causes of this phenomenon are of supernatural origin. Having been made aware of contraception and birth control issues, Gladys asked whether she could go on the pill as she was in "perdisyon". A few days later, a psychosocial worker took her to the health center so that she could get a contraceptive pill. Gladys was delighted, consciously or unconsciously, she had found a culturally acceptable explanation allowing her to stay with her boyfriend without having another mouth to feed.

Gladys who, upon her arrival at the center, was a young woman with a closed expression, often aggressive and who did not take much care of her child, has become a smiling young person, aware of her abilities and individual resources who links with other teenage mothers and has a more than satisfactory relationships with the little daughter.



When she left the center, Gladys received her “IGA kit” and began her own small business. The staff of the program pays regular visits on the market or at home to be sure everything goes well for her.

MENTAL HEALTH AND CARE PRACTICES PROGRAM INTEGRATED WITH TREATMENT OF MALNUTRITION PROGRAM (2008 – PRESENT)

Overall, severe acute malnutrition is not very widespread in Haiti, but we do see substantial malnutrition in some areas. In response, ACF has developed a program to support the Ministry of Health in establishing treatment of malnutrition in Artibonite. This means on one hand, working on a national malnutrition treatment protocol and on the other hand, training hospitals and health centers staff in the medical treatment of severely malnourished children. In this type of project, ACF adds a health care practices component that includes, at a minimum work on child reception, caregiver/care beneficiary relationship, and stimulation of the child. In Artibonite, given the psychosocial issues and the profile of severely malnourished families and children (especially teenage mothers’ children), we have improved this component by adding a psychologist who can conduct both individual interviews and group therapy sessions.

Robenson: Strengthening a father-son relationship¹

Mithson, aged six months, was admitted to the Nutritional Care Unit of the Hôpital de Secours with his father, Robenson. Psychological counseling was therefore proposed on this occasion.

Robenson is 39 years old. He had five children, out of which three of them have died. His wife died of cholera eight days after Mithson was born. Since then, he has been the child’s sole caregiver. Robenson has clearly been very affected by his wife’s death. He repeatedly says that the child would not be ill if his wife were alive. At first, Robenson bought canned milk to feed Mithson, but because of his economic situation, he was unable to continue, and began preparing solid food for him.



© ACF, Lucile Grosjean - Haiti

Robenson is a farmer and apprentice bricklayer, but he has no stable work. He tells us that his situation has worsened considerably since the death of his wife, who had regular income from her trade. Furthermore, as he is now alone in caring for his children, it is very difficult for him to work. He mentions that his neighbours help him out from time to time.

Robenson appears to be a very caring father to his children. However, he says that, despite his efforts, he often feels «incompetent» to take care of them. It is true that his wife did all the child-rearing, and Robenson is not very good at identifying their needs, bathing them, and so on. When he saw that Mithson was losing a lot of weight, he took by himself the decision to bring him to the hospital and get him admitted. The child has good appetite, but Robenson says he cannot feed him enough, though he would like to. When the child cries, his father says, he often is at a loss to identify what Mithson needs, and has trouble coming up with sui-

table responses. All of these difficulties are a cruel reminder that his wife is gone. Sometimes, he says, he cries when he feels overwhelmed by the situation.

¹ Case followed and reported on by Jules Luckson.

Since their arrival in the Nutrition Care Centre, Robenson says he is confident and optimistic that his son's condition will improve, because he is drinking therapeutic milk with great appetite, and Mithson's behaviour is changing little by little as he becomes happier. Robenson shows how eager he is to listen to all the information provided to him by the nurses, and the companion mothers in the NCU. «My child is in God's - and nurses' - hands,» he says. Robenson is taking an active part in the support group, and the team notices the affection he shows to Mithson. This investment has seemed like a true asset, both to his son's successful treatment in the Nutrition Centre, and to the psychological follow-up. During the interview with the psychologist, we see how Robenson tries to meet the child's needs. For instance, when the child cries, he takes him in his arms and rocks him to calm him and stop the crying. However, he is hesitant and awkward. We also see that the child reacts little to the stimulation of the toys and has a faraway look.

The team focused on and supported this father's motivation and efforts, despite his critical situation, to help him reinforce his self-confidence. Observations of the child's progress were also explained in great detail.

In view of the urgency of this father's - and his children's - situation, psychosocial support was geared toward improving his social network, his economic situation, and working on verbalizing his emotions, on reinforcing the father-child relationship and stimulating the child through play.

Fairly soon, Robenson says that it is taking him less time to identify the child's needs (hunger, thirst, feeling hot, needing to be cleaned, etc.). He also says he is ready to ask his friends and neighbors for help in taking better care of Mithson. In addition, he points out that he has been having trouble washing the family's clothes since his wife's death (she used to be in charge of laundry at home) and is thinking about solutions to solve this problem.

The psychosocial team worked on the father-son relationship during play sessions, showing him he needs to play with the child (with or without toys) and the importance of play for his development. Robenson said he loved tickling his son and jiggling his hands in front of him, which Mithson responded to with pleasure, laughing a lot.

We noted that at the beginning of the counseling, the child reacted little to the stimulation, and was fearful of strangers. Gradually, Mithson became less insecure, playing and laughing with other people too, and looking for more interaction.

On the financial issues, the team supported Robenson so he could improve his economic situation. He discussed some ideas for income generating activities and identified some people who were likely to help him achieve them.

When the psychosocial counseling was over, Robenson appeared optimistic, because his baby was eating heartily and gaining weight quickly. After a few weeks of treatment at the NCU, Mithson was transferred to the outpatient nutritional center.


We see that although this father's situation remains precarious, both financially and regarding the care he is prepared to give to his children (nutrition, hygiene, etc.), he does show a strong desire to improve, ask for support, invest in the relationship, and apply any advice that is given to him.

This attitude, and his ability to ask for help and use existing mechanisms, is very positive factors for this family's future.

FAMILY SUPPORT PROGRAM GONAIVES (2011)

The Family Support program was set up in the city of Gonaives as part of a coordinated Food Security pilot project (food voucher distribution) and access to Water and Sanitation (rehabilitation of anti-cyclone shelters). The initial project had been defined after the earthquake of January 12, 2010, for the refugees from Port au Prince and their host families in Gonaives.

Before activities began, the cholera epidemic had hit the North Artibonite region hard, and we had to



adapt the program and focus our action on people who had survived multiple potentially traumatic events. Indeed, these families shut themselves away, suffering discrimination because of their socio-economic or health situation (with one or more members having cholera). All of the targeted families were cut off from social ties, had a poor image of themselves, and no longer trusted outside authorities. Most of them did not have the information required to help them meet their needs or improve their overall situation.

The family support program offers regular in-home counseling by psychosocial workers for the poorest families. It means supporting these families to identify and prioritize their needs, develop their ability to respond appropriately, and use existing services to improve their living conditions and develop their autonomy.¹ This approach implies listening and improving self-confidence. In addition, the parent-child relationship is the focus of family support, and is sometimes the primary factor and objective of the counseling.

These are the results expected in beneficiaries:

- Supported and counseled families improved their self-confidence and their skills, and acquired the abilities required to meet their needs and resolve their difficulties.
- Families are able to identify their needs and use the existing services to tackle them.
- Parents are able to meet their children’s emotional and educational needs. Children have the opportunity of developing their full potential.
- Families are prepared to carry on the results obtained and to keep improving their situation at the end of the in-home psychosocial support.
- The team is prepared to provide screening and prevention of acute malnutrition in children under five by improving the parents’ practice of appropriate caregiving.
- The team ensures that the caregiving practices do not suffer from any disruption (earthquake, cyclones, cholera).

By establishing the family support program, it becomes possible to strengthen the impact of the other actions set up in Gonaives, to improve understanding of the context in order to adapt programs in the most appropriate way and not to further dismantle the social or family environment or interfere with their abilities to handle events.

Family support teams (in Haiti or elsewhere) often see that some families display knowledge on the topics that are relevant to them (e.g. the rules of hygiene or young children’s needs), but are incapable of applying them in real life. For these families, then, the change in attitude and the concrete application of appropriate caregiving practices require a personalized and individual approach as part of behavioral change support.

Indeed, the fact that beneficiaries are putting all their energy and attention into adaptation and day-to-day survival, combined with the impact of the crisis on the mothers’ (or stand-in mothers’) mental health, complicates the way that care is given to young children. Hence, the work on re-establishing a trusting relationship with a professional takes on a critical aspect, even as there has been a loss of confidence in the physical and human environment. We have noticed that going to meet the beneficiaries at home (regardless of the home’s condition or the outside environment²) often makes it possible to more quickly establish a relationship of trust and active aid that is more rapidly invested in by family members. For beneficiaries, this process involves a sometimes dramatic reinvestment in their existence, as they return to an active position; the development of income-generating activity; a change in their living conditions; and improved communication and relationships within the family...

In addition, home visits can include the different family members, potentially give rise to mediation if there is a conflict, and restore communication within the family. This allows the team to acquire

¹ This program is based on a methodology developed by Inter Aide and adapted for the prevention of malnutrition by ACF.

² Sanitary conditions are most often very poor in the areas inhabited by these populations.

detailed knowledge of the family dynamic and of different aspects of their daily life and of their existing needs, as well as positive or problematic issues in the family's functioning.

Very often, coordination with the psychological support program for people in distress, and the opportunity of providing psychologist counseling to some beneficiaries (especially in situations of difficult or pathological mourning) has, in addition to the greater well-being resulting from this counseling sessions, made it possible to step up the changes in practice and to develop greater autonomy. We saw that the families wanted this support. Moreover, they proved themselves very involved in the work, even when they were no longer receiving food aid from ACF. Many of them were proud to be visited by a psychosocial worker who made time and space for dialogue. As they recovered their self-confidence, they often also resumed their activity, had a change in attitude about their children, or took initiatives that had not been defined or worked on as objectives after the initial needs analysis performed with the psychosocial worker.

Marie, a story of loss

Marie, 27, lives in small low house in a poverty-stricken neighborhood. She shares this dirty structure with her brother who has contracted cholera. Marie appears sad and frail. Yet, this young woman has good personal hygiene habits and dresses neatly. Our staff considers her very warm and friendly. She is able to buy local fresh food through the food vouchers provided by ACF.

Marie was displaced from Port-au-Prince to Gonaives following the earthquake on January 12, 2010, when her house collapsed killing her husband and her two children (1 and 4 years old).

Marie shows symptoms of flashbacks of the traumatic event. Because her husband and children are always in her thoughts, she has difficulty coping with their death and the start of the grieving process. For example, when she returns home, she often thinks that her husband and children are waiting for her in the house. Marie suffers from a variety of somatic complaints, including insomnia, loss of appetite, tachycardia, headaches, and fatigue as well as symptoms of severe anxiety and deep depression.

Her husband was a mason and family's sole breadwinner; Marie never had a proper job. She was then alone confronting a very critical economic situation. After a few months, she opened a restaurant on wheels ensuring a minimum income for her survival. She found outlets for her sorrow and comfort through building ties with her neighbors and joining a religious group.


During our second meeting, Marie was able to talk about her story and the loss of her family. She expressed very painful emotions, the depth of her suffering, and the full extent of the void left by the passing of her loved ones. «I was not like this before. The loss of my husband and children has left me in this condition,» she explained. To make her words more vivid, she held up photos taken before the earthquake. Indeed, she looked in better health condition, glowing with confidence and pride. Encouraged by staff, Marie sought counseling from an ACF¹, psychologist. It was indeed essential to obtain psychological support before addressing other issues, given the depth of psychological suffering and difficulty stemming from the loss of her family.

The psychologist treating Marie focused on the process of grieving over her husband and her two children. She was therefore able to move from denial to depression. In addition to clinical interviews, the psychologist prescribed deep breathing exercises for Marie at the end of each session. He recommended practicing this exercise several times a day including in the morning and in the evening before bedtime. Marie was also advised to breathe deeply whenever she had symptoms of tachycardia, fatigue, or any other somatic disorder. These exercises allowed Marie to relax, regain her physical well-being, and control her emotions. At the beginning of the treatment, Marie rated her suffering as high as 6 on a scale of 10.

Along with this treatment, the psychosocial worker suggested to Marie that they work together to carry out guidelines for dealing with hygiene issues. Since her brother was affected by cholera, it was important to inform Marie about preventive measures for this disease.

Working on hygiene issues (such as water treatment, hand washing, etc.) was well received by Marie

¹ The proposal for psychological support depends on the situation and the diagnosis of the family; but it is not always necessary.



and proved to be efficient: she complied and followed hygiene rules and her house became cleaner and fresher. At the end of the home-based follow-up, Marie was still chlorinating water and cleaning up her surroundings to protect herself from diseases.

Marie realized that she felt much better after visiting the psychologist, and that the follow-up by the psychosocial worker provided a source of valuable support for her. Our staff observed steady and gradual changes in Marie including a return to her normal weight, a glow in her face, and a warm and happy demeanor.

The combined efforts of the psychologist and the psychosocial worker had a positive impact on the improvement in Marie's mental condition. In addition, she sought medical consultations at the hospital where the physician responsible for her follow-up treatment also noticed dramatic improvement of her mental health condition.

During the last psychological treatment session, Marie realized that she was doing well. She had more control over her emotions associated with the difficult experiences that she had gone through. On a scale of 1 to 10, Marie rated her suffering at zero.

Johanne: from the perception of fate to positive control over her life

Johanne, a participant in the «Koupons Manjé Fré¹ Program, is a young woman from Gonaïves. She meets the psychosocial support criteria and therefore qualifies for home visits with family support. She resides in a neighborhood made up of intertwined alleys without names. While looking for Johanne's house, I fortunately came across a program participant who graciously led me to her street. Once there, I asked where Johanne resided; but unfortunately no one seemed to know her. After several inquiries, a young man said, «Maybe you mean Dou. Go ask for her over there by the fence.» I met Johanne's twin sister. I explained to her why I had come and scheduled a meeting with Johanne. Their alley is dusty or muddy according to the season and children play there alone like abandoned waifs.

The next day, I met Johanne. She and her sister were like two peas in a pod except for their life stories. Johanne is young and tall and smiles when you meet her. Physically she is all skin and bones. We easily made the first contact.

Johanne lives in a house that was formerly a two-room house with a tin roof. But only the devastation from two hurricanes remains. The fence is made of pieces of wood and the walls are eroded by water. The kitchen and bathroom were destroyed. The front yard serves as the living room where the family welcomed me under the burning heat of the sun. Johanne and Dou, both 27, are the oldest in the family of six children. Their brothers and sisters are respectively 21, 20, 18 and 16. They are the children of three different fathers who left them to be raised by their mother. Johanne has three sons aged six, three and two years. A female cousin and a male cousin also live in the household.

In 2005, at 22, Johanne became pregnant and moved in with her husband. She gave birth to her first child in 2006. But the couple constantly argued. Subsequently the child's father left Johanne who went back to live with her own mother.

In 2008, Johanne became involved with another man who would father her second son. During this pregnancy, Hurricane Hanna destroyed her pig farm forcing Johanne to receive food aid. Later on, the son's father abandoned her only to move in with another woman. He soon reappeared and became involved again with Johanne who became pregnant with her third child. She found employment as a street vendor and continued working throughout her pregnancy. She had her third child in 2009. Eventually, she sold her street vendor's business and set up a small retail shop that went bankrupt. Today she does not receive support from anyone and is the sole breadwinner for her children. She is prone to depression and fears contracting cholera. She was greatly relieved when she began participating in the Koupons Manjé Fré Program.

¹ «Fresh Food Vouchers»: innovative program to prevent malnutrition among earthquake victims providing access to a variety of nutritious food such as fresh fruits and vegetables as well as meat and fish.

