

TAKING MENTAL HEALTH INTO ACCOUNT AT ACF

Making the programmes more humane
by integrating anthropological and psychological dimensions
in the fight against hunger

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First part

**Background and arguments for the
“mental health” project at ACF**

Introduction

In my arguments I have decided to associate the beneficiary (in this case a malnourished adult or a malnourished child and accompanying adult) and the national staff, for the needs in mental health. The members of staff are indeed at the same time the inhabitants, or refugees or displaced persons in the areas in which we intervene. As such they may also have gone through or been witnesses to acts of violence and be traumatised, they may have been subject to coercive politics and may live in conditions of extreme poverty. At the same time they form part of ACF and are not beneficiaries in the same way as the others.

They are therefore in an in-between situation, which is not always easy to apprehend. I have chosen to integrate them into the population of beneficiaries as their needs, as far as mental health is concerned, are close to those of the beneficiaries. On the other hand, it is obvious that the responses we can offer them are different because of their professional commitment within ACF.

As far as the mental health of the expatriates is concerned, the Human Resources Department is responsible for them.

I. What is mental health?

Mental health covers different realities that are inter-linked : problems disturbing the social stability that the authorities have to manage, pathological disorders that the psychiatrists have to treat, psychological suffering that the people working in the health or social sectors have to relieve.

I have chosen to refer to a wide notion of mental health linked to public health and proposed by WHO : *the state of mental well-being* and not only the absence of mental illness or of addictive behaviour (drugs, alcohol...). As such it concerns all human beings and is an integral part of health, defined by social, environmental, biological and psychological factors.

The term “mental health” is perhaps not the most appropriate and may frighten some people but I have not found any adequate expression. Moreover you will see that strictly speaking the ground covered is vaster than that of mental health : *it concerns the integration of human, psychological and cultural dimensions in the ACF programmes.*

II. Why should we consider the mental health dimension at ACF?

A whole set of reasons has converged to the question of taking care of traumatised beneficiaries : questioning from the field concerning the limits of our approach, the headquarters’ intention to improve the quality of our services, the experience of psycho-social programmes carried out by different NGOs in Eastern Europe, and ethical questioning regarding the beneficiaries’ needs at a psychological level.

The idea of a pilot project has grown with the aim of defining propositions dealing with mental health in the ACF programmes and based on the following elements :

- Situations in which ACF intervene are often crisis situations, that of social destruction and/or of political and/or physical violence, which obviously have an impact on the

mental health of the beneficiaries, the national teams and the expatriates. This may disrupt the daily life and entail the loss of reference points. How can ACF take into account this aspect in their daily work?

- The beneficiaries have often gone through or been witnesses of acts of violence, of physical and/or social violence, have had to abandon their homes and their land, do not know what has happened to members of their families... What responses can ACF bring faced with this psychological suffering? How can we still improve the services proposed in emergency situations as well as in post-emergency or in more chronic situations?
- In particular how can we avoid that the time spent in the nutrition centres does not have an additional traumatic effect on people who are already very vulnerable?
- How can we try to prevent the medium and long-term psychological effects of the traumas encountered?

III. Mental health at ACF : an integrated approach in the different programmes

In the humanitarian context, we can consider mental health from two complementary angles :

- **A vertical approach** : setting up in the field of psycho-social¹ programmes carried out by professionals (psychologists and psychiatrists) and supervised at the headquarters by a scientific department. This approach has existed for about ten years (cf. Philippe Leborgne's presentation to the Scientific Committee in June 2000 – annex 1) and has been particularly set up in the missions in Eastern Europe, no doubt made easier by the cultural proximity and the existence of local professionals in mental health. Work is done on a medium and long-term basis and, by means of psychological support to traumatised or vulnerable people, their psychological reconstruction and their resilience capacity to make choices are encouraged. Not many experiences of this type have been carried out on other continents, except in Rwanda and more recently in Sierra Leone.

We can find some information on these questions, mainly written by the team supervisors in the field, but with few concrete elements. In spite of the interest of this clinical work, it is a shame that there is an absence of precise evaluation of the psycho-social programmes. This is due to intrinsic reasons : mental health is difficult to evaluate (criteria as subjective or objective, ethical problems concerning group control – a group given a placebo or not given treatment), but also for reasons linked to the context. What are the diagnostic scales? What are the relevant therapeutic processes outside of the West? What intricacy exists between the social and the psychological (for example psychological repercussions due to collective violence)? And it is all the more difficult to apprehend in cultures that are not ours.

- **A inter-disciplinary approach** : taking into account (which is not currently possible for ACF) the psychological suffering of the beneficiaries and their individual and collective stories in the programmes that already exist. During the last ten years, the technical nature,

¹ The psycho-social programmes are programmes that take into account the psychological aspects as well as the social aspects because of the strong inter-action between the problems dealt with : children from the streets, traumatised people, children who have been soldiers...

the professional attitude and the demand for efficiency have over-ridden a less sophisticated model that was perhaps more humane, also based on the relationship with others. To reintegrate this more humane dimension into our existing programmes, to develop assistance that shows more respect for the communities and for individuals, seems to me to reply to an ethical requirement and also opens up a sphere of reflection and innovative practices.

In the beginning the inter-disciplinary approach corresponds more to the background, the motivations and to the present capacities of ACF and forms the basis for eventual future developments. To take the individual into account in a more global way in our programmes, to transcend the body/spirit dichotomy, to encourage people to talk, to listen to psychological suffering, opens a new perspective and would ensure quality service.

To feel well and to regain confidence in oneself and in the future, one needs to be recognised as a full citizen with all one's identities (family, cultural, social, professional...) and to be treated with dignity. Sometimes, in emergency situations, the extent of the human disaster can lead to actions with the use of systematised programmes, which do not sufficiently take into consideration the beneficiaries' human reality, for which they were made. If ACF as a whole decides to take into account the cultural and anthropological dimensions in its intervention contexts, we believe that the setting up and efficiency will improve and also that this knowledge will influence the implementation and organisation of extreme emergency missions.

A word about the connection between gathering testimony and mental health. If there is no doubt that these two dimensions are part of the same ethical concern that incites ACF to take into consideration the more humane and perhaps more individual dimension of its beneficiaries, I think it is necessary to recall that they are interventions that respond to different aims (ACF's intention to gather evidence in order to denounce facts versus the beneficiaries' need to be psychologically helped and to be listened to, with the guarantee that what they say is confidential). They must be carried out by professionals with different specialities and do not necessarily have to take place in the same areas (the choice of places to gather evidence replies to a strategy of communication, whereas mental health must be considered in all the missions), nor with the same beneficiaries (some of them want to give evidence so that the whole world learns their story, while others want to be listened to and have moral support for themselves; some will do both and others neither).

I admit that this position is a bit rigid but I think that we must avoid confusion. When gathering evidence and when taking mental health into account we need to have well established methods that are accepted and mastered by all the ACF members. Perhaps then we will be able to ask ourselves what are the eventual links between testimony and mental health.

Aims of the inter-disciplinary approach

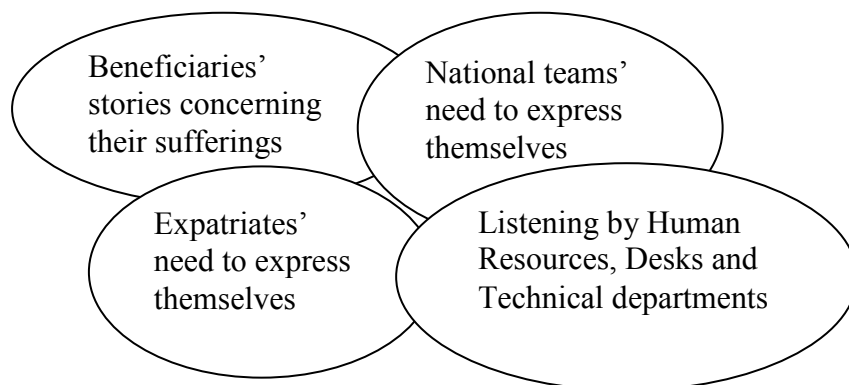
Taking into account the humane, psychological and cultural aspects of individuals has multiple, direct and indirect, aims :

- To prevent medium and long-term after-effects of psychological traumas.
- To avoid the time spent in the Therapeutic Feeding Centres being experienced as another trauma (being anonymous, beneficiaries' dependence and passivity, miserable environment), but as a living space where one is considered as a person.
- To reinforce the community's capacities to deal with traumas.
- To reinforce the re-nutrition process : to improve efficiency with those we take care of, to decrease the number of those who abandon or relapse, to encourage the continuation of treatment at home.
- To adapt our programmes in a better way (in terms of implementation, of food actions...), to improve communication with our partners, to adapt the management of the national teams and our training periods in order to achieve better comprehension of the social and cultural customs, and to avoid our programmes having a destructive and destabilising effect on the community.
- To be in a better position to anticipate the development of the geopolitical context and the programmes for the future months by improving the exchanges between the beneficiaries and the national staff.

The awaited result is of course a global improvement of the services we propose.

However this improvement can only take place if it is a collective project that incites each member of ACF to be attentive to others. Confronted with violence, with the horrors gone through by certain people (beneficiaries, national teams or expatriates), a means of protecting oneself is to work a tremendous amount of time, to place oneself in the position of a technician and to avoid meeting others. It is a normal defence mechanism, especially as one is also in a situation of vulnerability in particular due to being expatriated. If we ask the national teams and the voluntary workers to be ready to listen to the beneficiaries, we are going to ask them to take a risk for themselves, to let themselves be affected by the sufferings of others and to limit their protection. This means that we must be careful, that we must not oblige people to listen to others if they do not feel capable of doing so, and that we must respect their choice. In particular this means that we undertake to support the beneficiaries and to be present to listen to them.

If we encourage people to express themselves, each person's need to share the sufferings heard of or experienced, and in particular the first people to have heard the story, will increase and so forth...

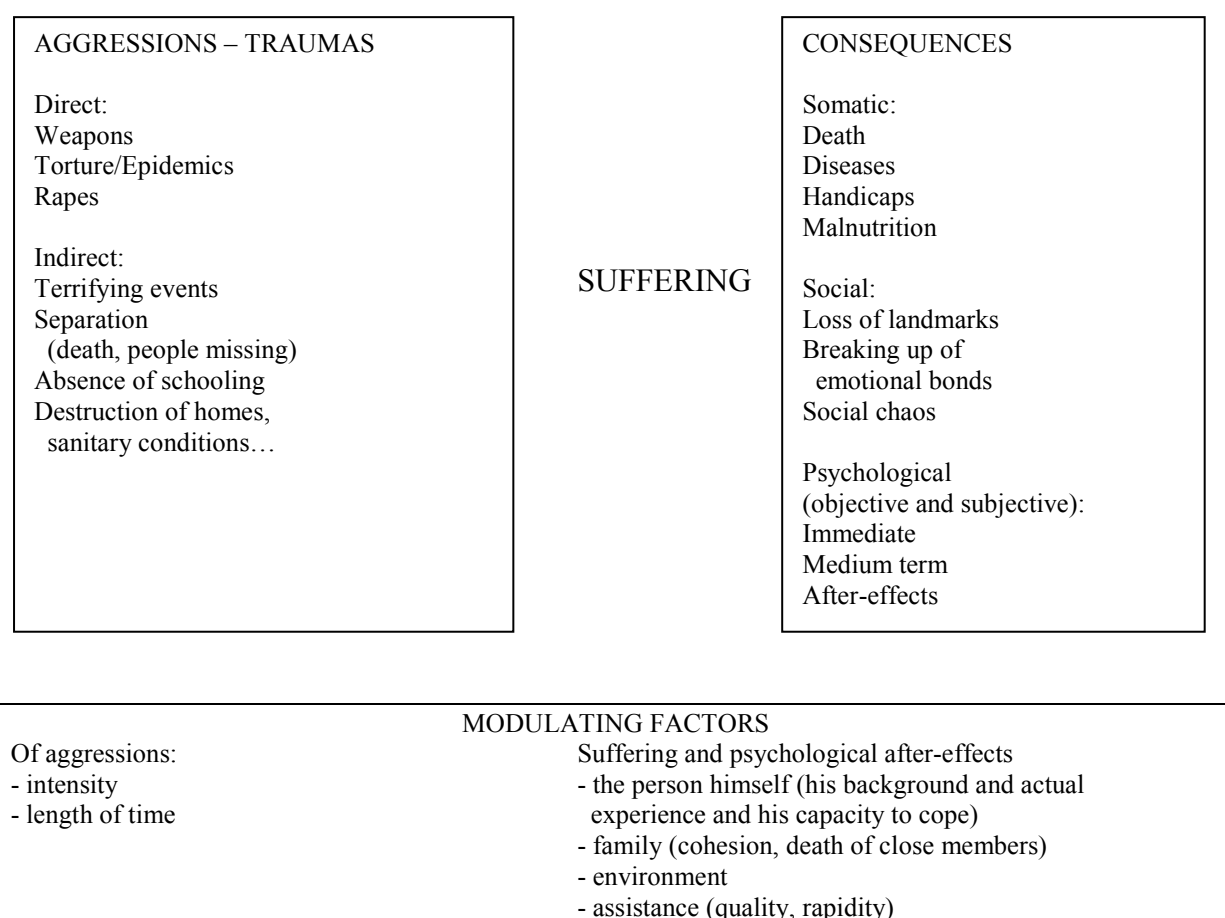


It is therefore important that at all levels of the organisation each person feels he wants to participate in this project and makes himself available to listen and pay attention to others.

IV. For which beneficiaries?

ACF's intervention contexts are situations of crisis, of violence or of post-war social de-structuring that have collective or individual impacts. ACF also have a few missions in more stable contexts such as Haiti and Chad but I think that we should not under-estimate the impact of poverty or of dictatorial political systems on the mind (psyche) and think that the beneficiaries of our programmes have no needs at that level. Without finding exactly the same problems, we are often faced with a loss of landmarks, with behaviour that is justified by the need for survival, with an incapacity to foresee the future and with great psychological suffering.

Michèle Bertrand (*Les enfants dans la guerre et les violences civiles – approches cliniques et théoriques*, l'Harmattan, 1997, p.17) proposes an outline that I have modified for ACF :



There is of course no question of ACF intervening at all these levels. However ACF can take these elements into account in the usual fight against hunger. The beneficiaries and the national staff have been faced with aggressions and traumas. This has an impact on their capacity to work, to be in good health, to look after their children, to be capable of providing for themselves at short, medium and long-term.

As you can see in the outline above, assistance and environment are factors that influence psychological suffering. The attitude of NGO staff and the conditions in which people are

admitted and live, especially in the camps, can therefore decrease the impact of traumatic events or, on the contrary, reinforce the beneficiaries' despair.

We have chosen to direct this pilot project firstly towards the Therapeutic Feeding Centres. Indeed the access to beneficiaries is easier there : they stay for an average of one month, which is sufficiently long for a relationship to start. The TFCs are also the most well known ACF programmes abroad and therefore it is an interesting base for developing a new aspect of beneficiaries' care programmes and for motivating the sponsors.²

However it is clear that credibility would be gained if this aspect was integrated in all the ACF programmes. Moreover a certain number of things, easy to set up and not expensive, are indicated in the charts concerning the means to implement, at the end of the second part of this document.

I do not believe it is relevant to target a specific group among the TFC beneficiaries :

- How can we draw up a graded classification among traumatised people? We would take the risk of making the individual experience commonplace when in fact ACF intervenes in de-structured, abnormal, even chronic contexts, where each person is affected in his individual and social references. In fact what does it mean to find yourself in a war, to be obliged to leave your home and land, not to know where your family is, not to have enough food to feed your child and to be afraid that he dies, to find yourself in a nutrition centre where you are completely dependent and inactive and where the rules are not yours??? And here I am talking about the least violent situations. Furthermore all the surveys on traumas show that no event has an objective traumatic impact : faced with the same incident, certain people will be traumatised and others not. There is no apprenticeship for traumas : you can be "used" to extreme situations and develop a post-trauma syndrome³.
- What are the criteria to be used? Must we trust the American diagnosis of Post-Stress Traumatic Disorder for which internationalism is ideological but not relevant, or follow the criteria of the community, or combine the two?
- Who are the people within the ACF teams capable of making a psychiatric diagnosis? How can we avoid ignoring people who are traumatised but who do not show the symptoms.
- What deviations in terms of blame could these practices bring about (these people are traumatised, we must be careful! whereas those "are alright"; what does this mean?)