The beneficiary is a young mother of three children. They live with Johanne's mother and other family members. The fathers of two generations are absent. Johanne's life has been a carbon copy of her mother's story. She considers herself a victim of fate. Her mother apologizes for all of her daughter's misfortunes. Johanne feels that her hands are tied, and lives solely on day to day basis, without any means of planning for her future or that of her children. She often cries and wallows in distress.

Johanne was neglecting her children. During my first visits, I hardly saw the youngest child because he was often asleep. His immunizations were not up-to-date. The middle son was always dirty. When visitations started, he had diarrhea and the flu. She still did not know if she was going to send him to school. She had very little faith in life or in the future. She saw her life as a series of unfortunate events, and this lowered her confidence in her abilities and limited her aspirations for the future.

First of all, it was difficult to agree on the most efficient approach. We focused on hygiene while trying to integrate sound therapies into this family and foster the mother-child relationship. I encouraged her to ask about several schools in the area, although she was not ready to enroll her children. We also reviewed birth control options in case she wished to protect herself with a new partner.

Initially, she seemed to complain all the time. But given the circumstances, she chose 6 out of 10 to register her level of complaint. As the visits continued, I suggested a few simple things that she could do such as bathing her child and also taking advantage of opportunities that may arise. Complaining increased when her uncle and son became ill; but fortunately their illnesses lasted a short time. This prompted reinforcing the visits dealing with hygiene and health care practices. The sessions were very animated and productive. She became aware of the role played by hygiene and health care practices in preventing illness. She spent time with her children helping them with drawing skills. I duly acknowledged and highlighted all the progress made. During the third and fourth visits, she had already begun to show overall improvement. She took free sewing classes in the neighborhood. She was making a straight skirt when I visited her. Before I arrived at her house, she had bathed her youngest son and brushed his hair. While recounting her life's journey, I saw that she realized how courageous she had been going through such challenging experiences. She finally visited several schools and felt confident about the choice she made for her son. We talked about the need to bring her middle son's immunizations up-to-date. On the fifth visit, she told me that she was going to borrow money from an aunt. She was gradually regaining significant control over her life and seemed determined to take constructive initiatives for herself and her family.

A month later during the sixth visit, I found a healthy family. Johanne told me that she had enrolled her son in school and would soon have an income. There was no change on the complaining scale, since she still did not have any money. But she truly appreciated the external support. She could share her problems and find mutually supportive advice. During this last visit, we reviewed everything that she had gone through since receiving support and the developments pertaining to her mental well-being. Johanne was very optimistic about the results; but she was still seeking help and wished that her support system could be extended.

Finally, in keeping with the «Kay Timoun¹» project guidelines, I went to Johanne's home to invite her and her son to attend the parents' meeting later in the day. She was not at home because she was out selling cosmetics. At the time of the meeting, I no longer saw a sad and fearful woman, but a happy person full of hope.

However, I still wonder whether she is capable of managing her money and reimbursing her aunt. Unfortunately our monitoring duties are designed to end at this stage. Our beneficiaries have benefited from a short-term psychosocial support program. We feel that they should have additional time and support in the program to develop sustainable skills in order to cope with future challenges that may arise.

¹ «Baby Tents» in creole

CHOLERA VICTIMES SUPPORT PROGRAMS (2010- PRESENT)

The cholera epidemic reached the Artibonite region and the city of Gonaives in the second half of 2010. Starting in October 2010, ACF implemented a coordinated program of water, sanitation and hygiene as well as psychological care for families affected by the disease. Historically, ACF has responded to this type of epidemic solely by water, sanitation and hygiene operations. However, given the accumulation of disasters the population of Haiti has suffered, as well as their impact on mental health, a joint program was immediately considered. This approach also proved to be useful given the beliefs about cholera which limited the impact of prevention campaigns. Indeed, cholera is a new disease for Haitians, who were not familiar with prevention measures or treatments. Explanations citing ill fate or voodoo quickly circulated, differentiating for example between real cholera and fake cholera, which led people to resort to voodoo practices and harmed the efficacy of hygienic prevention mechanisms. These explanations led to instances of stigmatization and isolation for the affected people, as well as for their families.

The involvement of the mental health team consisted first of an effort to better understand local beliefs about cholera in order to be able to adapt messages about prevention and the treatment of the disease, to minimize fears about the disease, and to prevent risky behaviors. In addition, there was work to be done at the community level to prevent the stigmatization of those affected as well as their families, by (re)establishing social ties between the affected and general populations, and by providing support to the mourning process. Last but not least, the team was also responsible for identifying people suffering from the disease who also presenting significant psychological distress, in order to provide them and/or their families with individualized psychological care.

This program encouraged numerous requests for aid to emerge, and the team quickly found it difficult to respond to the range of needs presented by the population. The need to offer such a program for the Haitian communities affected by this disease became clearly indispensable.

Simultaneously, cooperation with other organizations (Doctors without Borders, International Medical Corps) and with the Haitian Ministry of Health was developed, in order to work on-site at the cholera treatment centers established by those organizations. The team offered assistance to the patients and the accompanying persons throughout the duration of treatment, in the form of support groups and individual follow-up. People in psychological distress (patients at the treatment centers, as well as companions and/or family members of the deceased), identified through psychosocial assessment, were referred at the end of their treatment to psychologists working in the community. In addition, supervisory control of the teams working in these centers was proposed in order to offer these professionals a space to speak about and obtain information on the disease, and to tackle questions linked to the perception (and sometimes stigmatization) of those affected, of the numerous casualties that these teams are confronted with, and to the specific experiences of cholera victims and the psychological impact of this disease, etc.

Starting in July 2011, after the MSF and IMC centers had closed following epidemic decrease, the team's work was directed towards identifying persons who had been affected by cholera and required psychological or psychosocial care. This work was carried out in collaboration with the Water and Sanitation program teams along with the Haitian Ministry of Health. In addition, training and support continued for the local medical teams working with the affected people. In 2012, when the epidemic resurged, mutual aid groups between peers were formed with the help of health agents. The objective is for these groups to become autonomous and sustainable in order to reinforce the network of social solidarity (social links) against the stigmatization related to cholera, and to increase resilience capacities.

Ritha's story: a family reconstruction¹

"Ritha lives in a very disadvantaged neighborhood in the south of Gonaives, in a small dilapidated two-room house, where she lives with her husband and their nine children, aged from one to eighteen years old. There is no access to latrines and the house's courtyard is in a state of extreme insalubrity.

¹ Casework reported by Charles Hunter.

The children, most of whom are enrolled at school, contracted ringworm and two of them (aged 12 and 16, respectively), suffered from cholera. The children seem quite affected by the family's situation—their hygiene and clothing are neglected and they sleep on a sheet directly on the floor.

Ritha and her husband no longer know where to turn in order to improve their situation, as the family is heavily indebted. Ritha and her husband have indeed lived through difficult times following the two devastating hurricanes that ravaged Gonaives in 2004 and 2008: the husband, a tractor driver, found himself unemployed after his tractor was damaged by the 2004 hurricane, and they were forced to borrow money to be able to look after one of their sons who had contracted cholera.

Before the cholera epidemic, Ritha had an outdoor restaurant that generated additional income for the household. Fearing the disease, clients stopped coming to the restaurant and Ritha had to close it.

Ritha's husband informed the team that these serious financial difficulties and the fact of his unemployment had upset the relationship between him and his wife.

At first, discussions about hygiene and ways of preventing cholera and other communicable diseases were complicated by the voodoo beliefs held by the couple (who for example explained that a fetish had been sent to make the children fall ill...). The team felt that this belief was important to them in that it allowed them to avoid confronting their own responsibility for the state of their children's health by identifying mysterious outside forces as the root of the problem.

Despite this, work on hygiene issues was conducted with the family, by focusing first on the treatment and prevention of ringworm, which the children had contracted. An additional goal was to improve family relations by providing support on this topic.

The team stressed hygiene by establishing the nature of cause and effect relationships when examining the risk of illness (while taking care not to question parents' actions) while also underlining the positive steps Ritha took to prevent cholera and to take care of her children. Ritha listened to the team's suggestions, saying that she would try to implement their recommendations.

Subsequently, the team members offered to accompany the parents and bring the sick children to the Gonaives hospital so they could be treated. Ritha and her husband accepted this accompaniment, which marked a change in their approach to the disease their children had contracted, and was an opening to other treatment methods as a complement to voodoo beliefs.

Soon the team noted multiple marked improvements in the children's situation as well as in the household environment (for example, the courtyard was cleaner). Ritha was able to express the satisfaction she felt from having the team's support, and explained that with the help of ACF food vouchers, she was participating in a "sabotay"¹ and was planning to open back her restaurant. The team strongly encouraged her in this endeavor.

Three weeks later, the restaurant was open and operational despite the still reduced number of clients. However, Ritha did not have chlorinated water available for the clients to wash their hands and ensure prevention of cholera. We worked with her husband to set up an access to and treatment of water. The older children were involved in the maintenance of the water system.

At the conclusion of the psychosocial support, the husband was responsible for the treatment of the restaurant's water, and helped his wife welcome their clients. The children were fully recovered, their clothes were clean, and they now slept on a mat. Additionally, the parents had plans to build a latrine in the following six months.

¹ Sabotay: a sort of cooperative system where each person contributes 300 gourdes each week and, taking turns, the total amount is given to one of the contributors each week.



Ritha and her husband also proved themselves to be active information vectors for the other families in the neighborhood regarding cholera preventions and hygienic measures for the prevention of diseases and their risks.”

This family has a complex situation and number of issues still need to be tackled. However it seems that the new dynamic in which the parents are participating, their active position when facing their problems, the investment in parent-child relationships...all of these are essential elements that reinforce resilience mechanisms and increase their ability to handle the difficulties of daily life.

SUPPORT PROGRAM FOR DISTRESSED PEOPLE (2010-2011)

The support program for distressed people was implemented in Port-au-Prince in order to provide access to individual psychological counseling or discussion groups for the most vulnerable earthquake victims (women, children, seniors, underprivileged persons, disabled persons, etc.). Several months after the disaster, a significant part of the population still suffered from psychological troubles related to the event, and though the number of psychosocial centers had increased through multiple NGOs, the number of centers was insufficient when faced with the high demand for services.

The critical situation of the inhabitants of Port-au-Prince following the earthquake (limited work, no shelter, life in camps, basic needs left unfulfilled, general instability, etc.) clearly inhibited the development of behaviors among Haitians that would allow them to come to terms with their fears and anxieties. Abuse against women was also reported in the camps.

The main complaints prompting most of the counseling sessions were linked to the earthquake. Since the psychologist's role was little understood by most of the lower class population, many care recipients came to these sessions to speak about their socioeconomic difficulties. The psychologists' work here thus also consisted in coaxing out the underlying symptoms of these recurring complaints. The team's work revealed that 30% of patients suffered from post-traumatic stress (with recurrent symptoms including anger and aggressive behavior, sleeping trouble, memory disorder, flashbacks leading to panic attacks or paralyzing anxiety attacks) and 25% from depression (with symptoms that revealed extremely low levels of self-esteem, inferiority complexes, feelings of desperation, and a tendency to self-isolate and cut off social links). Emotional problems were often highlighted by beneficiaries: relationship problems either with partners or with family members, as well as separations linked to the new living conditions were often at the center of these patients' concerns, especially for mothers who found themselves financially dependent on their living partners.

Observations made by local psychologists underlined that the psychological care provided through these support centers and the opportunity to express their anxieties, helped beneficiaries to reduce the effects of post-traumatic shock. Many program participants were feeling released from the fear of having gone "crazy", from the feeling of loneliness they had gone through or from feeling weakened or diminished. Other positive results expressed by beneficiaries include a feeling of having regained their dignity, of being able to feel like a person again instead of feeling like a mere victim, etc.

The local psychologists observed that six to eight meetings were typically necessary in order to obtain improvements in patients' symptoms.

Last but not least, through these psychological interventions, ACF was able to gather information concerning the mental health needs of the population and to forward it to a mental health think tank in Haiti, led by the WHO. Though mental health strategies are still being developed, this sort of data enables the optimization of future psychosocial and psychological care practices for patients in distress and in psychological pain.

6 - MENTAL HEALTH AND CARE PRACTICES IN CENTRAL AFRICAN REPUBLIC (2008-2010)



© Emmanuel Simand - RCA



CONTEXT AND PROGRAMS

The Central African Republic is a vast, sparsely populated country landlocked within a sub-region whose political and security situation is particularly volatile. The resurgence of violence in the north since the early 2000s has entrenched this region in a deep crisis, notably in the sub-prefectures of Paoua and Markounda, leading to massive destruction of property, human rights violations and mass displacement of people (75,198 displaced¹).

In socio-economic terms, economic growth is too weak to actively reduce poverty and generate new employment. The CAR remains fragile and vulnerable to the slightest economic shock. Indicators for the education and health sectors are currently among the weakest in the sub-region and state investment in these two sectors² is very limited.

ACF began its actions in the Central African Republic in 2006 following a call from UNICEF to resolve nutritional issues. ACF's «historic / founding» project in the CAR is based on a development approach, aimed at strengthening the capacities of the Ministry of Health in Bangui and the Ouham prefecture. In 2007, ACF turned its attention to an emergency issue, supporting victims of conflicts in the north of the country (on the Chadian border). Since this period, ACF has continued its initial commitments in the CAR to reinforce malnutrition detection and treatment capacities while developing solutions, within ACF's areas of expertise, to manage the underlying causes of malnutrition.

ACF has strengthened its presence via «emergency actions» while laying the foundations for future development projects (revitalizing the State's technical departments, capitalization of proposed technical solutions).

During a food security assessment of the zone conducted by ACF from January to March 2007, certain indicators of psychological suffering were highlighted during discussion groups. ACF subsequently decided to conduct a Mental Health assessment that aims to identify the psychosocial needs of the various groups affected by the conflict and the types of programs susceptible of meeting these needs, while also evaluating the possibility of taking into account psychological aspects when implementing Food Security, Water–Hygiene and Sanitation activities.

This investigation helped to demonstrate that attacks in villages of Markounda region have had a strong impact not only on the mental health of the men, women and children, but also on the basic foundations and balances within the families and communities of these villages of displaced people. Given the important needs, ACF decided to implement a mental health program in the region of Markounda, which began in March 2008. It consisted of restoring and consolidating the psychological and social environment of families severely affected by displacements, violence and precarious living conditions, and rebuilding social links.

Discussion groups with men and women of these communities, as well as individual psychotherapeutic consultation were conducted over a six month period in fifteen towns, in the areas most affected by the attacks. Mediation and support work has been conducted on resilience capacity of the displaced population, enabling them to resume normal life by reducing the level of anxiety and taking into account children's suffering. During non-mixed discussion groups, men dealt with questions surrounding the re-launch of economic activity, while women discussed well-being, children, child care practices and spousal relationships.

The activities conducted within these communities created a certain dynamic with feelings of appeasement for a large majority of the 200 people questioned during the program's evaluation. Unfortunately, the mental health activities in the Markounda region had to be suspended for safety reasons, in December 2008.

In the Paoua sub-prefecture, the situation was also alarming: the zone was the target of repeated violence; successive attacks on the population had a highly traumatic impact. Alternating periods of

¹ Source: HDPT CAR – Fact sheet June 2012.

² 1.3% of GDP invested in education in 2010.

living in the bush and unsuccessful returns to the villages lastingly marked the confidence that these populations may have had in their future.

Three years after the displacements began, upon the arrival of ACF, 19,000 of the 30,000 displaced persons still lived in total poverty, hidden in the bush.

The opening of an ACF office in the Paoua sub-prefecture enabled the implementation of the same type of interventions as in Markounda. An assessment conducted in February/March 2009 in the Paoua region, highlighted the significant psychosocial needs: psychopathological disorders (anxiety, depression, sleeping disorders, psychosomatic disorders), the deterioration of family relationships (bereavements, weakening of mother-child relationships, conflicts and domestic violence) and the breakdown of community foundations (a decrease in the authority of chiefs, difficulties coming together, weakening of associations enabling an improvement in living conditions).