I think that we can consider all the TFC beneficiaries as vulnerable people, who have gone through difficult times (even their present state of malnutrition) and who need specific attention to their bodies and their minds.

² I think that a sufficient number of arguments are developed in this document to show that mental health is an integral part of ACF's treatment of malnutrition and fight against hunger (and is not just a plus).

³ See annex 2 concerning psychological traumas.

The responses we offer depend upon three elements :

- Beneficiaries or national teams : a certain number of responses can apply to both groups, such as encouraging people to talk, taking into consideration the culture and background of each person; others concern more specifically the beneficiaries (places for people to meet, self-actualisation of the mother/child relationship), or the national teams (exchanges with the expatriates on the difficult situations encountered, on cultural facts, on their background).
- The beneficiaries' age : a child's capacity to face up to things depends closely on his parent's reactions. Working with adults is therefore imperative for children and for the adults themselves. At the same time it is essential to install specific play activities for the young children and teenagers.
- The social-cultural context : the therapeutic practices vary according to the countries and we must take them into consideration and adapt our activities to the local customs.

Second part

**How can we take mental health
into account at ACF?**

Second part : How can we take mental health into account at ACF?

As mentioned before, the inter-disciplinary approach does not consist in specifically taking care of people who are suffering but in taking into account the mental dimension of the usual ACF caring practices. There is no spectacular organisation of a psycho-social programme but a group of activities and attitudes that will change our way of looking at beneficiaries, our attitude with regard to them, that will encourage them to talk or express their suffering and therefore help them to overcome their difficulties.

I distinguish three types of response :

- Understanding and respecting the social-cultural environment of the missions and preparation in meeting people. This point concerns the TFCs as well as all the ACF programmes and must be systematically implemented.
- Improving the welcoming of people and accommodation in the TFCs.
- Developing specific responses to each programme.

Some of the following propositions may seem to be far from the mental health and trauma spheres. Nevertheless I shall try to explain how each proposition has an impact on the mental state of the people who are taken care of. I recall that the aim is to give support to the individual and to his community, to improve his welfare and his psychological reconstruction but sometimes the results are obtained by detours and roundabout means.

I. For all the programmes

Our presence as such is already important for the beneficiaries because it means (even if it is sometimes an illusion) that the international community is concerned about what is happening in this region and about the people living there.

1. Improve our knowledge of the social-cultural environment and respect the people in all ways

1.1. Improve our comprehension of local culture and the context

Our concern is not to enter into the debate between universalism and relativism to have an ideological quarrel, or to drift from one extreme (he is like me) to another (he is totally different from me), but in fact to join a movement of reflection and interrogation on this other person whom “we would like to help”. What is his life style? What religion does he belong to? What is his family system? What are the man/woman relationships? What importance has polygamy? What is the child’s place in the family? What are his feeding habits? What is his educational system? Who rules the community? How does he see his life or death? What are the funeral rituals? What is his description of illness, of insanity? What are his methods of healing? Who takes decisions within the community? What is his background?

All these questions and many others can guide us in implementing a programme that makes sense in the social-cultural environment that already exists. We often discover this environment in times of confusion because of wars or crisis. Nevertheless the populations have their beliefs, their ways of life, and to go against them or simply not to take them into consideration can be of great violence or result in mutual misunderstanding. Each mission must therefore adapt itself to the beneficiaries; there is no single means of intervention (cf. Sironi, L’universalisme est-il une torture? - in the reference list).

To accumulate information concerning the country, apart from the geopolitical aspect, in the field as well as at headquarters, to question the local populations (and in particular the national teams and the beneficiaries), to find people to give us information, all these are good ways of learning about this country where we are staying for a certain period of time and implementing programmes that will not de-structure the community further.

To understand the culture also enables us to understand certain behaviour that seems strange to us and that we would have a tendency to judge a little too quickly :

- In certain African countries, public demonstrations of emotions as well as rituals are intended, amongst other functions, to confound the harmful supernatural forces. To belittle a child, to speak of him in a pejorative way, to conceal his illness, will prevent drawing the attention of the evil spirits on him.
- Sometimes babies a few months old do not have a name. This can be interpreted as the mother’s lack of interest for the child. But who names the child in the ethnic group? It may be the grandfather of whom they have no news since the beginning of the conflicts and whose authority and function of choosing his descendant’s name must be respected.

- A mother does not give the dried ration to the malnourished child, as she has been asked to do so, but shares it between all the children. If this is so, what does it mean to give food to a child in particular when normally they all share the same meal? It is more acceptable to buy medicine (that concerns an individual need) than to favour someone with food (that corresponds to a collective need). This idea of giving importance to one child in the family also risks generating a conflict between the different wives and drawing evil spirits on him.
- Why do we feed children as a priority when it is the elderly who guarantee social harmony?
- A mother refuses to breast-feed her baby because her milk is not good. This is what she thinks because her previous child died when she was breast-feeding him.
- We plan the agricultural production of a region in order to allow storage for one year. But the farmers immediately eat 80% of their production because they have just gone through war, they have previously lost everything, they do not know what to expect in the future and are incapable of foreseeing the medium and long-term.

These examples show the difficulties we encounter when faced with another culture and it is essential that we search for explanations and try to understand.

Without realising it, we have a tendency to use our own cultural images and to pass judgement on behaviours that do make sense in certain cultures.

As with us, the national teams and beneficiaries have images concerning us that can influence the way in which they accept our arguments and our behaviour. “One of the expatriates tells me that is important to explain his illness to a patient, but for us in Africa we cannot speak like that as the person would be shocked. In Europe you can tell a patient that he has cancer and he will accept it” (example given to me by a Liberian).

These preconceived ideas deform acts and words and considerably complicate communication.

1.2. The example of African representations of malnutrition

Concerning malnutrition, we are also confronted with different interpretations and explanatory systems of the reality. Let us take the situation in Africa⁴, since the majority of our TFCs are set up on this continent and it is also the zone where the greatest number of surveys have been carried out concerning malnutrition representations due to culture.

A child’s thinness is rarely perceived as a sign of morbidity and is only exceptionally associated with nutritional problems.

⁴ With all the limits of such a wide approach : what is the African culture? A real analysis would necessitate a much more reduced geographical approach or an ethnic approach.

If a child is simply thin, they do not try to understand why and they do not use therapeutic methods. It is associated symptoms (vomiting, diarrhoea, etc.) that are going to incite searching for the cause.

In Burkina Faso it is believed that these symptoms of the malnourished child are a direct result of “Sogo”. During pregnancy the mother experienced a traumatic event during which she contaminated the foetus. They are also associated with “Sere” (the mother having sexual intercourse in spite of the social taboos forbidding it during the breast-feeding period). They are due to social and cultural causes. The women therefore resort to traditional practices because for them it is not a medical problem that can be treated in a dispensary.

We can find a specific explanatory system : mechanical (a child born small), witchcraft, social (sexual taboo because of transgressed post-partum), or medical. The risk for us is to impose our knowledge, even if technically correct, on a cultural and personal reality.

Below is a chart summarising the medical profession’s interpretation and the common interpretation. The data comes from research in Niger (Jaffré, 1996). It would be interesting to apply all this data to each ACF intervention context to show the diversity of beliefs and popular practices.

Symptoms	Medical interpretation	Common interpretation (Niger)
Peeling skin	Dermatosis caused by a deficiency in trace elements	“Problem” transmitted by the mother’s milk
Anxious look	An “expression” produced by emaciation	Apprehension, fear of a supernatural person or of a witch doctor
Cries	Temperament disorders	Apprehension, fear
Sleeping problems	Temperament disorders	Apprehension, fear
Oedemas	Protein deficiency ⁵	Swellings
Thinness	Calorie deficiency ⁶	Not noticed apart from weaning practices

Our ignorance of traditional beliefs often brings us to pass judgement on the mothers’ behaviour. The data on the following chart comes from several African countries. It is therefore fairly general and a little simplistic and needs to be re-examined with regard to specific cultures. My aim is only to show that it is often necessary to go beyond appearances in order to understand more clearly the associated representations. Behaviour always has a meaning in one way or another.

⁵ Nowadays we would rather talk of micro-nutritional unbalance

⁶ We would now say consumption of bodily reserves (fat, muscles)

Interpretation of the medical staff	Mothers' beliefs
Mothers do not anticipate their children's needs	The child is free to choose : you must respect his refusal to eat
Useless medical intervention	You must respect the child's refusal to live (before 1 year old a child is in-between two worlds and can choose to stay in the visible world or can return to the invisible world)
Malnutrition = feeding problem	Thinness is not spotted individually or is associated with supernatural or social causes
Essential medical treatment	They resort to traditional practices
Mothers wait a long time before worrying about their children and only bring them when they are severely malnourished	The mothers had been worried for a long time and had already carried out traditional practices
Mothers don't seem to care	A witch doctor had already told them that their child would die

1.3. Adapt our nursing and educational care to the cultural representations

Contrary to what we could imagine at first, the national teams are often still more influenced by the western medical reasoning than we are ourselves. In spite of their knowledge of local beliefs they often have a tendency to ridicule them, according to their social position and their education.

Their attitude towards the beneficiaries very often shows this. They know the scientific truth and resort to a normative speech given in the form of advice and instructions (that are not explained), and that are often far from the beneficiaries' daily realities. Very often they widen their tasks to educating the beneficiaries regarding their rights and wrongs. For example the national team wants to prove to the mothers that the talisman cords worn by the babies have not given the intended protection, because the babies are malnourished, and consequently the cords must be cut. We have the impression that the two systems (medical versus traditional) are mutually exclusive and are in competition, whereas they can very well exist together (we can have treatment and at the same time pray to be healed). Being an expatriate, I have the impression that we are intrigued and curious about these "exotic" beliefs, whereas the national teams have a tendency to reject them and forget that they have a collective and individual function, and they replace them by scientific or pseudo-scientific elements.

It would be interesting to show that many medical recommendations also depend on beliefs, certain of which have been contradicted by scientific progress, and that science thrusts forward in evidence the limits of our present knowledge.

We can therefore question whether :

- When the mothers do not comply with the medical propositions, is it because they do not understand, they voluntarily refuse or because popular beliefs concerning prevention are opposed?
- How efficient is the hygiene and health education that we dispense?
- Would there not be fewer relapses and desertions in the Therapeutic Feeding Centres if our advice was less normative and less axed on our sole western medical scale?

A good knowledge of the intervention environment is therefore essential. Pressure and orders do not change behaviour in a permanent way; only the free acceptance by the beneficiaries themselves can change it. This acceptance must obviously be obtained through a dialogue that takes into consideration the reality lived by the beneficiaries. This means that all the members of ACF, whether expatriates or national teams, must not try to force the beneficiaries to enter into their system by repudiating or condemning their beliefs. On the contrary, they must take time to get acquainted with the beneficiary's world and accept it, then present his own and imagine a link from one to the other.

2. Training in preparation for meeting other people and other cultures

In the same way as for point 1, training the voluntary workers in meeting others and in gathering anthropological data would facilitate communication with the national teams and the beneficiaries. It is not easy, and even more so in a crisis context, to open our minds to discover others, to escape from our role of rescuer and to open up to other people. We can be frightened, we often feel fragile, we are tired, we are afraid of being powerless, sometimes we do not understand what they are saying and not least of all what they are thinking. At times we do not speak the same language and have to work with a translator. As for babies and young children, I think it is sometimes good to let ourselves go, including in our own language, because to make an infant enter into a relationship is more important than what we say.

How can ACF help to overcome all these obstacles? When recruiting people this dimension could be part of the essential motivations (perhaps it is already the case). During training before a first mission, we could work for example on role-play concerning the participation in a humanitarian project in a context in which we are the foreigners, and see how we can avoid certain awkward situations and value judgement by knowing local cultural references.

3. Use of participating methods

We talk a lot of participating methods but we never define them. It does not only consist in seeking the views of all those seated around a table and finally imposing our own opinion. It consists in a completely different educational method in which the contributor/participant relationship is transformed and which is based on practice, experimentation and discovery by ourselves of the message transmitted.

If we want to avoid forced feeding in the centres, so that the meal times do not become an aggressive and unpleasant moment for the children, we can say so to the medical team. They will repeat it again and again to the mothers, and finally obtain a fairly poor result. If instead of this reasoning we propose the following exercise to the team :

Form groups of three people. Each group consists of one person who plays the role of the mother, another who plays a child of about two years old and another an observer. It is mealtime. Jars of baby food or stewed fruit are given to the mothers who have to feed a malnourished child. But in half the groups the child will have been told to refuse the food, whereas in the other half he will have been told to eat with a good appetite. After about 10 to 15 minutes of the exercise, each person will explain what he has observed and felt in his specific situation. If this exercise is carried out correctly, it allows us to understand how the mother feels when feeding her child who is in danger of death, and how she feels controlled by the nursing team who checks the milk intake when the child refuses food. It brings the team to have a certain amount of sympathy and decreases value judgement of the mothers' behaviour by showing the complexity, and encourages an exchange of views on how to help the mothers with their difficulties.

This approach must be developed in each technical department in order to gather the anthropological elements concerning certain themes (such as food or bereavement), or to adapt programmes to the community (such as the implementation of wells according to the needs but also taking into consideration the balance of power that can take place in the territorial lay-out that we propose). Professor Chevrolet has helped a few missions of the wat/san department by creating methods to facilitate negotiations and community approach and by using adapted tools for participation

Methods allowing participation have many advantages : by the local implication they arouse, they enable us to grasp the social cultural environment in a better way, to adjust ourselves to the real needs by understanding the cultural representation of a phenomenon (what is the cause of a child's malnutrition?) and to ensure a longer durability of the project. Furthermore as far as hygiene is concerned, and also the continuation of treatment when people return home, the impact of the message will be more important if it is customary in their culture (i.e. theatre show to explain hygiene rules in certain African countries). Finally it is obvious that by attracting people from the community, we can help them to make a big effort and regain confidence.

In the case of mental health, group discussions with the community can help us to understand local representations of trauma, the etiological explanations and the practices of customary treatment. In a documentary film on the consequences of the war in Mozambique, a man had obviously changed his behaviour following a psychological shock. His family did not recognise him, as he did not react as before. They therefore sought the help of a witchdoctor. By helping the man to verbalise and by having a culturally accepted approach, the witchdoctor enabled the man to reintegrate his family and the community. Speech is therefore cathartic⁷ in other cultures and we can encourage its emergence and/or refer to specialists.

The story of an ex-soldier was also told. His family had found an explanation to justify this man's behaviour during the war; the man was possessed by an evil spirit and could no longer control himself. This was why the man had committed such atrocious crimes. By rituals of

⁷ Catharsis : to express one's sentiments and emotions relieves a person

magic this evil spirit was driven away. The man was therefore not responsible for his acts since he was under the influence of the evil spirit. Now that his is healed he has reintegrated his family and no longer wants to talk of this period of his life in order to forget it more quickly.

All these cultural elements must be known in order to grasp the situations and propose adapted answers.

4. Reinforce our partnerships

ACF widens its range of competence and hopes to include the psychological and anthropological dimensions in its programmes. The propositions I make in the second part of this document are our first step in this field. Others before us have tempted the phase. To share their experiences and to adapt them to improve the fight against hunger would ease our task. ACF cannot reply to all the needs of the beneficiaries. On the other hand we can improve our services, open our minds to understand the collective and individual dynamics and reinforce our partnerships at several levels, at the headquarters and in the field.

4.1. Favour theoretical-practical exchanges

Certain local and international NGOs, universities, traditional practitioners and nursing structures have a long experience of psycho-social programmes, a whole range of knowledge on the approach to traumas, nursing practices, mental health, animation and the anthropological aspects of a culture. Exchanges enrich our vision of a country and our understanding and enable us to gain time instead of discovering it for ourselves. In Europe, Handicap International, MSF, MDM, Afrique Conseil (a group of African psychologists who give consultations and thematic training on Africa), amongst others are open to a dialogue, publish and organise conferences on these questions. Bernard Doray, psychiatrist at the CEDRATE (Centre for research and action concerning traumas and exclusion), is doing research work on psychological traumas and therapies in different countries. He is ready to make a partnership with ACF and introduce us to people implicated in the various intervention regions of ACF.

4.2. Develop exchange through specific training periods

Why not take advantage of the experience of specialised professionals to adapt it to our specific task?

Since the middle of the 1980's, Enfants Réfugiés du Monde (Refugee children of the world) have organised programmes to treat traumatised children by means of play and are at present carrying out research with children, over a period of two years on the importance of play to overcome traumas, in three experimental fields : Guinea, Bosnia and Cambodia. They make trauma scales, define the play schemes according to age and country.