The investigation showed strong similarities between the mental health needs of the two regions, with greater psychological distress in Paoua. The population has effectively lived in a constant climate of insecurity and continual mistrust due to the omnipresence of armed men, to whom they are extremely vulnerable. The frequent theft of cattle and agricultural equipment has robbed these populations of any possibility to be self-sufficient and to take control of their lives. Men, who are no longer able to provide for their families, feel they are no longer fulfilling their role and are suffering from humiliation. In fact, society operates in a patriarchal system in which men abruptly become inadequate. This has a direct impact on the workload of women who often feel helpless when faced with the extent of their responsibilities (finding food, in addition to taking care of the children, preparing meals, caring for the family, etc.). This upheaval of roles and positions leads to conflicts, and sometimes domestic violence. Dispersed families are no longer able to rebuild strong bonds of solidarity within the community, and women are rarely supported by their husbands. They are often perceived by the latter as lazy when overcome with fatigue or when they enjoy a moment of relaxation with other women.


As for the children, they are often neglected, while they need more parental support in order to better deal with anxiety.

The lingering danger pushes adults to sometimes impose obedience by force, in a reaction to distress. The continually reaffirmed probability of a new wave of violence endorses feelings of fear. This is coupled with the loss of dignity caused by such deplorable living conditions, and the feeling of powerlessness to deal with this situation.

A travelling program was implemented in various abandoned villages, offering one intervention per week for eight weeks, aimed at three levels of needs: individual, family and community. The team, composed of two psychologists, an interpreter and eight psychosocial workers, focused on reducing feelings of insecurity, increasing solidarity within social groups and addressing the population's psychological issues. This intervention aimed to offer inhabitants the opportunity to gradually re-appropriate their living space, by inviting them to engage in dialogue and exchange necessary for post-traumatic reconstruction, so that horror and anxiety can be replaced with a new desire to live. Putting their past experiences into words and working together



© Emmanuel Similand - RCA



through the trauma thanks to a safe and secure discussion space allowed them firstly to express and relieve their suffering and secondly to plan for the future.

Unmixed groups of men, women and teenagers, from ten to fifteen individuals, along with a broader group of children, were formed to enable collective reflection on the very specific issues encountered by these populations. Overtime, confidence grew and the groups addressed more intimate subjects. Through group development work, each participant was able to put together individual and collective strategies to enable them to deal with the difficult situations they had encountered. Individual psychological care and support was also set up for people (children and adults) particularly affected by the conflict and seeking for greater assistance.

The inhabitants expressed great gratitude to the ACF team for having enabling them to associate pleasurable experiences with a place previously tainted by only pain and horrendous memories. In addition, they appreciated how this approach enabled them to show their five and six year old children the village in which they were born.

While trying too hard to stand up, it's our children who collapse¹

«Luisa lives in a bush camp attached to a very small village in the area that was destroyed by the assailants. A widow since the massacres, she is also the mother of five children. She is a bubbly woman bursting with energy, which at first is very surprising considering the string of catastrophes she has endured. She very enthusiastically welcomes the psychosocial team as soon as they arrive, in strong contrast with the other women's melancholy. Her big, truly communicative smile never leaves her face, and she continually mobilizes her community to take a positive attitude and to forge ahead. Nevertheless, this joy of living almost appears false; happiness does not seem in tune with what this woman must be feeling deep down. The context is too serious for this joyousness not to be partially defensive.

The psychologist, Stephan, was thus rather surprised when one day she asked him for an interview. As it was time for the team to leave, the interview was set for the following week.

When they meet again the next week, Luisa arrives accompanied by her five children. Her usually smiling face is straighter than normal. Stephan suggests that her children be looked after in the play area while the interview is carried out, but Luisa replies that she came for her children, because they are the ones who need support, not her. Somewhat disconcerted by this not very conventional suggestion, and not used to carrying out clinical interviews with entire families, the psychologist accepts while specifying nevertheless that he wishes to see each member individually afterwards.

The family then sits themselves down in a line on a bench, with Luisa having rediscovered her cheeriness while showing with a certain pride that she knows how to «control» her children. Stephan begins the interview by asking Luisa (through the interpreter) to explain more precisely what was happening with her children.

There are five of them: a 3, 5, 9, 11 and 13 years old; the two youngest are boys and the three eldest are girls. And their mother starts by discussing the youngest girl. She starts a litany of symptoms from which her daughter has suffered since the events, mixing somatic problems, i.e. biological and bodily injuries, with more psychological injuries linked to the trauma, while all are of «relative» seriousness. Despite the translation, Luisa's speech is still full of pomposity, and Stephan cannot escape the idea of a disharmony between Luisa's words and the feelings she expresses. It is a bit like the mother was giving a speech about an absent person. Stephan is gradually being smothered under the verbose abundance of speech, when all of a sudden, Luisa pauses awhile.

Stephan and his interpreter have no time to investigate this case further. Luisa resumes her discussion on the youngest of her children with renewed vigor. He suffers from scars that are more psychological than somatic. The mother evokes delusions and strange behavior at night, resembling night terrors. Once more, the child in question is not moved by the speech, and seems distant from

¹ Clinical case followed and reported by Stephan Richard.

what is being said. Stephan's first impression at the start of the interview is confirmed and he feels that no one really identifies with the mother's speech. Her anguish does not seem to lie with her son. Leaving little place for discussion, Luisa continues her speech and moves on to the problems of her two eldest girls, evoking numerous psychosomatic symptoms, to do with both trauma and behavioral disorders, for which it is impossible to determine whether they are attributable to adolescence, a lack of paternal authority or the intrusive presence of maternal pressure... the lines are blurred. The monologue runs out of steam and becomes lost in more mystical interests. Her talk declines. Stephan bravely continues to follow Luisa's speech while wondering what he could do with this heavy mass of information. Nevertheless, their suffering is present; it is tangible, hidden behind Luisa's words, behind her unbreakable fake smile.. The children seem serene or absent. Luisa is finally silent and seems to be waiting for the psychologist's reaction. Stephan is once again struck by the dissonance between the expressed suffering and the mother's light-hearted expression. So he simply asks her: «And how about you, Luisa? How are you doing?»

A moment passes. The children still do not budge. Luisa's face noticeably changes; her smile seems to retract a little, and then disappears. Tears begin to flow down her cheeks, and she gives the clear impression of collapsing both emotionally and physically. She pulls herself back together just as quickly, but the essence of her request remains. This vulnerability which has finally been revealed is the key to beginning clinical work with Luisa and her children and continuing it right throughout the program.

This initial situation encountered with Luisa is rather representative of clinical situations encountered in humanitarian contexts; even if the cheerful behavior of Luisa, while defensive, is attributable more to her personality than to trauma itself. Indeed, it is common to see individuals that, following a crisis, seem to hold themselves rather well, while identifying the suffering of their close family members: projection onto others is a means of distancing themselves from suffering. Nevertheless, this defense mechanism is not without consequences on the possibility of working through mourning, relationships with children and also one's capacity to focus on the near future. It is not uncommon that this type of attitude might be a source of misunderstanding between humanitarian teams and beneficiaries, considering the conflict between visible, expressed feelings and internal suffering.

Impairment and transmission anxiety¹

With emergency responses, it is standard practice to offer psychological care only for those who have been traumatized after a crisis which justifies an on-site humanitarian presence. This story demonstrates that mental health programs must focus on all people with serious issues, even if the problems are not directly linked to the very crisis situation, but are likely to carry on, if left unaddressed.

Indeed, emergency intervention, by its very setting during a serious crisis, focuses only on the consequences of this specific situation, without necessarily taking into account the 'timeless' issues that affect individuals beyond the political and social climate.

“The child/mother relationships are often discussed during women work-groups. During the discussion sessions and exchange groups, it is possible to address the question of guilt for not having been able to protect children during massacres, or for not being available for their children, as they themselves have been overwhelmed with their own difficulties and responsibilities

The question of a disinvestment in the mother/child emotional bond when children are no longer vitally dependent on their mother is naturally addressed by the women. During one of these discussion groups, the situation of Felicia, a mother in the village experiencing this type of difficulty and who is completely withdrawn from her relationship with her baby, is brought up. According to the women, this child grew up but became 'strange'. They evoke a collection of tales of sorcery, beating and disease. The subject generated a certain prevailing tension within the group. The mental health team thus decided to try to meet Felicia.

¹ Clinical case followed and reported by Stephan Richard.



It was easy to find her, but she initially expressed mistrust towards the team, which at the very least was understandable given that she had not asked for anything. The members of the team informed her of the reason for their presence on the field and offered to meet her if she wished. The following week, one of the participants in the discussion group who is a neighbor of Felicia's, explained that she had had the occasion to talk to her about the group's activities. This has stimulated Felicia's desire to meet the team, provided they met at her place. Stephan, accompanied by social workers, thus went to her home and immediately noticed the filthy condition of the child, demonstrating a clear lack of care. The team rather quickly observed significant motor disorders. Some of the team then played with him in order to briefly evaluate his abilities in comparison with his age. It was discovered that the child was presenting noticeable delay and seemed to suffer from a mental disability. The team then sat with the mother and proposed they recapitulate the child's disorders. She then clearly and precisely retraced her child's medical history. At birth, the child had appeared healthy and hadn't shown any clinical signs of mental impairment. After a few months, he caught malaria. This was left untreated until finally he was brought to the hospital at a late stage, where he «died» before being brought back to life. A long time passed before in fact the child was resuscitated, with his brain being deprived of oxygen for a while, causing brain damage. Nevertheless, while this 'biological' explanation of the phenomenon makes sense to us, it is not the explanation that the mother can, culturally, give her son's situation.

According to the local social model, the fate of the child is attributed to witchcraft, bringing shame on the family and driving them to hide away from the eyes of the rest of the social group. As soon as there was a possibility of transmitting the impairment through contact with body secretions (nasal, oral, urea, etc.), making it impossible for anyone to deliver basic care to the child due to the risk of developing his disease, the boy was divested by his mother and avoided by the community.

Substantial work was undertaken with Felicia and her child through the game, to enable her to re-appropriate her role of mother. Without abruptly changing her beliefs, this rebuilding of the relationship through the mediation of social workers has allowed her to once again enjoy moments with her child while gradually regaining confidence. By playing an active role in building a maternal bond, she has been able to see how the quality of the child's capabilities are directly linked to the quality of the emotional, motor and cognitive stimulation he receives. The child has thus been able to continue his development, rediscovering a desire to eat and confirming to his mother the 'harmless' nature of his fluids.»

Attached for protection¹

«Manuella is a young girl aged around ten who came one day accompanied by her two parents to visit the psychologist. She arrived in silence, with her father firmly holding her hand and followed closely by her mother. The family sat down on the bench opposite Stephan, with Manuella's father making sure she sat next to him, while still holding her hand. With extreme manners and many verbal precautions, he shared what he had heard about the team's work and what had decided him to pay us a visit. It seemed that the positive results of psychological care given to certain children had been publicized in the camp. The father was thinking in particular about the care for children with enuresis disorders following attacks (i.e. children wetting the bed at night who didn't have this problem before), and with whom it is rather easy to achieve a fast improvement. The disorder is rather frequent in children having suffered from significant trauma. While relatively «benign» in psychological terms, the consequences for the child can be much more dramatic due to the parents' reaction (hitting, humiliation, rejection from home at night, etc.), and thus far more psychologically serious due to the reaction this produces. This is why the psychosocial team has taken an interest in these issues.

Stephan's attention is quickly drawn to a rather visible injury in the process of healing, located on Manuella's ankle. The father catches Stephan's look and immediately explains that his daughter «walked in fire» last week and severely burnt herself on the outside of her right ankle. Nevertheless, the injury seemed rather deep and it was difficult to establish whether it had been caused by pro-

¹ Case followed and reported by Stephan Richard.

longed contact with fire or medical neglect. It is true that domestic accidents are rather frequent, given that food is prepared on the ground, in a room that is also used as living room, bedroom and play room for children.

The father continued his discussion, evoking the attacks, their escape, the shots fired in their direction, camp life and the associated difficulties. Gradually it seemed that the session was beginning to be a little too long for the young girl who started to wriggle about, distracted by the other children playing outside. Stephan then asked her if she wanted to get up. In the absence of a reply, he addressed her parents, asking them if their daughter could speak. The response was ambiguous: she speaks, but never replies to anyone. She only speaks to herself since the events, or at most to express discontentment or to give orders to her brothers and sisters. Stephan then suggested he send for a colleague to take her out to play while they continued the discussion. The parents didn't particularly agree but did not dare object.

The girl that had begun to become irritated left under the team's supervision. The mother then started to talk for the first time during the visit. She explained rather bluntly that the young child has become «crazy» since what happened, that she runs away from home all the time and places herself constantly in danger in order to hurt herself. The burning episode was the result of a second of inattention by the mother, who had quickly gone out to check that the girl's two small brothers were outside. Manuella had taken advantage of the occasion, «throwing» herself into the fire. When asked if she frequently acts this way, the parents told the psychologist that this happens almost every time she is not attached...

Taken aback, Stephan asked the interpreter to confirm with the parents what they had just said. They confirmed their statements and highlighted that this habit began a little over two years ago, a few months after fleeing to the bush.

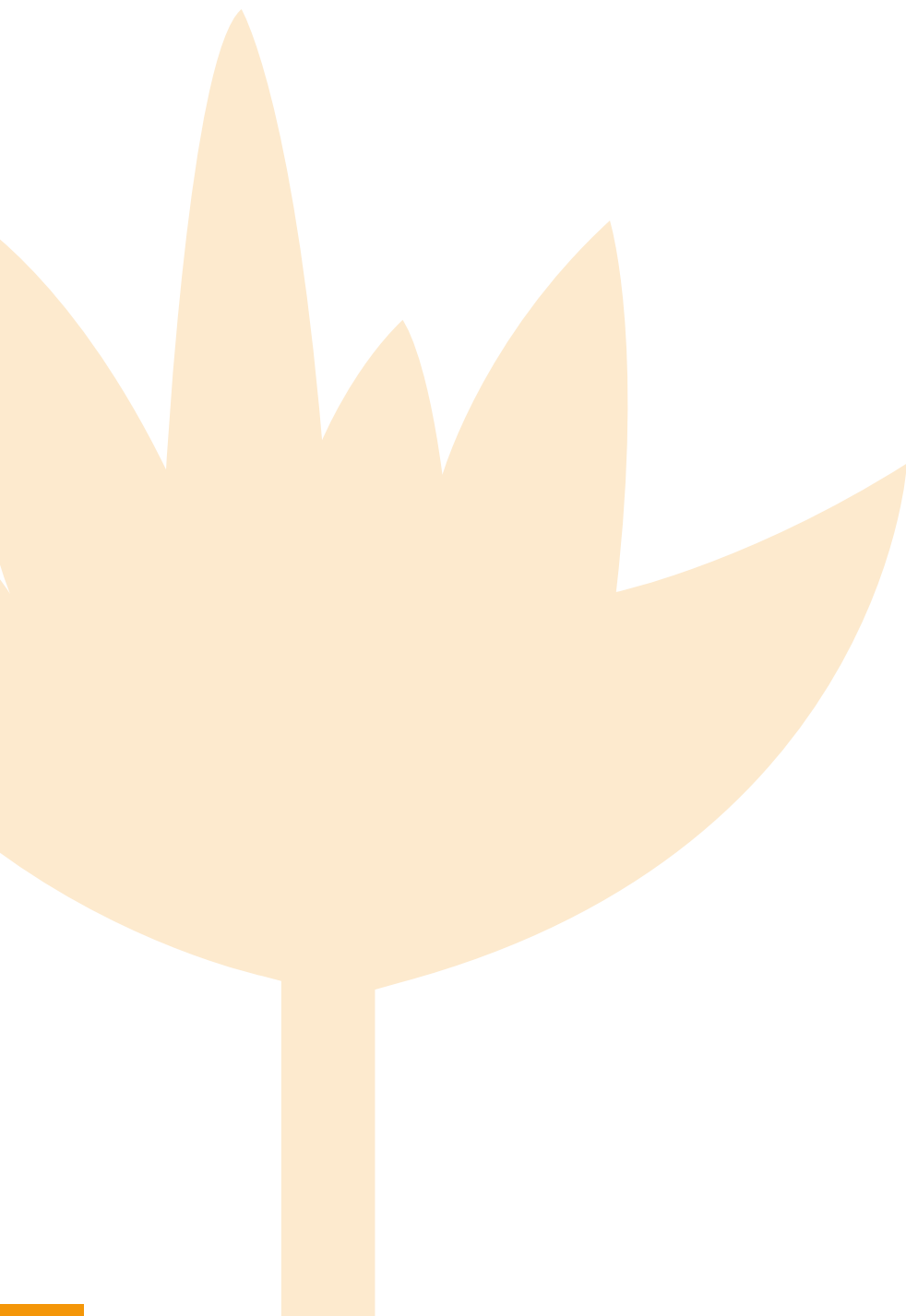
Confronted with the deafening silence of the psychologist and his interpreter, the father began gently sobbing while maintaining that they know that «this is not good for the kid». As for the mother, she remained impassive. They explained that they had found no other solution than to shackle their daughter to ensure nothing happens to her during the frequent occasions when they must leave house to go to work in the fields or fetch water. Having found her seriously injured several times, and since they are not able to stay at home to take care of her, they had to find radical solution «to protect» the child from herself.