Beneficial co-operation has already taken place :

- Training people from the TFC of ACF in Guinea with their own leaders.
- Intervention of a professional from ERM concerning play activities with a child during the medical-nutrition co-ordinators' training in Paris.

For the moment these exchanges are based on individual relationships. Why not formalise them and generalise them even more?

Jean-Claude Métraux, a Swiss psychiatrist, who has led a community experience in Nicaragua and who works with refugees in Switzerland, could be approached to give talks to the technical departments on the inter-cultural educational and participating methods.

4.3. Implementation and application of a co-reference system

The countries in which we intervene are never devoid of traditional and/or western nursing practices of mental health. When a society is completely de-structured, it is often the international NGOs who take over and many of them carry out psycho-social programmes, including in Africa (Sierra Leone, Guinea, Rwanda, etc). It seems essential to know who they are and to make ourselves known in order to find answers to the beneficiaries' needs.

Everybody cannot do everything. If, amongst the ACF beneficiaries, we are confronted with traumatised people who need specialised treatment that we cannot give, then we must refer them to adequate structures with all the necessary discretion. For example if a team intervenes directly in the TFCs to take care of women who have been raped, certain beneficiaries feel automatically stigmatised and this does not facilitate either the therapeutic process or their own social reintegration.

It is not our role, as we do not have the necessary qualifications, to decide who is in need or not of specialised care. It must be proposed to the beneficiaries in a more general manner and to those who have clearly requested it.

4.4. Requests for specialised interventions in psychological treatment

A certain number of tracks must be explored that go from giving the alarm regarding the beneficiaries' need of psychological treatment in certain contexts and motivating our partners regarding requests for specific interventions. I am thinking here in particular of Clowns Sans Frontières but I do not know their working methods, or perhaps giving a show in a Therapeutic Feeding Centre or having a group of musicians, in this way dealing with the well-being of the beneficiaries and giving them joy in life.

4.5. Elaborate joint NGO programmes

ACF is beginning to question the mental health aspect. Why not imagine setting up joint NGO programmes in certain very specific emergency contexts? I know this is totally unusual for NGOs – unfortunately. But it is good to disrupt habits a little and to experiment new working methods. I am thinking more particularly of Handicap International. They are interested in the idea of starting a programme of psycho-social treatment in a Therapeutic Feeding Centre of another NGO. I myself have already taken part in this type of programme with MSF where we intervened for the psychological support of mothers and under-nourished children in a Terre des Hommes consulting centre in Hebron (Palestine). The results seem very positive - the multidisciplinary explanatory approach of malnutrition, the increase in efficiency of treatment means and the decrease of desertions and relapses.

II. Working with the national team⁸

As I have said in the introduction, the national teams are in an in-between situation. They are the inhabitants of the country in which we intervene and at the same time ACF staff.

As inhabitants of the country they may have gone through very difficult situations, have had close relations killed, have lost all their belongings, be or have been displaced or refugees, have an intellectual reasoning conditioned by a totalitarian regime⁹. Sometimes we know their background and sometimes we do not. But these elements certainly have an effect on their way of thinking, on their emotions and on their behaviour, and sometimes even on their capacity to work or not¹⁰.

The psychological factors described in the first part are applicable both to the beneficiaries and the national teams. We know that the staff we recruit are no doubt people who have important personal resources in terms of training and professional experience as well as individual capacities because they have managed to face difficult situations and after that have again adopted a strictly professional status. In turn work often becomes support, financially of course, but also morally (I have a social function again) and sometimes politically (I am doing something for my country).

As with the beneficiaries, we must be prepared to listen to the national teams, be receptive, try to understand their cultural logic and their representations.

The difficulty is to find the right measure¹¹ and to position ourselves clearly. To listen to people with whom we work does not necessarily mean that we are great buddies.

In my opinion it is part of our job as expatriates to listen to the national staff, as we are responsible for a team. If I listen to a member of the national team who tells me about his difficulties, his background or the problems encountered with the beneficiaries because this refers him back to painful events in his own life, then I am doing my work. I am not doing him a favour.

I think that this refers back to more general questions of team management.

As ACF staff we work with national staff. Very often they have been in the field much longer than us and will still be there when we leave. They are often the mission's memory. They have seen many expatriates pass and each time they have had to adapt to them, sometimes accepting new working methods and different priorities.

But sometimes we have a tendency to limit our discussions with them to purely exchanging information directly linked with the programmes, even reducing them to a role of performers.

When we arrive in a country that we do not know, with a multitude of aims to attain, and not always with an experience in staff management, we feel a little lost and we do not know

⁸ See the works of Maquéda on this question in the reference books

⁹ As seen in Rumania for example.

¹⁰ Moreover it is interesting to think that the people who are not competent and who are the first to be dismissed can sometimes be people suffering psychologically.

¹¹ It is strange however that we do not ask the question of the right measure with the beneficiaries.

where to start. But I think that the national teams can be much more than people to whom we give orders. They know the mission, they know the country, they know the cultural habits and can become mediators for us, the foreigners, and they can help us to understand the social-cultural and geopolitical context.

We are frightened of feeling indebted to the national teams after hearing their experiences and of no longer daring to make any remarks because of all they have suffered. But on the one hand we then place them in the role of victims and do not consider them as professionals, which does not help them to progress or to develop their professional competence. On the other hand they sink into the breach left open by our floating position. We recruit teams for their professional competence and for their humanitarian commitment and not because of what they have gone through. We expect them to be professional but they will be even more so if we are likewise with them. To be professional does not mean being cold and distant. It means working together to attain the same target, to use and develop each person's experience, to take time to listen, to make criticisms but also compliments.

In the context of the more humane approach that we hope to develop within the ACF programmes, we cannot forget our responsibility towards the national teams at two levels :

- How can we develop the fact that we take into consideration the psychological and anthropological dimensions of the beneficiaries if we refuse to take them into consideration for our colleagues?
- How can we ask the national teams to listen even more to the beneficiaries if we ourselves listen neither to the beneficiaries nor to the national teams?

In the same way that I advocate respecting each person's sensitivity (staff at headquarters or expatriates) regarding their wish and capacity to listen to others, I also advocate the respect of the national teams' sensitivity regarding listening to the beneficiaries' stories (in as far as the latter give them the choice - their need to talk may be so intense that they force the other person to listen). The beneficiaries' stories are often similar to events gone through by the national teams themselves and there is the risk that painful moments will be recalled. It is up to us to help our teams, to be interested in the stories they hear and therefore to facilitate the exchange of experiences.

In the case of serious incidents involving national teams, I think it is essential to take time to discuss, talk and exchange views. The people can be in a state of shock and unable to work again immediately. For others, to continue to work can help them.

There is no ready-made solution but I am sure that :

- If we have a friendly and humane relationship with the national teams, managing crisis will be easier.
- We must not treat people only as victims but ask them what is better for them and how we can help them.

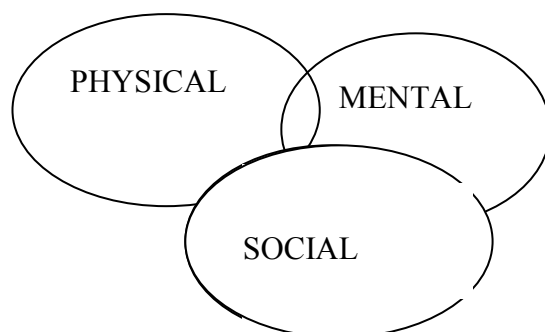
- We must help them to find reference people and methods to enable them to face up to their difficulties.
- We must be patient and ready to listen to the same story several times. It is not because we have listened to the national teams once that for them the page is turned.

III. A new look on nutrition and malnutrition : beyond the technical aspect

I am focusing on the psychological aspects but obviously it is interesting to have a social-economical vision of the problem.

1. Transcend the body/spirit dichotomy in order to improve the fight against hunger

Physical, psychological and social aspects turn in a very complex way and more and more surveys show the incidence of one on another. WHO insists on the fact that it is essential to pay attention to mental health if we want treatment (and therefore nutrition) to be efficient : “Health promotion must of necessity include concern for psychological well-being and the quality of mental and emotional health (...). WHO advocates that mental health care should be decentralised and integrated into primary health care, with the necessary tasks carried out as far as possible by general health workers (...). Attention to mental health is essential if primary health care is to be effective”. It means overcoming the vision of a man divided up to fit the body/spirit dichotomy (issued from our western medicine but unknown to non-occidental cultures) to take into account the global dimension of the individual in his community.



In the ACF fields of action, these relationships between the social, the physical and psychological aspects are particularly interlocked as it is always external reasons (drought, wars, etc) that disturb the usual cycles of food self-sufficiency, entailing famines, displacement of the population and makes the people vulnerable.

2. Defining a more global approach to nutrition

It is important to ask ourselves what is signified by “feeding” beyond the purely physiological aspect.

The different human groups have formed their own nutritional projects¹², specific to each one, according to the environmental possibilities, where classifications appear and preferences are expressed. The ways in which they feed are a reflection of their values, their beliefs, the aspirations of a society or a culture. And these projects, far from representing stable entities, are in constant development. The nutritional conditions of a population are the result of a combination of biological and cultural forces elaborated throughout history and closely linked. Food is the sign of identity and of belonging to a group. The nutritional habits have an internal logic that is often not biological. People do not only eat to survive and certain people prefer to die rather than abandon their identity and eat food they are not used to.

In this chapter I am going to concentrate more on the psychological aspects of nutrition.

We will separate nutrition with a child and with an adult.

2.1. Feeding an infant

What a baby does not say with words, he shows with his body : sleeping disorders, dermatological problems, repeated illness ... and feeding difficulties. To eat is of course a biological phenomenon but it is also part of relational exchanges.

Spitz's works on hospitalism during the Second World War have shown that giving treatment in a mechanical way to babies a few months old is not sufficient to ensure their correct development. Baby orphans were cared for by qualified staff and had all the necessary daily treatment but the number of children compared to the available staff did not allow individual caring of the babies such as taking them in your arms to bottle feed them. This lack of mothering led to a change in the babies' behaviour. After trying to attract people's attention by constantly crying, they would give up and lie quietly in their beds where they would stimulate themselves by rocking to and fro, by playing with their feet and hands in a repetitive way. Weary and depressed by the lack of emotional exchanges and interactions, they became apathetic and had an expressionless look. In this way babies who had essential basic care let themselves die because of a lack of mothering.

In the continuing line of Spitz's research, Bowlby carried out an experiment with baby gorillas placed in a cage with two dummy gorillas. One of them was made of wire and gave milk, enabling the baby gorillas to feed; the other one was covered in fur, emitted artificial warmth, but gave no food. All the baby gorillas chose to stay with the dummy gorilla made of fur and giving off warmth but no food and stayed close to it when in danger.

¹² Feeding behaviour and representations

This experiment, together with other observations including those of Spitz mentioned above, have concluded to the theory of attachment : *the attachment to a mother or a maternal substitute is a primary necessity, as important as daily care for a child's survival.*

To feed a child and ensure daily care are privileged moments of exchange between the child and his maternal substitute. The way in which daily care is given is as important as the act of giving care. During the first weeks the main contacts take place during breast-feeding or when giving a bottle. Moreover the baby's vision is perfectly adjusted to the distance between the mother's breast he is sucking and his mother's face (vision is clear between 20 and 25 cm) and encourages the exchange of looks. Later on his knowledge of the outside world continues by taking all objects to his mouth, showing the importance of the oral character of things with a young child.

A malnourished child (excluding cases of children who are ill or in generalised famine situations) informs us on relational difficulties.

Feeding is therefore part of the exchanges between the child and the outside world. The mother/child relationship and nutrition act one on the other and we can make the assumption that situations of conflict, crisis and traumatic events have a negative influence on this relationship and consequently on nutrition.

2.2. Feeding oneself : an older child and an adult

The older child and the adult's relation to food are greatly influenced by their early experiences. Early positive relationships will enable them to associate food with pleasure, with sharing and with enjoying life¹³. On the contrary, relationships of conflict in early childhood, psychological suffering and current uneasiness can entail nutritional pathologies such as anorexia and compulsive eating. Depression or depressive symptoms coinciding with psychological trauma also limit appetite. It is therefore necessary to pay attention to this dimension when taking care of people. Sometimes by giving the desire to enjoy life we also give the desire to eat.

2.3. Hunger

Now that we have a few elements concerning what it meant by feeding a child and feeding oneself, we can question ourselves about hunger on a psychological, physical and cultural basis and according to the ACF mandate.

The only reference I can think of concerning the psychological and physical impact of hunger is L'espece humaine (see bibliography). Antelme describes very well the changes in behaviour and way of thinking : pain in the body, difficulty in concentrating, attention focalised on food and the aggressiveness created. Who has not heard of parents, pushed by an irrepressible force, who stole their own child's bread in the concentration camps and after felt guilty and completely disgusted with themselves? Without any doubt hunger is a weapon and

¹³ However this representation of food is greatly influenced by the western culture.

a means of degrading people that leads to a loss of dignity and limits all forms of social solidarity (the Nazis had realised this and we would certainly find data if we looked at documents treating concentration camp experiences).

On the anthropological basis, what manifestations of hunger do we find in the different cultures? Hunger is not always experienced as such and hunger situations are considered as normal during certain seasons. Moreover food is not always felt to be a priority and it is interesting to observe the place occupied by food in the population's scale of values.

Food is often supplied according to each person's capacity to provide for the community's needs (for example the majority of food will go to the men who hunt or work). The child's malnutrition or that of certain other people can be accepted or treated with indifference at group level.

The individual or collective aspect of food can also influence our perception of it. "Famine can be named and said when it applies to a group confronted with a calamity. This question is different when you pass from a collective group to the first person. It brings about shame since it signifies that the family solidarity network has not functioned" (Bouville, 1966 in the reference books).

All this concerns a part of Africa. And elsewhere? What are the consequences on our life when we are hungry, on the way in which treatment is accepted?

I know that the information I have given is a bit simple but an NGO whose specificity is the fight against hunger must permanently think about nutrition, malnutrition and hunger, beyond the physiological aspect. In fact certain symbolic elements such as religion, identity, social, anthropologic, psychological and physiological factors converge on the relation between food and hunger.

3. Understanding the impact of the psychological aspects in the triggering off and/or the aggravation of malnutrition

This chapter follows the theoretic argumentation on the interest of dealing with malnutrition in a more global manner, written by Franck Flachemberger, nutritionist with Handicap International. The work carried out on the link between culture, psyche and malnutrition is no longer exactly relevant in the description of the explanatory paradigms of malnutrition and does not differentiate chronic malnutrition and acute malnutrition. However I feel it is important to retain the more global approach that he proposes rather than the theoretical data on malnutrition (I think the necessary modules exist at ACF).

We will use the main factors put in evidence in this reference summary as a basis for making propositions to improve the way ACF beneficiaries are taken care of.

How do the psychological aspects and malnutrition interact? We will see that some psychological factors are directly linked to malnutrition¹⁴ (risk factor or consequence), to which are added specific psychological factors regarding the ACF intervention contexts described in the first part of this document and in the annexed document on psychological traumas.

We will distinguish the problems of the child and of the adult because the causes, the stakes and the responses are different (see chapter 3.3 – for a more global treatment of malnutrition).

3.1. With a child

Psychological elements intervene at two levels, as a factor of additional risk of malnutrition as well as a consequence of malnutrition.