Without much hope, Stephan inquired about care already carried out in a health center. Nothing had been set up, and nothing will be possible after the departure of ACF considering the nonexistence of available appropriate expertise.

Stephan and his colleagues observed Manuella outside. She seemed effectively rather restless, but smiled, and became friends and played with a younger child. The team accompanied and assisted the family for three months, while setting up individual help for Manuella in order to better understand her psychological suffering and to help her overcome her 'crises'; while working creatively with the parents on alternate solutions.

Every time the team visited the village, they paid special attention to Manuella and her family; Stephan and his colleagues took the opportunity to organize game sessions for Manuella and to meet up with her parents.

The departure of the team put an end to Manuella's support. Unfortunately, no structure had the capacity to sustain the action undertaken. Today we do not know where Manuella and her family are, however the ACF team will have at least allowed this family to envision new outlooks on life and to open up a field of possibilities.»



7 - MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN SRI LANKA (2005-2007)



© ACF - Sri Lanka

CONTEXT AND PROGRAMS¹

ACF was already present in Sri Lanka since 1996 when the 2004 December 26th tsunami hit the country. The NGO was essentially helping war victims in the North of the country (Food Security, and Water and Sanitation programs). Emergency aid was set up in camps for the disaster affected population in the rural and coastal region of Batticaloa where the inhabitants had been victims of Tamil Tiger conflicts for years (ACF was already present in this region previous to the tsunami). The interventions have been developed in the displaced population camps nearby or in the city of Batticaloa.

One month after the start of the emergency action, an assessment of the mental health needs of the camp populations was carried out. This assessment revealed some important psychological disorders following the tsunami. The trauma symptoms found are superimposed to previous individual difficulties resulting from the population's experience of war. (The story of a man supported by a psychologist from ACF is recounted at the end of this chapter. The tsunami revived in this man's psyche the war trauma that he experienced years before, leading him to commit suicide).

The psychological problems observed in the aftermath of the disaster were mainly trauma symptoms and mourning process troubles. Indeed, the mourning was complicated by the facts that few bodies of disappeared people were found, thus funeral rites could not be carried out and many survivors were in denial. The ACF teams noted that in the most affected areas, more than 30% people lost a parent or a child, and 17% lost several children. Alcoholism has also been identified as a problem to be addressed because of the resurgence in alcohol consumption among men after the catastrophe², and all the consequences that entails: acts of violence, banditry, etc. ... Lastly, the situation of elderly people living in the camps caught the attention of the team.

■ Preventing risky behaviors

Indeed, the elderly represent a particularly vulnerable group that is usually given little care by NGOs operating in emergency contexts. Yet this fragile population's needs are important notably in terms of psychological difficulties related to the tsunami experience. In addition to mourning issues, psychosocial workers have identified a high frequency of depression and anxiety troubles superimposed to various health problems, feelings of guilt to have survived whereas younger family members died, feeling of uselessness, material concerns related to their destructed homes, etc.

It is important to note that in this country, the elderly play an important role within the community, because they perform the functions of trans-generational transmission and of mediation in case of conflict. After the tsunami, lots of these people found them socially very isolated, finding it difficult to cope with the breakdown of the traditional environment and the social organization of their community.

In addition, presently the elderly had to look after their grandchildren while their parents were outside the camp to find the resources necessary for family survival³.

A community work around the traumatic tsunami experience including elderly people was implemented to encourage dialogue, help the victims to think about and put into words what they lived through and to determine the psychological care needs.

A project to stage theatrical plays was developed, to dramatize traditional tales and small performances in the camps and neighboring villages affected by the disaster. The themes directly concerned the tsunami (fear, water, death, loss...), and presented messages which were important to be able to work through and communicate to the people in the disaster affected areas. These perfor-

¹ This introduction is largely based on Cécile Bizouerne's thesis (2008), *Insuffisance en lait maternel et souffrance psychologique en Afghanistan – approche psychologique clinique en situation humanitaire, [Mother Milk Insufficiency and Psychological Suffering in Afghanistan – Clinical Psychological Approach in Humanitarian Situation]*. Unpublished Doctoral Dissertation, Université Bordeaux 2, 230-235.

² It is known that experiences of war and life in a camp correlate to addictive behavior (alcohol, drugs...) in most countries.

³ Usually it is the mother who takes care of the child during day time, but the very chaotic situation after the tsunami and the emergency coping mechanisms have disrupted the traditional family organization.

mances were staged with young people from the villages affected by the tsunami and now living in the camps. This initiative aimed to reinsert the traumatized and/or isolated elderly into the community, and to work on the disaster and its consequences at a social group level. The aim was to prevent risk behavior (especially alcoholism).

■ Parental support in the context of disaster aftermath baby boom

Eight months after the tsunami and the start of these actions, an assessment of the displaced people present in the camp revealed an important number of pregnant women about to give birth. This phenomenon can be assimilated to a “post-tsunami baby boom”.

Indeed, there is almost 20% extra births for the third quarter of 2005 compared with 2004. In the Batticaloa camp for example, we can notice an increase of birth numbers in September 2005, i.e. 9 months after the tsunami, a drop in December on the anniversary of the disaster and another rise from January 2006. “*Sometimes the sudden disappearance of a parent or close relation coincides with or we could almost say provokes, an involuntary conception. The increase in sexual need, the libidinal increase after the death of the object, the maniac celebration, is a classic clinical occurrence*”¹», noted Karl Abraham in 1922². The teams quickly mobilized their actions on the question of welcoming the future child in such a crisis context. It was decided to start working in the Thiraimadhu camp (in the town of Batticaloa) where about 1,000 families were gathered.

1) Group work targeting pregnant women and mothers with an infant of less than six months. Two-hour sessions were organized every two weeks around topics linked to pregnancy and maternity during which themes such as the adjustments necessary due to the destruction of homes, the death of family members and life in a camp, were all addressed.

2) Individual work, with three types of sessions:

- Psychological assessment of all couples in the week after birth
- Psychological assessment of pregnant women who lost a child
- Psychological care if necessary³.

A frequent problem was the place occupied by the deceased child in the representation the family had of the coming one. Parents wished to rebuild their family as it was before the tsunami and “replace” the dead children with new births. They wanted the new-born to be the same sex as the child who disappeared, and have the same first name as if to erase the traumatic event, the deaths and perhaps also, in some cases, their guilt. Indeed, the force of the wave ripped the children from their parents’ arms and prevented them to save their own child, thus presently letting them face their own insurmountable guilt.

For a start, women were invited to participate in two discussion groups. The first group was composed of pregnant women and the second one of lactating women. The objective was to talk about and work on the idea they had of their pregnancy and/or the arrival of the infant in such a particular context, on the difficulties they faced, on the way they responded to their own needs and to their child’s needs, on the way the couple experienced the pregnancies and births, etc. Individual psychological care was proposed to women expressing the biggest difficulties. When a baby was born in the camp, the team systematically went to meet the family to evaluate in-depth the situation and quality of care that the parents were or were not able to give the new-born... If difficulties were identified, individual psychological support was proposed. After these home consultations, a large number of families benefited from psychological care.

¹ Bydlowski, M. (2005). *La dette de vie, itinéraire psychanalytique de la maternité*, [The Debt of Life, Itinerary Psychoanalysis of Motherhood]. Paris : PUF.

² This clinical occurrence has been more recently developed in its meta-psychological dimension by Maria Torok. According to her, “the sudden libidinal upsurge at the moment of loss of the object would be a common even universal, phenomenon.” (Bydlowski, 2005).

³ The expatriate psychologist (Joséphine Antoine – Milhomme, ACF expatriate from April 2005 to May 2006) evaluated the psychological state of 38 women between August 2005 and February 2006. Among them, 22 needed psychological care (i.e. 60% of the women evaluated and 16% of all pregnant women and mothers with an infant of less than six months).



While this individual support was carried out, the team observed that the mothers often found themselves alone and in great distress in their home. Indeed, traditionally, after a birth the mother's mother or grandmother is present in the house to take over household duties, help the young mother care for the baby and carry out the necessary rituals for the mother and child. These rituals are particularly important, and if not carried out the families think that the baby will not grow up normally and the mother will remain weak. They also play a vital role in accepting the new-born into the family, and in developing mother-child bonds¹.



As most of the mothers or grand-mothers of the parturient women had died or disappeared in the tsunami, the young mothers strongly felt their absence. They had to manage the arrival of a baby alone and the children's father sometimes had to stay at home to support them (as they couldn't work anymore, the household found itself quickly facing substantial financial difficulties...). ACF hired a child-minder among the women of the community, so

she could assume this role and help the women at home after birth. The presence of a third-party, able to mediate relations between mother and new-born, proved particularly invaluable due to the complexity of mother-baby problems linked to the tsunami.

Strengthening childcare practices in rural area

Additionally, ACF resumed its activities for the population affected by the two decades of Tamil Tiger war. A project on Mental Health and Care Practices was developed in collaboration with existing Water, Sanitation and Hygiene, and Food Security programs. This was a community work, combining the supplementary food support for young children and the distribution of grain to the families to create "baby vegetable gardens"² and ensure the availability of varied food for children – the idea being to fight malnutrition on a long term basis. Group meetings with mothers/fathers/babies about childcare practices were provided by the MHCP program's team. In connection with hygiene improvement actions set up by the Water and Sanitation program, the team worked with lactating mothers on stocking breast milk in order to prevent malnutrition. Indeed, in these villages, mothers often breastfeed their child up to the age of two, but the care practices for young children can change, particularly if the mother is looking after the child alone and/or must leave the home to work. In this case, the grand-mother or the great-grandmother generally takes care of the baby while the mother works. Stocking breast milk at home allows keeping breast milk intake by the child and prevents the risk of malnutrition.

Finally, work was carried out on the psychological difficulties related to the long and violent armed conflict.

The two stories below illustrate the work achieved by the team with pregnant and lactating women program in the camps housing tsunami victims. In these two situations, it is a case of individual and family psychological care coupled with group activities.

We believe that the intensity of the suffering of these people, of their needs, the complexity of the situations and the intercultural dimension is clearly reflected.

¹ Culturally, it is after birth that the mother bonds with her baby (and not during pregnancy).

² Setting up vegetable gardens in order to cook recipes adjusted for supplementary food for very young children.

Senuri's story: a child replacing... Gihan

“Senuri, 24, lost her only child, a nine-month-old, in the tsunami. She is now seven months’ pregnant; she became pregnant after the death of her older child. Before the tsunami, the parents were using a contraceptive, but their son’s death changed their minds. The mother tells the psychologist in a weak, monotonous, emotionless voice about how she was feeding her baby when suddenly she heard an old woman shout that the water was coming and that everyone needed to run. Her husband picked up the baby and they started running together. The baby got stuck in a fence and the father could not pull him out. He could only run away and leave the baby there. Since then, the mother continues to occasionally talk to her child, and she talks to the unborn baby as if it were the deceased little boy. Unlike Senuri, her husband refuses to say the word ‘tsunami’ or to talk about his child’s death, but he stays and listens to his wife’s story.

During the subsequent visits, the couple, particularly the husband, frequently complains about physical pain. He attracts attention and monopolizes a lot of the consultation for his complaints at the expense of his wife’s. He describes many dreams of the mother and her dead baby in several situations. Senuri attends the group for pregnant women. During a demonstration on bathing with a doll, one woman who knew Senuri’s baby told her that her baby would not have been able to stay as calm as the doll because he loved to play and move around in the bath. They laugh as they recall this trait of Senuri’s child. During the massage session, she remembers that she was worried about his learning to walk and that she focused on leg massage. These moments shared with other women from the group who also lived through the tsunami have given her a space that she did not have at home for her mourning. The home visits gave her time to go into detail.

At the end of one of these visits, she described her feelings when she was in the water: she thought she was slowly dying and she was thinking about her baby stuck in the fence. She would have liked explain to him what was happening and tell him that she wanted to save him but that she could not.

She gave birth to a beautiful baby boy. Her husband called the psychologist to announce the good news and said that she was the first person whom he had thought of because his entire family had perished in the tsunami. After a little time, the psychologist visited them. The mother had stopped breast-feeding after the doctor told her that she did not have enough milk. In piecing together the story (the couple was staying with relatives for the birth, not allowing private meetings), it came to light that Senuri had gone through a phase of rejecting the baby: she was incapable of holding him because she was thinking about her deceased child. In the end, the eagerly awaited child was not like the first boy and all the thoughts and images that she had during her pregnancy were related to this deceased child rather than to the unborn one. The psychologist supposed that stopping breastfeeding when the first boy died should have been a difficult time. Senuri expressed how hard it was to see her milk flow from her breasts without having a baby to give it to. Her breasts ached; she didn’t have any medicine to stop the lactation and nobody to talk to about it. “The two people with whom I could have discussed it, my mother and grandmother” had also died in the tsunami. The fact to have highlighted the origin of her difficulties to breastfeed her new infant resolved the problem and she was able to breastfeed him again few days later.”

This case study highlights how difficult it can be to welcome a new born after the death of a child. In this particular context, the parents tend to assign to the imaginary unborn child the face and characteristics of the deceased one, as a way of denying his/her death. The later does not leave any space for a different projection. The birth always confronts the imaginary child to the real one. But in this particular case, the new-born causes an even greater disillusionment, since he is very different from the deceased one. Indeed, the mourning process that was suspended, like frozen - during the pregnancy, starts again, after the birth. In consequence, it turns to be painful or even impossible for the parents to take care of the new infant. This situation revives parents’ loyalty as well as its guilty side: how to give to the new born what they could not/did not know to give to the previous child?



In natural disasters like this one, many parents mention their powerlessness to protect and save their children and their guilt: they survived but they did not manage to save their child(ren). The parent's psychological suffering isolates them from each other. It is too difficult for them to talk about their loss; it is also risky because it is likely to lead to conflict. Indeed, the parents often reproach to the other their responsibility and this increases even more their guilt.

Moreover, the couple not only lost its children, but many family members also disappeared; many of them were the oldest ones, those who in normal times are present during pregnancy and childbirth, ensure intergenerational transmission and help to perform rituals.

Moments such as pregnancy and birth revived the absence of important members of the family. Indeed, the new mother, father and the infant miss the persons supposed to support them (her own mother, her mother-in-law or her sister for example)

In the Thiraimadhu camp, a nanny was hired to play this role of accompanying person. During one month after pregnancy, she would go to the homes of the new mothers and their babies in order to help with household tasks and in taking care of the other children, just as a woman of the family would have done. She reassured and guaranteed a daily presence to the mother and her newborn. She also enabled fathers to continue working and earning money during this time because another adult was staying with their spouse and baby.

Natural disasters can lead to "manic celebrations," as Budlowski¹, (pg. 169) calls them, with planned or unplanned conceptions. In Sri Lanka after the tsunami the desire to replace the family and give birth to new children was important. Pregnancies came to negate the disaster and its losses, and help the couple "orphaned from child" to give sense to their life again. A couple whose children have perished loses all its meaning and its members have to rebuild so that every person's existence and that of their couple might acquire a new meaning.

The newborn's "mandate" is to identically replace the firstborn, but he will of course fail trying. The birth of the new baby and their difference with the first one confront parents to their unfinished mourning.

They might have various reactions. First, deny the subjectivity of their new child and associate the personality of the firstborn to the newborn. Second, reject the newborn who does not replace the first one as expected.

Breastfeeding is part of these psychological movements: several mothers were not able to breastfeed because the intimacy underpinned by the bodies' contact is too painful.

They were unable to hold their child in their arm and to offer him their breast. They were crying each time they looked at their child. For some of them, the milk coming from their breast reminded them the milk which came after they lost their first child.

For others, this milk flowing from their breasts was reminiscent of the milk that was flowing after the death of the previous baby, and that no one sucked. These individual difficulties are seldom perceived by humanitarian aid professionals as an expression of the mourning process. They only consider or even anticipate the immediate response, by providing high quantity of artificial milk in emergency situations and medical prescriptions based on breast milk deficiency. This material solution hides the underlying symptom and undermines the opportunity of accompanying the parents in their mourning process and in welcoming the newborn on a psychic level.

¹ Budlowski, M. (2005). *La dette de vie, itinéraire psychanalytique de la maternité*, [The Debt of Life, Itinerary Psychoanalysis of Motherhood]. Paris : PUF.

The following story also illustrates the difficulty of mourning process and the complex place of children born in the aftermath of a disaster

Madushani's story and the importance of rituals surrounding birth¹

Madushani was 28 years old, pregnant and about to give birth when the tsunami hit. She lost her three children (two boys aged 8 and 4, a girl of 7) and 13 family members in the disaster. Her husband (a quite wealthy fisherman before the tsunami) survived.

Madushani was seriously injured and the doctors had to induce labor few days later. At the time, she was only half-conscious and she did not know that her children had died. She learned the terrible news after the birth of her son.

During the initial home visits, Madushani never looked at her baby and we never saw her holding him. She talked to us at length about her three children and about the violence of the trauma. During the home follow-up, Madushani is seven months pregnant again. Her husband decided to reconstruct the family identically in an effort to erase the disaster and the loss of the children. They are currently anxiously awaiting the birth of a girl so they can give her the same name as the deceased girl. The mother seems deeply depressed and the father spends all his earnings on purchases for his wife and the baby: he has bought a television (even though there is no access to electricity) and a carriage (the roads are impracticable).

Madushani says that she feels extremely guilty about not having been able to save her children because she was pregnant thus unable to carry them. The distance she keeps from her child who was born after the disaster may result from the fact that this baby reminds her of the death of her first three children, as well as her inability to devote herself to him as the mourning process could not be set in motion. Madushani explains this difficulty by her inability to breast-feed. A doctor advised her not to breast-feed because she had drunk water from the tsunami, she reports (we do not know if this would



© ACF - Sri Lanka

have affected her maternal milk, but the psychological impact of the image of this water carrying away corpses cannot be ignored). Madushani suffered profoundly for not being able to breast-feed her baby. She is very respectful of the maternal rituals to perform for the child after birth, and she explains that because she could not perform them, the child is not 'normal.' She describes him as a baby who cries a lot, is not very affectionate, and is different from the other children.

Through her explanation, Madushani tells us that she was not in a position to commit to this baby and that she is/was very depressed about all the potential effects on the child. In her defense, she can say that her depression is not the cause of her lack of commitment, but rather that of the lack of rituals (and the impossibility to breast-feed because she had drunk 'water with dead people in it'²). With this mother, the evocation of the rituals to carry out and the detailed description of the traditional practices as they were transmitted in her family aim to help Madushani to gradually recommit to her child, to place him in reality and the family legacy.

Madushani delivers on the birthday of her first son, who died in the tsunami. She gives birth to a boy; the couple is slightly disappointed but identifies 'signs' through his birth date and a physical resemblance to the first deceased son. They give him the same name. The mother is very tired after the

¹ This clinical case is described in the capitalization report on the ACF mental health mission in Sri Lanka. Case monitored and reported by Joséphine Antoine-Milhomme.

² We may understand this response by the fact that in their depiction, their son is half-alive half-dead.

caesarian section and returns home five days later. Madushani constantly wants to hold the child but she is not able to because of the effects of the caesarian.

When we ask the parents about the place of their older son, they respond that 'he is different.' According to their way of identically reconstructing their family, with the baby being associated with their first deceased son, it is as if their older son is 'eliminated.' Our worries about this child are slightly eased by the observation of a close bond between the father and his little boy even though Madushani is unable to commit to this child and 'give him life.' In fact, she gave birth to him while she herself was half-dead; death surrounded her in the hospital after the delivery, and she could not give him her milk—a symbol of life—because it was considered to be 'poisoned' by the dead and a carrier of death. The one-year-old boy is very aggressive with his mother, keeping his distance from her and the baby. Madushani receives the support of the child-minder, which enables her to feel better. She breast-feeds the baby and takes great joy in the action, which appears as a mending process. She has also been able to perform all the rituals thanks to the child-minder, insisting on the traditional practices a little more than for her other children, undoubtedly out of a desire to protect the child (and herself from depression).

We remain very worried about the one-year-old boy given the place he occupies and what he represents in the family, even more so because the child-minder cannot take care of him because Madushani and the newborn require all her attention. The only person likely to commit to the child and to give him attention, affection and the connection he needs is his father. Before ceasing the monitoring, we spend a long time insisting on this point so that the family pays attention to him.

Kumar's curse. The story of a suicide foretold in Sri Lanka¹

"This is the story of Mina and Kumar.

Mina is a beautiful, 32 years-old Tamil woman when the deadly wave comes knocking at her door. On this particular Sunday morning, she is in the middle of baking a cake for her children for their usual mid-morning snack. Two children are playing outside. One is a two year-old boy who is sitting on the sand, the other is his six year-old sister who is playing quietly by his side. Their nine year-old elder sister is taking private extra classes at school as she is very clever and hopes of big success are placed in her.

Her husband, Kumar, is a well-off fisherman who owns his own trawler. He is drawing water from the well in front of the house. This particular Sunday he is resting with his family. The house is located three hundred meters from the beach, perched on a sand bar between the lagoon and the sea, behind a Hindu temple that the locals believe to be endowed with great powers. The temple is dedicated to Gayatri Amman, a five-headed deity emanating from Kali the destroyer, Lakshmi the wife of Brahma (the earth god) purveyor of riches, Saraswati the educated and Shakti the powerful. It is said that Gayatri Amman hails from India and protects the fishermen on this strip of Sri Lankan land where Kumar lives. The strength of her powers makes her dangerous. The guardians of the temple are called Sidhars, and are capable of deep meditation to the degree that they are able to reach the summit of Mount Everest through their powers of concentration. These Sidhars have the reputation of being able to predict the future. This kind of temples are peculiarly constructed: the interiors are constructed using the most natural materials possible, such as coconut palm trunks, palm fronds, lime or the dung of sacred cows, in contrast with the richly colored outer architecture built from modern materials such as concrete.

The inhabitants of the region say that the tidal wave was brought about by the temple's great powers. In fact, when it was built ten years ago the Sidhar had the following dream: Gayatri Amman appeared displaying her arms and her heads, to announce that in the vicinity of the temple there would soon be many dead. Some of the survivors say that this premonitory dream was not taken seriously, which resulted in vengeful powers being conferred on the temple. One particular cult to Kali (a goddess of destruction under the control of Shiva, who ends one cycle and thus allows for a new one to begin) took up residence in the temple after the tsunami, as she is seen as having the power to destroy

¹ We would like to thank the publication L'Autre for giving permission to reproduce an article originally published in 2007 by Joséphine Anthoine-Milhomme: Antoine-Milhomme, J. (2007). La malédiction de Kumar. Histoire d'un suicide annoncé au Sri Lanka, [Kumar's Curse, Story of an announced suicide]. L'Autre, Vol. 8, n°2 p. 97-108.

evil spirits and protect the worshippers. In fact, the origins of her name lie in the word Kala, “time” in Sanskrit, destroyer of all things. Those who worship her are freed from the fear of destruction. We will see that Kumar made up his mind about the gods and, from the outset of the interviews, he will say that he hated his powerlessness in the face of their will, and he will fiercely reject them and “actively” side with death. As for Mina, she says she hates this temple, because the goddess Gayatri Amman deprived her of the love of her eldest daughter, who told her “You are just my second mother, because Gayatri Amman is my first mother”. She condemns this place because, when the first wave arrived, the water was hidden by the temple wall and no one from the little house saw it coming.

As the first wave batters the house, it takes the family by surprise. Kumar suddenly sees a wall of water falling and cries out to his wife to take hold of the little two year-old boy to protect him. Kumar himself bounds towards his daughter and takes her in his arms. But Mina can't move. She remains in a paralyzed stupor and doesn't react, despite her husband's screams. Everything happens very fast “the time it takes to draw a breath”; Mina sees the little boy thrown against the inside wall of the house and herself is also swept away by the violence of the tidal wave. They see their son crush against the wall. The second wave tears the little girl away from Kumar's arms and she is, in turn, thrown against the wall. Kumar suffers minor wounds to his feet and an odd fixed stare freezes onto Mina's face, which will remain there for a long while. Their eldest daughter, who is at the nearby school, will also be taken by the tsunami, but Mina and Kumar won't know this until later, when they have to go and identify their child “with a destroyed face and body”. Funerals for the children need to take place quickly; they are buried in the sand¹. And Kumar's long and painful anger begins. And Mina's long and painful suffering begins.

Three months have passed by the time I meet Mina and Kumar at their home where, over several months, I will make regular visits with my Tamil-English interpreter². They have only just returned to their house, with its unstable walls; they are the first of the villagers to come back. Mina could no longer stand the accusatory looks of the other women in the transit camp who, she says, accused her of being incapable of saving her children. As for Kumar, he is unable to accept his children's death and wants to be alone. So, they came home, to a half destroyed house, and they spend their time looking at the sea through a small kitchen window, in a sort of torpor mixed with the hope that another tidal wave will claim them, as it did with their children.

However, the couple now almost never speaks to each other. Kumar implicitly blames Mina for remaining frozen when the wave hit (and he blames himself, though not out loud, for having lost hold of his little girl). She lowers her gaze in front of him, and cries discretely. A few days later, Mina is in a terrible state: her body has woken up. She barely ever sleeps; her sleep is interrupted by visions of the bodies of her children; she feels nauseous, suffers dizzy spells and has lost her appetite; she is seized by sudden panic attacks that are accompanied by tachycardia and breathlessness. She feels like she's outside of her own body and stares off into space. This is when I hear the husband talk for the first time about the suicide he is planning.

Kumar is worried by the state of his wife. I take Mina to the hospital so that she can be medicated (anti-depressants and sleeping pills) which do afford her some relief. Mina starts to feel a bit better while Kumar then plunges into a deep depression, as if he has suddenly turned the anger he had projected onto his wife on himself in a form of guilt.

The depression manifests itself by the resurgence of intense bodily pain that “no one is able to do anything about”. When I ask Kumar if he has ever been tortured before, his face falls and the couple start to tell me about something tragic that happened to them.

¹ According to Hindu tradition, when an adult dies, their body must be cremated, because all the potential energy has been used up; however, if the death is that of a child, their body must be buried because it is still “fresh” and the energy that inhabits the body had not yet been used up, it must therefore be in contact with the earth so that its energy can be spread.

² It is in my role as clinical psychologist for Action contre la Faim that Mina and Kumar were referred to me. The spatial framework was established within the main room of their house. The visits were held regularly and were pre-arranged. Some visits took place outside of the home, in particular to monitor Mina (psychiatric hospital, the hospital's intensive care unit, the transit camp for women, then Mina's parents' home. It was not easy working through an interpreter, given the complexity of the case.



Ten years ago, the Sinhalese army held Kumar for three days, accusing him of collaborating with the LTTE (the Tamil “Tigers”). He was transported from one place to another blindfolded, tortured by three Sinhalese militia men, his back was beaten with a bag full of rocks and his toenails were ripped out. During all this time, Mina was trying to get him released, and went to see the representatives of the LTTE to beg them to write a letter exonerating her husband.

She has her baby with her, then six months old, when she manages to give the letter to the local military representatives. So, Kumar is freed, but the soldiers threaten to kill him and his family if he goes to the hospital for treatment. He sees this as a refusal to be considered a victim. Françoise Sironi reminds us that torture doesn’t make people talk; on the contrary, it is designed to shut them up.¹ So, he treats himself with local medicinal plants and doesn’t see anyone about it until the day, ten years later, when an excruciating pain in his back and legs leads him to the hospital. The doctors tell him he needs to go to Colombo for proper treatment. But he doesn’t want to. He says that, in fact, the doctors in Colombo are Sinhalese and the threat of reprisals, even ten years later, is still very real. He finished by saying that he can’t go to a Sinhalese doctor as his persecutors were Sinhalese too. Kumar seems suddenly surprised to have talked about a part of his life that he “had not thought about for ten years”, and which he’d never been able to find the words to express. He had not made the link between his pain and this episode of torture, repressed for the past ten years. His wife is by his side. In this single moment, I believe I glimpse a moment of tenderness passing through between the couple.

It is shortly after this that Kumar talks to me about the suicide he has planned for July 5th, the date of his eldest daughter’s birthday. She would have been ten years old, same as the number of years spent trying to forget the horror, the unbearable and the ignorance. He tells me he has thought of everything, and nothing will stand in his way.

He wants Mina to kill herself along with him. But Mina doesn’t want to end her life. What follows is a long struggle between Kumar and Mina, onto which he will project his great anger. Mina remains silent, but Kumar treats her badly, accusing her of being responsible for the death of their children², constantly pushing her, calling her stupid, incapable, a bad mother, reiterating on his wife the mental and physical torture he suffered.

In the weeks that follow, Mina’s state of mind worsens once again; she talks to herself, stares into space and has trouble breathing. She begs me to help her stop her husband from committing suicide. Kumar becomes more and more aggressive. He is mad at everyone, as well as the gods, even though he used to have such faith, and performed the most extreme of rituals like being suspended in the air from giant hooks dug into the skin of his back, or walking over hot embers... he would go to the temple every day to pray to Shiva. Right up until the time the gods took his children away.

Mina is scared of her husband’s vocal denunciation of Shiva. Her fragility is not lost on everyone: a religious organization takes advantage of this moment to give her a Bible and to tell her it is her path to finding peace. For hours on end, Mina recites passages from the Bible, seized by an ecstasy of mystical illumination. At the church that she now attends, they tell her that she will be reunited with her children in paradise. This annoys Kumar: he says that Mina is Hindu and no one should be forced to change their religion. He also seems to be angry because the Bible forbids him from taking his own life. Of course, he has no permission to kill himself according to the Hindu religion. Nevertheless, in the practice of everyday life, the priests do not have anything against it “if the person has good reason”. It will not have any impact on the next life, it will not affect his karma. And, who knows? He might have a better life, one of the Hindu priests I questioned on the subject tells me.