3.1.1. As a factor of risk in chronic and acute malnutrition

- In chronic situations

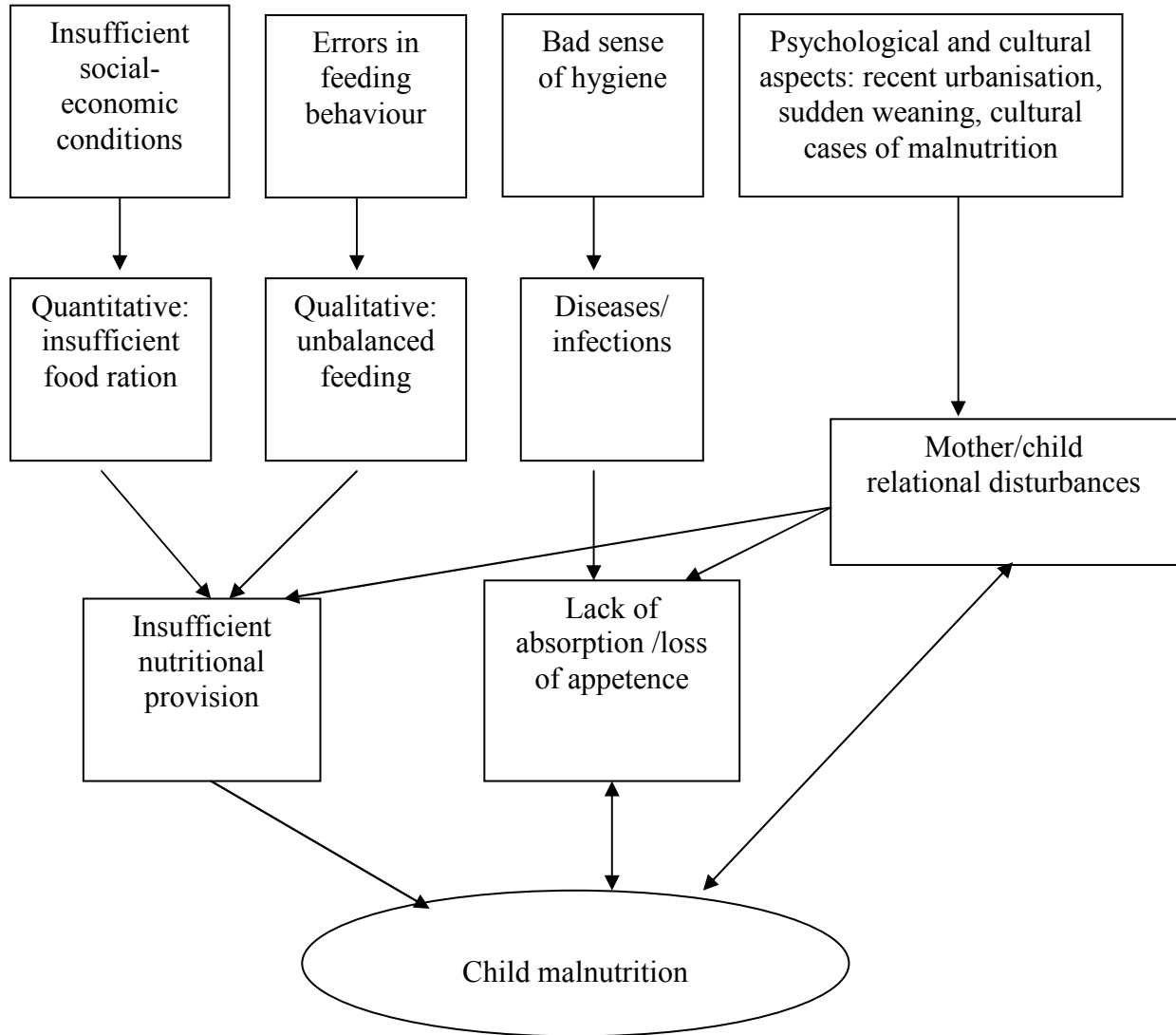
We can ask ourselves:

- Why do certain children, all having the same social economic level, develop malnutrition and not others?
- Why does one child in a family become malnourished and not the others?

The different surveys carried out show that an unsatisfactory mother/child relationship can be a determining factor in the triggering of and/or aggravation of malnutrition. Bouville therefore states “the hypothesis of an initial dysfunction in the child/family relationship brings about the child’s malnutrition. This hypothesis must be considered together with the other risk factors, but in fact only interaction leads to producing or aggravating the symptoms, the latter aggravating the relationship by having less reciprocal attraction.”

¹⁴ Does the term *kwarshiorkor* not signify “a child who is ill because he is not near his pregnant mother (who at that moment is with her own mother). This linguistic knowledge, already existing on the arrival of Westerners, puts the accent on the mother/child relationship, and not on the nutritional deficiencies in malnutrition.

The causes of malnutrition

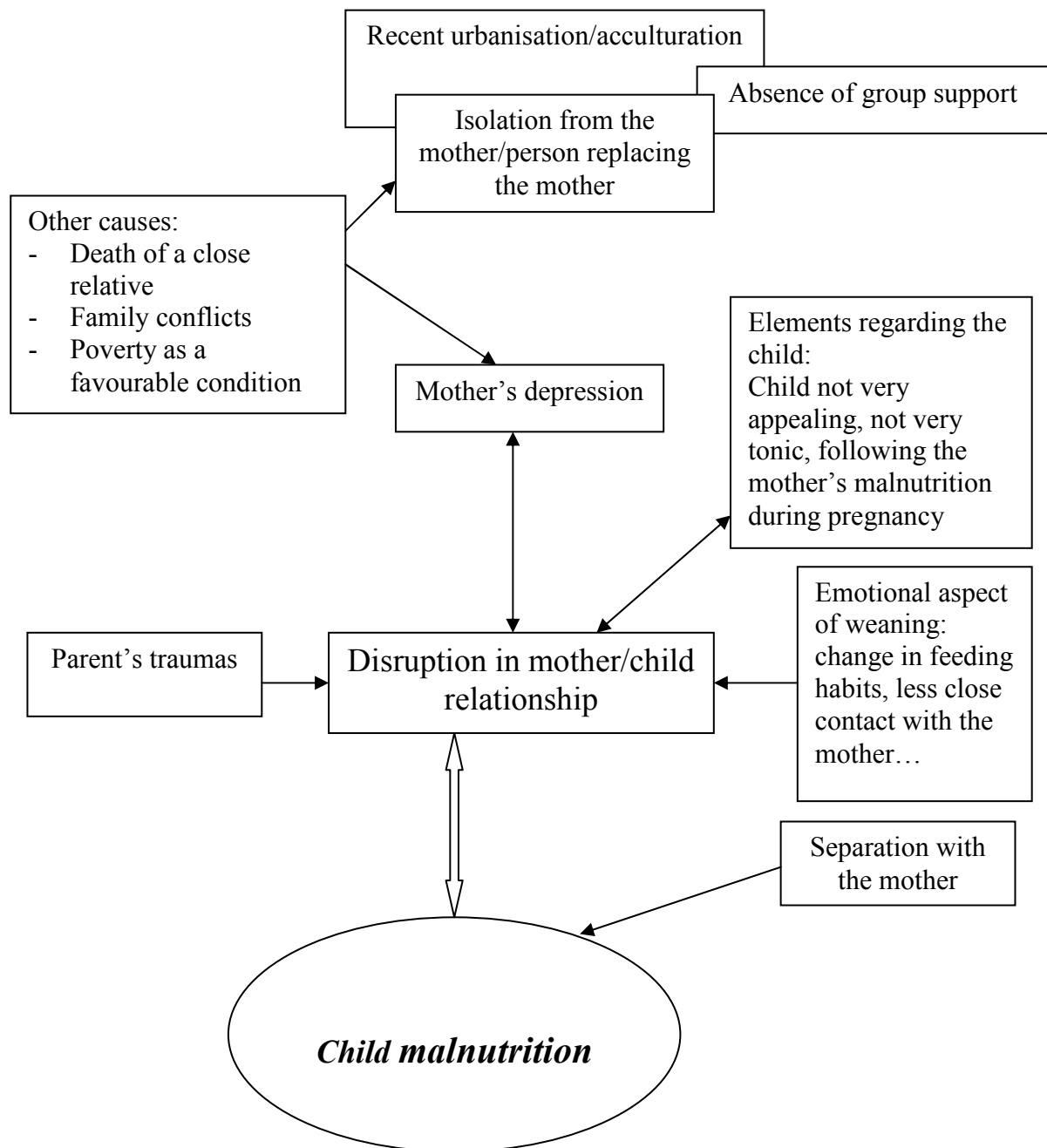


In the case of dysfunctioning of the mother/child relationship existing prior to malnutrition, we can emit the hypothesis that treatment is more often abandoned and that when returning home the risks of relapse are more important if nothing has been done to try to improve this interaction.

You will find on the following page a diagram showing the main causes of the disruption of the mother/child relationship leading to malnutrition, according to the different surveys quoted in the reference books. However we must take into consideration the fact that the surveys took place in stable countries. I certainly think that recent wars and crisis aggravate the mother/child relational difficulties:

- In a direct way : psychological traumas that generate an increase of irritability, aggressivity, violence, isolation, withdrawal into one's shell and a lack of capacity to invest in the future; an increase of depressions that lead to immense fatigue, a lack of interest in oneself and the environment, the wish to die...
- In an indirect way : social de-structuring, an absence of group support in the education of children, loss of members of the family and bereavement, poverty...