¹ Sironi F. Comment devient-on un bourreau? [How do people become torturers?]. Conference held at the Collège de France, 31st January 2001, text available on line in at www.ethnopsychiatrie.net.

² Even though it was he who let go of his daughter when the second wave hit.

The weeks that follow are difficult as Kumar prepares his suicide, Mina remains at home and talks to her children, she awaits and dreads her husband's death, searching for ways to "save his life (again)" once he has taken the poison. It is like it was ten years ago, when he was seized by the militia, when Mina got him freed, the hope is identical. Kumar buys a wall clock, tucks a photo of his eldest daughter behind the pointers and goes to put it up in the school where time stopped for her. Is this "suspension" of the clock the same suspension of time that reflects a denial of the reality of his daughter's death? Or, on the other hand could it be a period of mourning, set in motion by an attempt to repair time that should have continued? Or, even a "manifestation of the suspension of time due to trauma"¹, because it is at the hour that time stopped for Kumar that the trauma is made manifest and fixed on this symbolic clock. Time carries on, but for Kumar it stopped at the moment he relived his trauma, where previously he had been "suspended" in limbo between two traumatic states. Precisely, time flows slowly and violently for this couple whose days become precious. The waiting is too much for Mina. "She is going more and more out of her mind", a surprised Kumar tells me. But, once we're alone, I learn from Mina that Kumar is increasingly violent towards her, he pesters her with his desire to see her kill herself along with him. But she remains firm; she doesn't argue with him and, in her serious voice, says: "No, I don't want to die". Is it really her the mad one? Mina asks me to arrange medical transportation to take Kumar to hospital once he's taken the poison. Ambulances don't want to go into the zone where they live at night. The scene is set.

The fated date arrives. It is difficult for me to come out to the house and I feel a certain sense of relief when I see that Kumar is still alive on July 5th. He tells me he has postponed his suicide by a few days for administrative reasons. Mina's looks distraught, her stare more fixed than ever and she seems to be neglecting her appearance. This session is long and intense. I know I will never see Kumar again.

We talk a lot about his death and of the representation he has of death. His words are interspersed with moments of rage, which have become increasingly regular over the past few weeks. He knows that it will take a long while for his soul to find any sort of peace. He will be in limbo, awaiting his meeting with Yama, the keeper of the dead, who will pass judgment on him: henceforth alone, he could be reincarnated in another earthly body². He knows he will never see his children again; they too are with Shiva, god of creation and destruction.

His anger is aimed at everyone, including the gurus³ and the Sidhars who "talked nonsense in order to explain the tsunami", at Shiva who ordered the waves, at the NGOs who aren't helping them, at the government who isn't helping them either, and, last but not least, at "his wife who didn't love her children and is incapable of dying for them". He thus places himself in a perversely ambivalent position; he turns against her because he isn't achieving the desired outcome (his wife's suicide).

All of a sudden, I find myself perplexed in the face of a paradox when he talks to me about his health and shows me the x-rays of his back, telling me about a lumbar problem which requires an operation. Within this complaining, I see his need for this "victim status" to be recognized (as well as the confirmation of his ambivalence). But his anger is too intense and destroys this fragile base. I ask him, without any great hopes of being heard, to show some tenderness towards his wife before he leaves her. He doesn't respond and fires a look at his wife. I bid them farewell wishing him a better future life. Come the end of the week, and I know that Kumar will not miss his rendezvous with death.

As I approach Mina and Kumar's house, I dawdle a little, fearful and wishing to remain ignorant and dreading I might discover the(ir) body. I visit other patients in order to postpone this meeting and when at last I am ready, I turn up outside the house only to learn that Kumar and Mina are both in

¹ Comment by Muriel Génot while copy editing this text.

² The Hindu faith is based upon a particular funeral ritual and a specific concept of death. Metamorphosis lies at the heart of Hinduism, the body being merely a temporary vessel. When the time comes to leave this life, the soul, or ātman, leaves the body and can finally achieve freedom or Mokshā. However, if a person's Karma has accumulated the results of too many negative acts (bad actions), the ātman is reincarnated in a new body in a realm like earth (or an inferior one such as hell) in order to carry the weight of these negative actions. If a person has positive Karma, he will go on to live as a god or Deva in one of the celestial realms (higher than earth, or paradise) (where Kumar and Mina's children are now) Once a person's Karma has run out, the soul will return to earth in another body, and into either a higher or lower caste. This cycle of rebirths is known as Samsara.

³ Hindu priests.



hospital because they attempted suicide. I am somewhat surprised to find out that Mina is in intensive care. On arrival at the hospital I learn that Kumar has died only moments before.

In Mina's room, her mother is at her bedside and she tells me as an aside that her daughter was alone at home when she took the medication the hospital prescribed for her husband (Diazepam). Later I will learn that Kumar arranged for his wife to be at her parents, on the pretext of having to buy something, so that he could return alone to their house and ingest the fatal poison; then he telephoned her, his last words to her were of condemnation: "You are a cold-blooded woman, you didn't love your children, me, I loved them so much that I am dying for them, I am not leaving you anything and you won't get anything that belonged to the children".

I see Mina briefly and tell her mother about Kumar's death, and ask her to gently break the news to her daughter, when she thinks the time is "right".

Mina is shaken, but relieved. The coming days are difficult. It is the curse that follows Mina much more than the loss of her husband. The night following his death, Kumar's ghost disturbs what little sleep Mina gets, he calls her with a wave of his hand, and shakes her bed.

Later, we will learn that Kumar was well prepared for his death, his funeral, his bequests to his family (and even his post mortem photo which was waiting at the photographer's), deliberately excluding his wife. She has no right to anything, and her greatest sadness is to not have been able to retrieve the photo albums of her children.

Everything goes to her in-laws who openly accuse her of not having been able to prevent the death of her husband. But Mina is not angry with her husband; she excuses him saying that he was too miserable and that he was no longer the same man as the tender one she married. She wants to take up orders, but hesitates when I take her to an association for vulnerable women where, for the first time since I have known her, a real smile illuminates her face.

Kumar's pathological problem is complex. His depression developed against a background of trauma as a result of his torture. It seems likely that Kumar's mourning was depressive. First of all, the awakening of his bodily suffering is worthwhile in recalling the trauma. 'The body sends signals rather than making sense,' as René Kaes¹. One of the first tasks was therefore to start with the body, using the connections between his present physical suffering and the past trauma. A second stage in repairing the damage caused by the initial trauma was not able to take place and the patient was suffering melancholic depression.

It is worth noting, however, the place of suicide in Sri Lanka, which has a significant prevalence in the cause of death in adults. Sri Lanka has one of the highest suicide rates in the world², making this act more 'common' in Sri Lankan society. Eric Meyer³ even talks about a 'suicidal society', with as many as 47 in every 1000.00 people committing suicide in the 1990s. That does not explain Kumar's decision to commit suicide, but it helps us to understand his actions as an acceptable solution within his community, given his anger at not being able to save any of his children. Suicide was then his only possible 'way out'.

Today, I have a better understanding of Kumar's constant attempts to flee when my visits began: he would come and go, he would sit, but he would often get up and go again to do something else. It was only after talking about his torture that he managed to stay for an entire session. Indeed, "the greatest obstacle to therapy is mistrust of mutual relationships, of intimacy. This singular mistrust is a natural result of the victim/torturer relationship. Every face-to-face meeting can feel like a confron-

¹ Maqueda F. (2005). L'accès aux soins psychiques pour les demandeurs d'asile : position soignante, position citoyenne, [Access to psychological care for asylum seekers : care position, citizen position]. L'autre, Cliniques, cultures et sociétés, Ed.: La pensée sauvage, vol 6, n°1, 112 - 114.

² Quoted from an unpublished article by Ananda Galapatti: Asian Legal Resource Centre, 2003.

³ Meyer, E. (2001). Sri Lanka, entre particularismes et mondialisation. Asie Plurielle, [Sri Lanka, between particularisms and globalisation]. Paris : la documentation française, 124-125.

tation, an interrogation'¹.

The therapeutic alliance particularly came into play when we recognized Kumar's status as a victim, something which could not have been done ten years earlier and through the place taken by the clinical function of psychological containing expressed both by the holding (psychological care) and the handling (through regular physical attendance of sessions). It is not surprising to see how Kumar himself became his wife's torturer, directly attacking her abilities as a mother and refusing to give her access to photos of the children, even denying her identity as a human being, because, at that time, he compared her to an animal: 'She is like an animal, incapable of loving her children'. Then he would make sure that she was excluded from his family, excluded from all social activities as he left a letter to his family prohibiting them from giving his wife anything or speaking to her because she did not have the courage to kill herself.

In her text explaining how people become torturers², Françoise Sironi encourages us to consider the aggression to which people who have been tortured may be subject: 'Personally, I would put forward the idea that it is not about identifying with the aggressor to identifying the aggressor. Unbridled aggression, for example, is actually a repeated attempt to control another person's behavior, the sole purpose being to understand them. It is also an attempt to express their inner torturer. We should not forget that, under torture, a very distinctive and highly effective means of transmission takes place: transmission through actions. Actions include, among other things, the aims of the torture system that the torturer, the transmission agent, is responsible for enforcing on his victim. However, unbridled aggression also has another meaning; it is an act, an act of withholding and when circumstances allow it, it is a type of behavior that torture victims were unable to exhibit under torture, for fear of being killed. This behavior always manifests itself in the context of reliving the trauma, resulting from a trigger from a very diluted but similar relationship which reminds the victim of the initial trauma.'

The traumatic scene in question can be easily seen from looking at the bodies of his children thrown against the wall of the house and the bags of stones used to hit Kumar's body. After the torture episode, he risked being killed if he took care of himself. However, he also risked dying if he did not. It was finding himself in this paradoxical and ambivalent situation that led to the initial trauma and that is the situation he finds himself in again when talking about his operation when he is going to kill himself. At the time of the second trauma (seeing his children thrown against the wall of the house) he is at an impasse, with his physical pain due to the torture being reawakened to a great extent, but with the ban imposed on him by his former torturers from treating it anchored within him, under threat of death. His distress as a result of his physical suffering makes sense and does nothing to call into question his desire to end it all. The scourge inflicted by the soldiers ten years ago, 'if you take care of yourself, we will kill you', returns as the ghost of the uncontrollable fear of death and ultimately turned him into a torturer himself in the case of his wife, ordering her to kill herself. He is also his own torturer in an ambivalent and deviant way.

In an equal but opposite movement to the one he experienced with his torturers, his feelings of aggression upon meeting me were mere attempts by him to be hated; he was putting into action the intentions of his aggressors ten years earlier in order to play an active role. However, he would have wanted me to become the torturer in the transitional relationship and order his death, while taking on the characteristics of the torturers himself in a self-destructive mechanism in which he had positioned himself. Because he did not succeed in presenting this image of a torturer, the relationship was therapeutic, but it was also undoubtedly where my 'uneasiness' came from in the analysis of my counter transference which we will see below.

¹ Maqueda F. (2005) « L'accès aux soins psychiques pour les demandeurs d'asile: position soignante, position citoyenne ». *L'Autre, Cliniques, cultures et sociétés*, Ed.: La pensée sauvage, vol 6, n°1; p112-114.

² Sironi, F. *Comment devient-on un bourreau?* [How do people become torturers?]. Conference held at the Collège de France on January 31st 2001. Text available online at www.ethnopsychiatrie.net



Kumar's aggression cannot simply be explained by this period of torture; it is also because of the fact that he is angry at not having been able to save his children, and also that he 'let go' of his daughter when the second wave hit and was once again in a passive position.

He says that he cannot bear 'the madness of his wife', who was completely unable to move when the tsunami hit, although she was able to release him from his torture chamber ten years earlier. Kumar now has the possibility of being in an active and no longer passive position, as he may have been in during his wife's intervention with the LTTE or with his torturers, but also in his inability to save his children during the tsunami and letting go of his child, and perhaps also as a result of my own inability to help him. For, in the end, he took control of his own destiny (certainly his own destruction) and no longer depended on the will of gods, his wife, his torturers or any other external person, like me. Kumar said he hated the temple of Gayatri Amman beside his house because the gods of this temple had decided to kill his family. His suicide would be revenge on these gods because they would be furious that a man could take this power from them: '*You took my children, I will get my revenge by killing myself; I will take your power away*'. It is another way for Kumar to play an active role.

Kumar's anxiety about death as a result of his first traumatic experience could not be dealt with in the immediate aftermath and was engulfed by the second trauma. Winnicott¹ talks about 'agony' regarding trauma: 'When the patient had this (real) experience, the self was not mature enough to experience it. The self remains 'unaware', specifying that it is not the repressed unawareness of neurosis but that 'the self is incapable of processing something, accepting something' (p. 210) '[...] the initial proof of primitive agony cannot be put to rest until the self can accept the temporal experience of his own present' (p. 210) and in order to protect itself from torture the self can stay away (to return to Kumar). '[...] the patient must continue to look for details of the past which have still not come to light. He looks for them in the future' (p.210) 'The patient must 'remember' them but it is not possible to remember something that has not yet happened, and this thing from the past has still not happened because the patient was not there for it to happen to him. In this case, the only way to remember is for the patient to do the thing for the first time, in the present, that is in the transference, the proof of this thing from the past' (p.211 – 212).

It is time to ask myself the question that eludes me every time: what about my counter transference? It is clear that Kumar was not particularly pleasant with me, and he put all of his effort into that, in his ambivalent and deviant behavior. In response to this, my counter transference also became ambivalent, with what he did to his wife who rebelled against me and wanted to save him and to help him. I was therefore relieved but also disappointed by his death. Throughout our sessions, I took refuge in a stubbornness not to use all of my resources to save this man from killing himself, undoubtedly for fear that I would not succeed. I therefore imposed limits on my intervention, both as a result of the cultural difference and the fact that I intervened alone. Looking again at the allegory given by the goddess Kali, when she is honored, she becomes a liberator, liberating people from the fear of destruction that she herself is responsible for. Kali is visible in the course of events, destroying everything. By honoring her, it is not about ensuring that she does not destroy things, but rather destruction must be accepted in order to lift the fear of death. By my non-intervention, did I give Kumar the choice to play an active role in breaking the cycle?

I still go to see Mina, and together we have analyzed these last few months. In a few days it will be an important date because 41 days will have passed since the funerals², and she will return to the burial place of her deceased husband to tell him that she will not kill herself, not now, not ever, and that she will die of old age. She will bring him his favorite meal and will ask Yama, the guardian of the dead, to judge him so that he may quickly be reborn again in another form. Then, finally, she will find peace, she tells me.

Lastly, I would like to conclude with an extract from a text by Winnicott on suicide and one of his patients: 'My patients inspire most of my ideas and I acknowledge my debt to them. I owe the

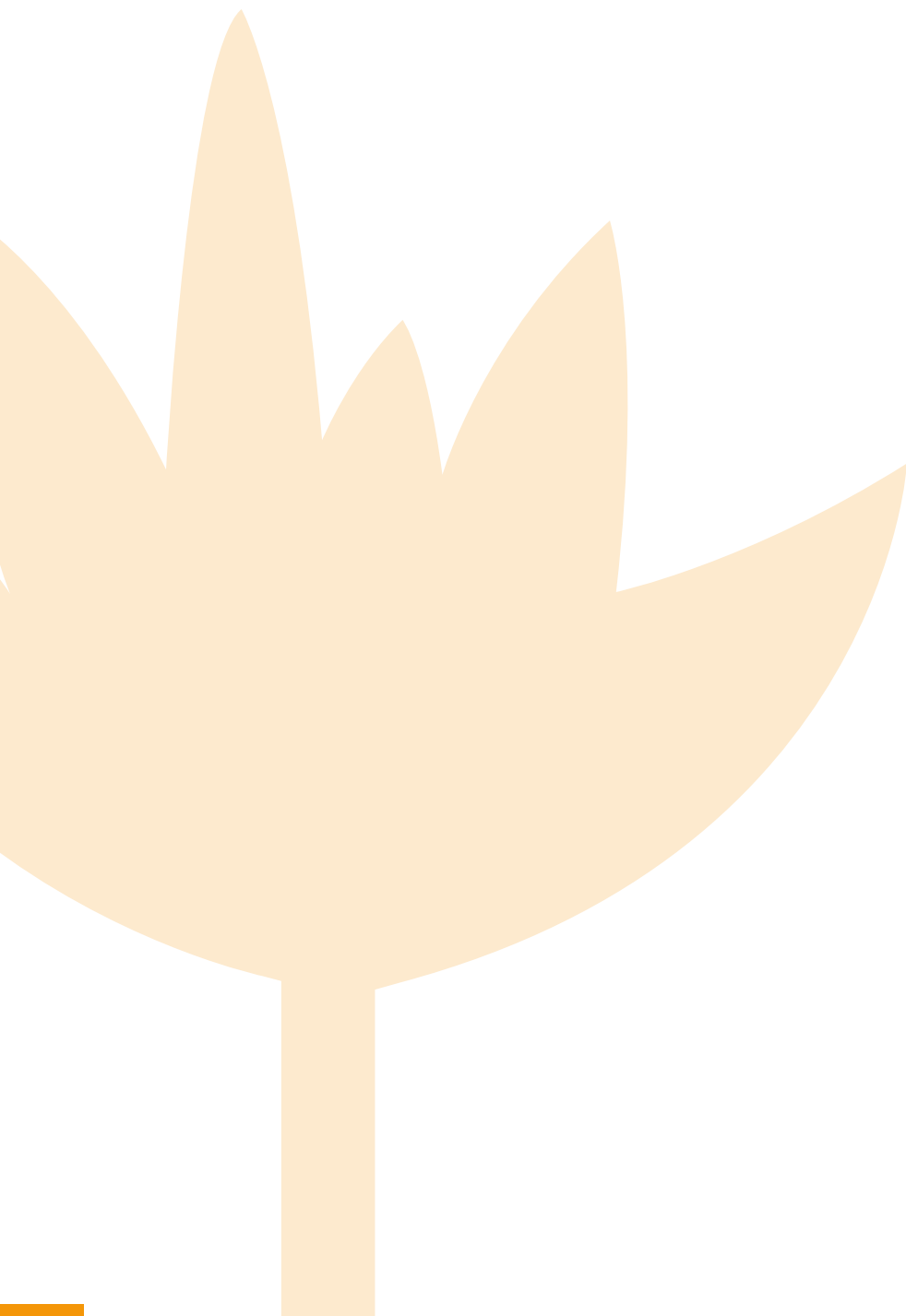
¹ Winnicott, D. W. (2000). La crainte de l'effondrement, [Fear of Breakdown]. In *La Crainte de l'effondrement et autres situations cliniques [Fear of Breakdown and other clinical examples]*. Paris: Gallimard.

² After someone dies, a month later (this can be either 31 days or 41 days later) Yama 'freese' the dead person's soul for one day and that is when the family can make offerings to the dead person by preparing their favorite meals. After this day, the dead person's soul will leave to be reincarnated or will wander the earth until it is judged again.

expression 'phenomenal death' to one of them. What happened in the past was death as a phenomenon, and not a fact like the death we observe. Many men and women spend their lives wondering whether suicide is the answer – suicide meaning sending the body to a death that the mind has already accepted. However, suicide is not the answer, just a desperate gesture. I understand now for the first time what my schizophrenic patient (who killed herself) meant when she told me, 'all I ask of you is to help me kill myself for the right reason and not the wrong one'. I did not succeed and she killed herself desperately trying to find a solution. Her aim, I see now, was to get me to declare that she had been dead since her childhood. Based on this, I think that we, she and I, could have enabled her to postpone the death of her body until the age would have taken its toll.' (Winnicott, 2000). I think, in Kumar's case, that he killed himself for the 'right reason' because he found that reason and expressed it during the sessions we had.'

BIBLIOGRAPHY

- **Asian Legal Resource Centre** (2003). *Preventing suicide in Sri Lanka*. In *United Nations Economic and Social Council Commission of Human Rights* (Ed.), New York.
- **Bydlowski, M.** (2005). *La dette de vie, itinéraire psychanalytique de la maternité, [The Debt of Life, Itinerary Psychoanalysis of Motherhood]*. Paris : PUF.
- **Kaes, R.** (1987). *La troisième différence. L'espace imaginaire des groupes. Culture, psychanalyse, éthologie [The third difference. Imaginary group spaces. Culture, psychoanalysis and ethology]*. In *Revue de psychothérapie psychanalytique de groupe*. Toulouse : Erès, 9-10.
- **Lachal, C., Ouss-Ryngaert, L., & Moro MR.** (2003). *Le deuil traumatique*. In : *Comprendre et soigner le trauma en situation humanitaire [Traumatic grief. In: Understanding and treating trauma in humanitarian situations]*. Paris : Dunod.
- **Maqueda, F.** (2005). *L'accès aux soins psychiques pour les demandeurs d'asile : position soignante, position citoyenne, [Access to psychological care for asylum seekers : care position, citizen position]*. *L'autre, Cliniques, cultures et sociétés*, Ed. La pensée sauvage, vol 6, n°1, 112 - 114.
- **Meyer, E.** (2001). *Sri Lanka, entre particularismes et mondialisation. Asie Plurielle, [Sri Lanka, between particularisms and globalisation]*. Paris : la documentation française, 124-125.
- **Sironi, F.** *Comment devient-on un bourreau? [How do people become torturers?]*. Conference held at the Collège de France on January 31st 2001. Text available online at www.ethnopsychiatrie.net
- **Sironi, F.** (1999) *Les états du traumatisme. Systèmes d'influence et traumatisme [The states of trauma. System of influence and trauma]*. Colloque Nevers, 26 and 27 November 1999. www.ethnopsychiatrie.net
- **Winnicott, D. W.** (2000). *La crainte de l'effondrement, [Fear of Breakdown]*. In *La Crainte de l'effondrement et autres situations cliniques [Fear of Breakdown and other clinical examples]*. Paris: Gallimard.



8 - MENTAL HEALTH AND CARE PRACTICES PROGRAMS IN CHAD (2007-PRESENT)



© ACF - Tchad



CONTEXT AND PROGRAMS

Chad, one of Africa's largest landlocked countries, is a complex ethnic mosaic composed of a wide variety of Sahelo-Saharan ways of life (herders / farmers, sedentary / transhumant / nomadic). The entire country is affected by strong demographic pressures weighing on ever shrinking resources, due to desertification.

Chad is one of the ten countries at the bottom of the human development indicators list (193 out of 197 according to the Human Development Index - 2011). Even though certain areas – the Lake Chad basin, the oil production zones in the South – remain strong economic drivers, its low HD index reveals the lack of structure and the country's chronic poverty. The country's resources, which until recently were solely based on agriculture and livestock farming, are, since 2003, largely dependent upon oil revenues. These revenues are however still poorly distributed and offer little benefit to the population or to the technical services of the state. Access to basic services (education, health...) still remains a problem for most Chadian people who experience high levels of food insecurity, mortality and morbidity rates.

These are indicators of a structural crisis that several one-off factors regularly turn into cyclical crisis (conflict, population displacement, epidemic, rainfall deficit, poor harvest). Food insecurity is not limited to poor people in rural areas and cities also shelter vulnerable populations whose food consumption depends on their ability to buy it.

The political and security context of the region is fragile, and the country has faced significant internal political challenges over the past few years. These two factors have led to large displacements of people to the east of the country (refugees and internally displaced persons).

ACF-France's action in Chad began in 1982. Between 2002 and 2004, ACF-France suspended its activities and a transfer was made to local NGOs. From 2004 to 2006, ACF USA intervened in the case of Sudanese refugees in the northeast of Chad. In 2006, ACF-France restarted its food monitoring activities in six Sudanese refugee camps run by ACF-USA. After making an assessment in the southeast of the country, ACF redirected its intervention. In 2007, the association launched a project to assist victims of inter-communal violence in the southeast of Chad, thus becoming a major humanitarian operator within the displaced populations of the Dogdore site.

A food security assessment in the Dogdore area showed significant psychological suffering and difficulty adapting to camp life. A series of tragedies had deeply affected the population. Individuals had lost one or several family members as well as their belongings in traumatizing situations, and they found themselves unable to deal with brutally disorienting conditions.

The situation of the Chadian people in the southeast convinced ACF to set up a mental health program in 2007. A team made up of an expatriate psychologist, an assistant and psychosocial workers worked towards opening a women's center in the Dogdore camp, which offered different activities tailored to their needs. Breastfeeding support groups targeting lactating women were implemented as well as sessions to raise awareness about breastfeeding.

Workshops to produce goods for family use (with the possibility of selling them at the local market) were proposed and material (straw for mat making and material for making soap...) was made available to the women who visited the psycho-social center. This allowed them to provide for some of their basic needs. The center was a place of exchange and discussion, where certain important issues could be brought up (life in the camps, fleeing, conflicts...) and the activities put in place could help to identify which women needed breastfeeding assistance or psychological support.

For women to participate freely in the center's activities, a «kindergarten» was created. These moments of intimacy with the children, focused on psychomotor stimulation and mother-child games, were an opportunity to revive interactions that had often been altered by the family's traumatic experiences.

Last but not least, individual psychological consultations were available on request.

This program was very successful. An average of 300 beneficiaries visited the center each week. The regular session attendance as well as the large number of participants shows the interest of the population for this program.

Unfortunately, because security conditions worsened significantly, the base was closed and the program was not restarted.

Along with these actions, ACF intervened in Kanem, a western region in the north of N'Djamena affected by a chronic nutritional structural crisis. Kanem, a particularly vulnerable area located in the Sahel belt, is affected by ever longer periods of drought. Because of the difficult weather conditions on farming and livestock, the people have had to adapt: many men have emigrated to the capital or to the neighboring countries for work, leaving the women overwhelmed by work, to care for the children and the crops by themselves.

At the end of 2007, a nutrition program was started in Mao (the main city in Kanem). An assessment on mental health and care practices was carried out at the end of 2008. The assessment revealed several key issues.

First, the study revealed many early marriages leading to very early pregnancies (at the age of 14 or even younger). There are many closely spaced births. No precautions are taken for pregnant women: they are often undernourished in order to avoid having heavier babies, which would make delivery even more difficult. In certain areas, women have very little access to pre-birth and post-birth care. They will rarely decrease their workload during pregnancy, which is mostly a period of anxiety. Deliveries, long and painful, take place at home, sometimes without help, sometimes with traditional midwives whose practices are not always suitable (risk of recto-vaginal fistula). Colostrum is not usually given to the newborn and complications in breastfeeding often occur. During the first six months and especially in the villages, few children are breastfed exclusively, and water, often of low quality, complements breastfeeding.

A care practices program was therefore integrated into the already existing nutrition program in Mao at the beginning of 2009. The next year, following another crisis in the western area of the country in Bar el Gazal, the same program opened a second base at Moussoro.

This program included several aspects:

- Training of health care centers staff on infant care practices within the framework of treating malnutrition in order to guarantee a holistic approach of childcare.
- Activities to stimulate children, to reinforce the parent-child bonds, as well as setting up areas within the nutrition centers where mothers and those accompanying them can speak up and be heard.
- Training and assisting traditional midwives to ensure that births at home occur more smoothly, not leaving out the emotional side of motherhood.
- Community intervention with the influential men of the villages.
- Organizing discussion groups to reinforce adequate health care practices among pregnant and lactating women with their young children in the villages.



The two programs are currently (August 2012) still ongoing and have evolved: the teams' technical abilities have been reinforced and their number has increased. The social centers in Mao and Moussoro are actively involved in organizing activities for women and their children. In addition, in both urban centers, assistance has been offered to the more vulnerable families to support them in changing inappropriate child care practices. Psychosocial work has been implemented in the

therapeutic nutrition centers in Mao, Mondo, and Moussoro, and in more than twenty ambulatory nutrition centers.

FROM HUMANITARIAN INTERVENTION TO THE HUMAN FACTOR – TRANSCULTURAL PERSPECTIVES¹

Humanitarian intervention abroad is currently evolving and continues to develop within mutual encounters when facing adversity and life's ups and downs.

While working for an international non-governmental organization (NGO), I went to a mission for several months in a region of Chad where many children were suffering from severe malnutrition. With the help of an interpreter, I was able to meet the men, women, and the key people from the villages in order to better understand the situation behind the mission's motivations and its justification. Beyond the difficulties surrounding access to food, water, and medical care, I wanted to understand why so many children were malnourished.

Understanding this region's maternal care practices while also considering regional beliefs and attitudes made it possible to assess the situation and implement the first phase of a malnutrition treatment and prevention program.

After a year and a half, I returned to the region to evaluate what impact the project had had on the initial situation. Thus, I will seek to describe the stages of this action through the story of Abbakar.

Abbakar or the limits of traditional care.

I met Abbakar and his mother at the Therapeutic Nutrition Centre (TNC) in Mao. Abbakar had been admitted two weeks earlier because he was experiencing all the signs of severe acute malnutrition: thinness, folds on the arms and legs, elderly features, as if his skin were too big for him. His stomach was bloated, he was groaning, and he refused to play or leave his mother, Fatimé. I notice burn marks on his stomach, which I also observe on most other children of his age. I have a talk with the mothers of the center; ask them to tell me what brought them there and how their child had lost so much weight.

Fatimé tells me that her son is three years old and is the fourth of five children. Her husband is working in the south of the country and returns once a year during the rainy season to plant the millet. The rest of the time, Fatimé lives alone in the village with the other women and the elderly (the majority of young men leave to find work). The father is sending money or food, fairly regularly. They live in a difficult situation, but most of the time the family has enough food. Abbakar was breastfed until he was eighteen months old.

Why until then? It's «tradition,» replies his mother, «You have to breastfeed girls until seventeen months and boys until eighteen months so they will be smarter.» The other mothers agree. They also weaned their child at that age. It is an important date, celebrated with a ceremony that brings all women of the community together. On the day the child was weaned, Fatimé invited the women close to her. An Imam came with a wood slate on which he had written a few verses from the Koran. He poured out some water and recited a few prayers. The mother then coated natron², on her breast, took Abbakar in her arms and showed him her breast while telling him: «You see! It is no good, you can no longer suck.» The other mothers then spat water on Abbakar's face, before Fatimé gave him to her own mother living in the neighboring village.

During the few days he spent with his grandmother, Abbakar cried and refused to eat. When he returned home, he had diarrhea and was vomiting. Fatimé was worried and asked her husband for advice. He told her to give the child to his own father so that he could take him to the wazambi, a traditional healer working in the market place. He might be a shoemaker, a merchant, or a blacksmith.

¹ We thank the Journal des Psychologues for permission given to reprint the following article published in February 2012 by Alexandra Bataille, Mental Health and Care Practices Program Manager for ACF in 2009.

² Mineral used in some traditional health care practices.

■ From the cultural to the therapeutic.

After looking in Abbakar's mouth, the wazambi said he was suffering from "uvula" and "false teeth." With the tools he had on hand, he cut off the child's uvula and pulled his canine teeth. But the diarrhea and vomiting continued. His mother tried to give him teas, but the child was no longer able to swallow. He began to lose a lot of weight. Since his belly was swollen, his grandfather took him back to the wazambi, who made burns on his stomach in the shape of a bird's foot around his navel. Fatimé also went to another healer who said prayers and provided verses from the Koran, also written on a wooden slate board. Despite those repeated treatments and the entreaties of the entourage, Abbakar's health continued to deteriorate. With her husband's agreement, Fatimé finally went to the health center located 45 minutes away (on donkey back). After weighing and measuring Abbakar, the nurse suggested that the mother send him to the TNC to receive the care he needed. While Fatimé was telling the story of her son's malnutrition, the mothers present explained to me that their child's experience was relatively similar. Most of the children admitted to the TNC had been weaned not long before and they had all received traditional treatments."

The variety of treatments in Africa and their rationales are displayed here (Fassin D., 1992). This cultural plurality, which Pierre Bourdieu had emphasized in the sociological components, would make it possible to welcome and live with new ways of doing things (1980; Moro M.-R., 2007). Thus an opportunity to think about the "how to do" rather than the "why" is offered. Thinking along with the other person would open onto intermediary mechanisms making it possible to work together in a common perspective (Kaës R., 1998).


■ From one world to the other, from anguish to method (Devereux G., 1980)

How can the beliefs and traditions of these people be respected while at the same time preventing malnutrition? At the beginning, our proposals seemed diametrically opposed to these practices. Our contemporary societies make it clear that it is necessary to take care of a baby's body; that a child is fragile; that it is necessary to avoid hurting him; that he must be touched softly, without violence, etc. – the opposite of what I had been able to observe in this region of Chad. Moreover, many people confirmed to me that the wazambis' treatments had great importance in this region (even if this is more the case in villages and less in the city since people have taken in the messages transmitted by associations and developed new ways of doing). What should I tell these mothers when they come to me and ask me for advice to avoid their child malnutrition?

I asked Fatimé about her feelings on Abbakar's suffering. My interpreter did not understand the meaning of the word "feeling"; for him these were physical feelings. So Fatimé was not able to answer my question. I therefore had to give a simple definition of an emotion, of feelings like sadness, anger, fear, stress, etc. So I used my own feeling about Abbakar and his mother as my general starting point. I tried to put myself in their position and tried to imagine what I would feel. But talking about one's feelings, putting words to an experience, this "western" way of having access to psychological care, was this a suitable method to reach a culture in which words seem to have different functions? Still, these mothers wanted to talk and share their experiences with me. But they were not able to talk about their own feelings, at least not in a way that was accessible to me. How could I understand a mother who tells me she has a swollen black face, that she is "cladjaou-dou"? How could this term that has no equivalent in French be translated? The cited symptoms made me think of depression, but also of psychosis. And then there was also the laughter, inevitable and necessary, that burst out at one point or another, as if to alleviate the pain and express the suffering. Even though I wasn't able to understand everything, I perceived, beyond the words, the moral impact of child's malnutrition and illness on these women.

■ Cultures, illness, and dynamics of treatment

What does it mean "to be sick"? What does the child's malnutrition mean for a mother? Among the words used to talk about malnutrition, the word "wolié" is especially striking; it means "The child is not well taken care of." In other words, "the mother does not know how to look after him." Community support is very strong in this region. However, it falters when it comes to malnutrition. The mother is then no longer "good enough" (Winnicott D. W., 1967). Fatimé thus told me how other women from



the village blamed her for her child's health problems. She was told that it was her fault because she didn't know how to take care of him. But she seemed not to let herself be overwhelmed by guilt and said she had done the best she could.

The anthropologist Karine Magen describes three kinds of illness in the Kanem region (2009):

- Illnesses that are “sent”: sudden illnesses such as mental illnesses or unknown illnesses. They are caused by sorcery most of the time aimed at one of the parents. Since the parents are often “armored,” in other words, protected by amulets, magic water, etc., the spell may fall on the child because he is more vulnerable.
- “Fate”: illnesses resulting from the determinism of the human condition subject to God's plan. These are illnesses leading to progressive deterioration of health, handicaps and birth defects or accidents.
- “Ordinary” illnesses having physical or environmental causes.

Malnutrition is not really considered as an illness, but for those who would choose to give it this status, it seems relatively obvious to place it in this category. For this class of pathologies, prevention is conceivable and treatments desired. That may be one of the reasons why malnutrition treatment and prevention programs implemented have had very rapid positive effects.

■ Setting up the action mechanism

Following the first evaluation, we developed a prevention program based on three areas of intervention: working with traditional midwives on monitoring pregnant and lactating women; working with health centers on receiving and supporting pregnant and lactating women; and creating support discussion groups with imams, traditional healers, village chiefs, women of influence, etc.

The activities developed included training sessions, workshops on infant massage, and support groups with or without visual aids for several months. They dealt with pregnancy, breastfeeding, development, and caring for children in case of illness, accidents, etc.

■ Over the course of time

After several months, I went back onsite to evaluate the impact of the program on the population. I was astonished by the progress we had made and the changes that occurred in such a short period of time within care practices that seemed difficult to change. I was also afraid that the population would reject our proposals, some of which seemed diametrically opposed to their practices. However, I observed people's involvement and willingness to follow our advice.

One of the decisive elements was to work using the beliefs and customs of the community as a general starting point and to rely on the key players of each village. During the interview with Fatimé, we had noted that the decisions regarding Abbakar reverted to her husband (especially those involving action outside the house like buying medicine, going to see the *wazambi*) and to her mother-in-law for decisions regarding what was happening in the house (the way of feeding Abbakar, the weaning method). We therefore decided to work with the mothers-in-law so that they could in turn convey important messages. We also relied on religious leaders and traditional healers in order to adapt the messages and convey more efficiently, and on the Koran, which, for example, recommends breastfeeding up to the age of two lunar years (Koran, II: 233).

The situation in Kanem has changed greatly in recent decades, in particular because of droughts and the advance of the desert which have forced men to move to other cities, even to other countries, to look for work. The men remaining in the area, like the women, have often lost their reference systems. Having only limited access to information, they are seeking advice, references, and an open ear to listen to the problems they are facing. Almost all the mothers have lost one or more children and seem to live with a strain of fatalism. But that does not put a stop to suffering and the desire to do everything they can to prevent it. As soon as someone from the outside comes to propose possible solutions to them, relayed by people who are listened to and respected in the village, they quickly abandon some practices to take up new ones.

■ The short-term benefits

We have been able to observe some changes in practices that are quickly visible, such as exclusive breastfeeding, gradual weaning, or moderation in resorting to traditional healers. Mothers who have acquired new habits often come to the assistance of other mothers, with remarks that make it possible to lift certain taboos related to pregnancy and thus promoting changes.

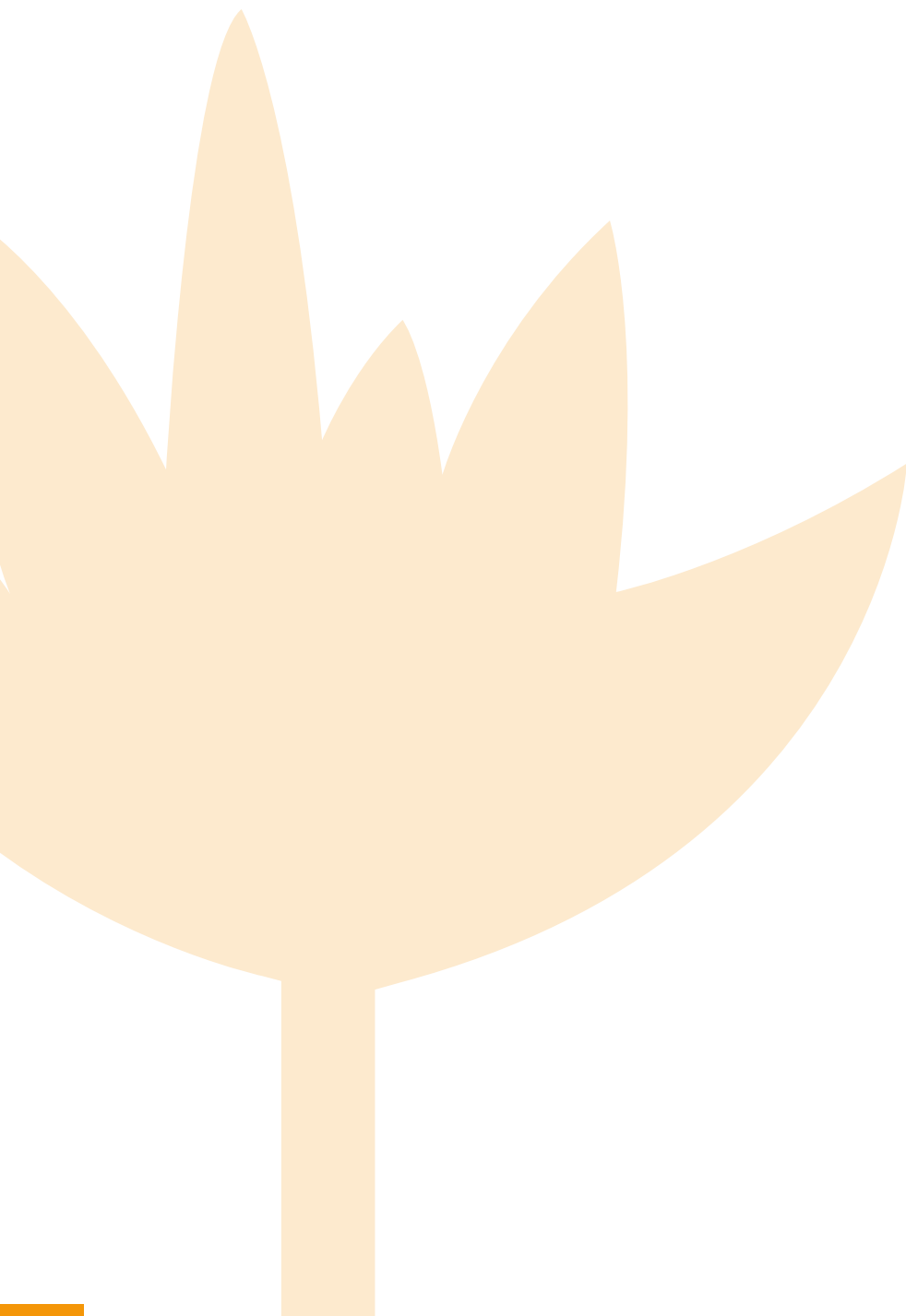
However, while encouraging, it is too early to conclude that the change in beliefs, attitudes, and practices will last. The initial observations mainly demonstrate that they are capable of being changed depending on many social, cultural, environmental, political, economic, and religious factors.

■ Conclusion

In an encounter with others, sometimes very little is necessary to move things forward: listening, observing, letting oneself be moved, and refraining from making judgments. It is therefore necessary to take the time to discover the other's mindset and try to take an action not for him, but with him. This is a form of mutual acknowledgment that objectifies the problems for which we are seeking culturally acceptable outcomes. It is a way to offer others freedom of choice and autonomy of thought and action. It is this perspective that humanitarian initiatives should fit into from now on; they should no longer think of the other as a victim marred by evil, but as a human being capable of carrying out their actions of care, prevention, and creativity. (Baubet T. et al. 2003)

BIBLIOGRAPHY

- **Baubet, T.; Le Roch, K.; Bitard, D. et coll.** (2003). *Soigner malgré tout. Bébés, enfants, et adolescents dans la violence [Care despite everything. Infants, children, and adolescents in violence]*. Grenoble, La pensée sauvage.
- **Bourdieu, P.** *The Logic of Practice*. Stanford, CA: Stanford Univ.
- **Devereux, G.** (1980). *From Anxiety to the Method : In the Behavioural Sciences*, Paris, Flammarion.
- **Fassin, D.** (1992), *Pouvoir et maladie en Afrique. Anthropologie sociale dans la banlieue de Dakar [Power and disease in Africa. Social Anthropology in the suburbs of Dakar]*. Paris, PUF
- **Kaës, R.** (1998). *Différence culturelle et souffrances de l'identité [Cultural differences and identity crisis]*. Paris, Dunod, 2005
- **Magen, C.** (2009). *Evaluation socio-anthropologique pour l'amélioration des programmes nutritionnels du Ministère De La Santé Publique Et D'Action contre la Faim du district De Mao [A socioanthropological evaluation for the improvement of nutritional programs of the Ministry of public health and Action contre la Faim from the Mao district]*. Valid international. ACF, Paris
- **Moro, M.-R.** (2007). *Aimer ses enfants ici et ailleurs: histoires transculturelles [Loving our children here and everywhere : transcultural stories]*. Paris, Odile Jacob
- **Winnicott, D.W.** (1967). *A Good enough Mother*. Paris, Payot et Rivages, 2006



9- CONCLUSION



© ACF, Elisabetta Dozio - Ethiopia



Since 2002, Mental Health and Care Practices programs have been conducted by Action contre la Faim in 18 countries.

As illustrated in this book, the programs implemented, the actions carried out, and the intervention contexts are very different and diversified. Testimonials presented in this book have tried to show the extent of this work and highlight its complexity. During the past ten years, the understanding of contexts, the ways of implementing the programs, the ability to measure impact, the development of intervention protocols and monitoring tools, integration with the other sectors of ACF (Food Security and Livelihoods, Water, Sanitation & Hygiene, and Nutrition) have evolved to better align themselves with the various cultural contexts and with the specific situations of each environment.

Through these programs, we have worked to ensure that children received the stimulation and emotional support needed for adequate development and growth while also contributing to reducing the pernicious effects of malnutrition on children's health.

To strengthen the parent-child bond and support the most suitable caregiving attitudes and practices, we have supported mothers, fathers, but also families and communities, which play a crucial role in the support given to the mother and child on physical and emotional levels.

In countries where wars, population displacements, or natural disasters often cause traumatism, depression, individual stress, and a destabilization of the family and community unit, the programs set up, in addition to strengthening and preventing the deterioration of good caregiving and breastfeeding practices, have also been able to ensure psychological support individually and/or in groups, aiming to strengthen the resilience capacities of the population affected by these events.

This type of intervention is characterized by community involvement and acknowledgment of specific cultural aspects.

The actions have often been integrated to programs of other ACF sectors to reinforce their effects and to guarantee a holistic management of individuals and communities.

Testimonials shown in this book bring to light the difficulty encountered by psychologists and teams in when faced with complex situations and suffering accounts. National teams often come from the same unstructured background and have experienced the same suffering and losses as the beneficiaries they find themselves treating and supporting.

In this case it becomes essential to set up regular supervisory mechanisms. These have multiple purposes:

- on the one hand, that allows teams to have a space for expressing and reformulating the suffering seen and listened to, but also the possibility of finding as a team the motivation and energy to “fight” against the frustration of not getting immediate results and having the impression, often reinforced by the beneficiaries’ comments, to not providing anything concrete (food, equipment, water, etc.)
- on the other hand, those moments of supervision are the opportunity to reflect on the psychological problems encountered in caregiving and in taking into account the cultural differences specific to the various contexts.

The experiences that we have shared in this book are intended to emphasize the importance of taking into account elements related to mental health and care practices in humanitarian contexts, in particular in the ACF core area of expertise.

Throughout these pages, we hope to bring into focus the underlying elements that have an impact on the well-being of children and their families, on the beliefs and practices related to child care and on the ability of families and communities to cope with crisis situations. Sharing our work experiences and the encounters of these past ten years is an important moment for us today and allows us to reflect on our practice in order to better open up to new ways of intervention.

Action contre la Faim

14/16 Boulevard de Douaumont - CS 80060

75 854 PARIS CEDEX 17

+33 1 70 84 70 70

info@actioncontrelafaim.org

www.actioncontrelafaim.org