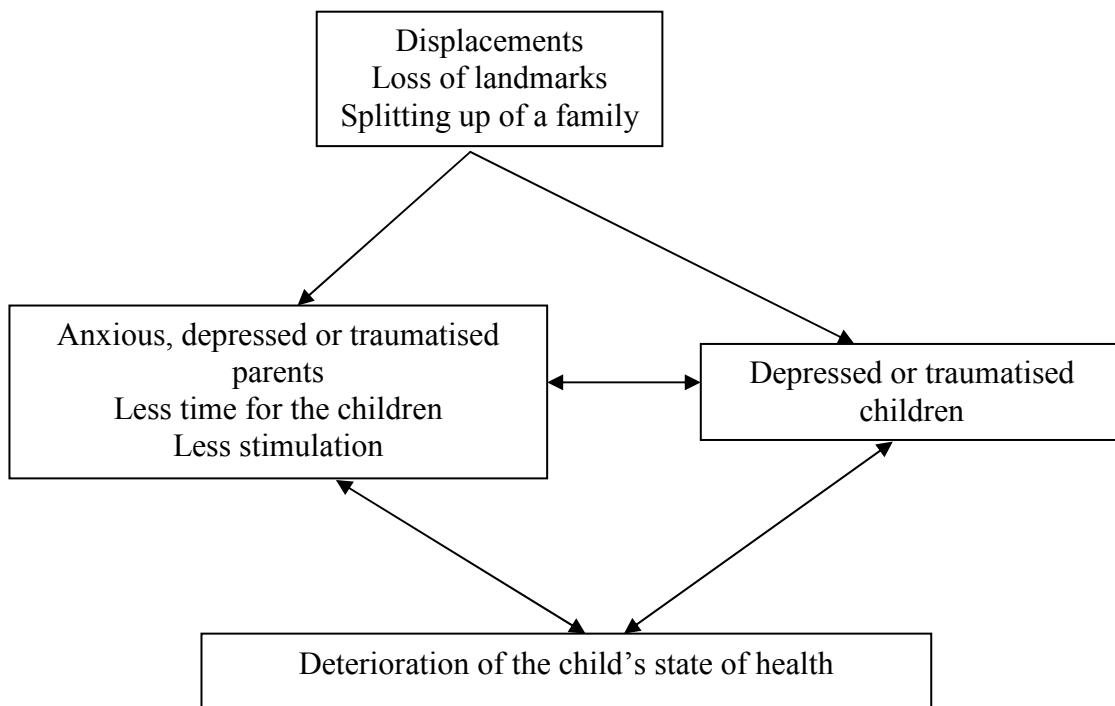
Psychological and sociological factors intervening in malnutrition in chronic situations (according to the surveys quoted in the reference books)



- In emergency situations:

The social-economic factors and access to food are of course very important in the outbreak of malnutrition. However I do not think that we must exclude the psychological aspects. On the one hand if dysfunctioning mother/child couples exist in normal times, I do not see why they should no longer exist in crisis situations. On the other hand the context in itself increases the difficulties. The adults indeed become vulnerable, anxious, depressive and sometimes traumatised. They try to ensure their survival and the survival of their children. The time and attention they can pay to their families are sometimes very limited, reduced to pure mechanical gestures. The children themselves suffer directly from the effects of wars and conflicts and also have to face their parent's suffering and incapacity to protect their children.

These elements are factors that aggravate the malnutrition situation.

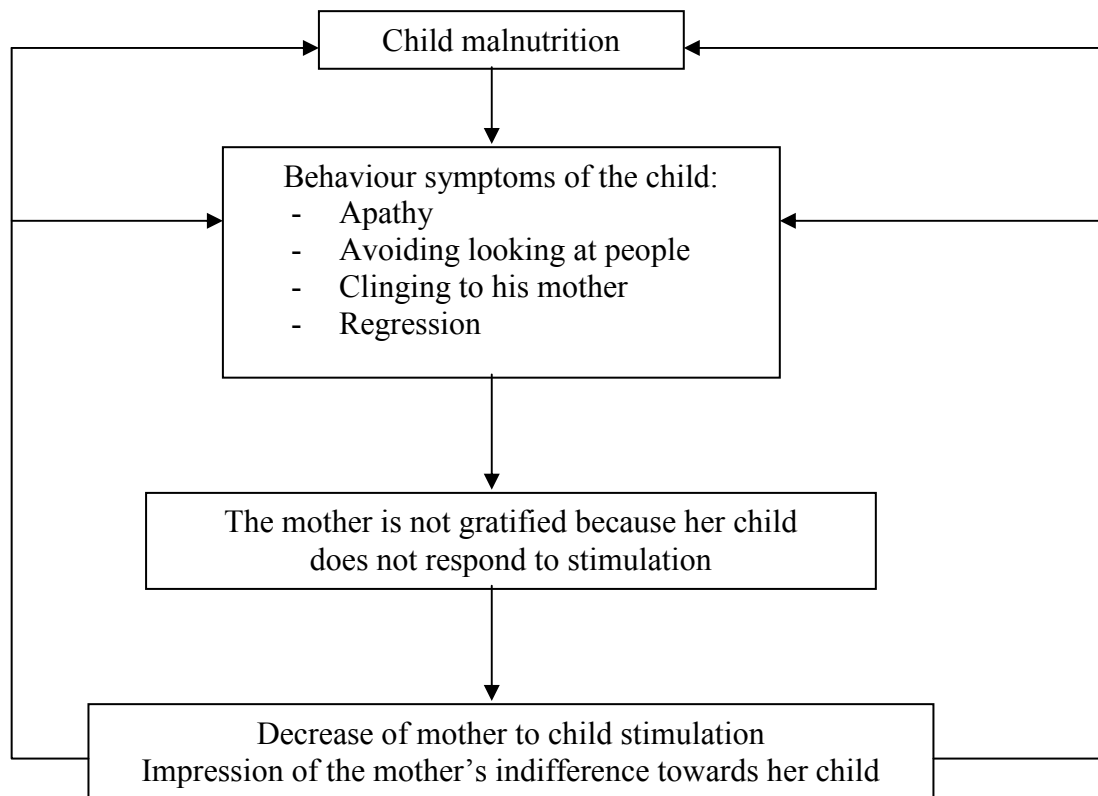


3.1.2. As an immediate consequence of acute malnutrition

- Behavioural symptoms of malnutrition

Whatever its etiologic causes, malnutrition brings about specific behaviour with a child, that is going to play an important role in the mother's reaction capacity and in the success of the therapeutic treatment.

The child suffering from *kwarshiorkor* is apathetic, irritable, cries, regresses, and clings to his mother. His behaviour often has a negative influence on the mother/child relationship and it rapidly becomes a vicious circle. Children suffering from marasmus are often more lively, listen more carefully, follow with their eyes and therefore remain more gratifying for their mothers. However we know that these two clinical states often have similarities and that a very weak child does not respond much to stimulation, stops smiling and playing and therefore his family no longer recognises his behaviour.



- The impact of pain and of the child's general weakness

For a long time we have under-estimated pain and physical and psychological suffering that lead to a general weakening in the state of health of babies, because they do not complain with words and cannot talk of their suffering. However their grizzling, their cries, their faces twisted with pain, and their sad expression make us understand how painful their bodies are, that they must be moved and treated with the utmost care. Too often we are not aware of a child's pain, linked with malnutrition and with the medical care that his state of health necessitates. Because we are convinced we are carrying out the right and necessary medical interventions, we forget to take time to meet the mother and child to explain the medical acts we are doing and why we are doing them. As the patients do not have this information, they therefore feel that the treatment is even more violent because it remains incomprehensible to them and was unpredictable. You only have to listen to the child's cries when he is laid down to be measured. Are we going to hurt him or give him an injection? It only takes a minute to tell him that we are going to see how tall his is, that his mother will stay with him and hold him, and that it is not going to hurt. Are we so short of time?

3.1.3. As a medium or long-term consequence on the intellectual development

We do not have much longitudinal data on the long-term psychological development of children suffering from malnutrition. However the majority of surveys show intellectual deficiencies at long term with children who have been severely under-nourished for a long period but we do not know if the causes are biological elements or a deficiency in the social relationships in early childhood.

The psychological aspects are therefore an activating and/or aggravating factor of chronic or acute child malnutrition and we must take this into account when proposing treatment.

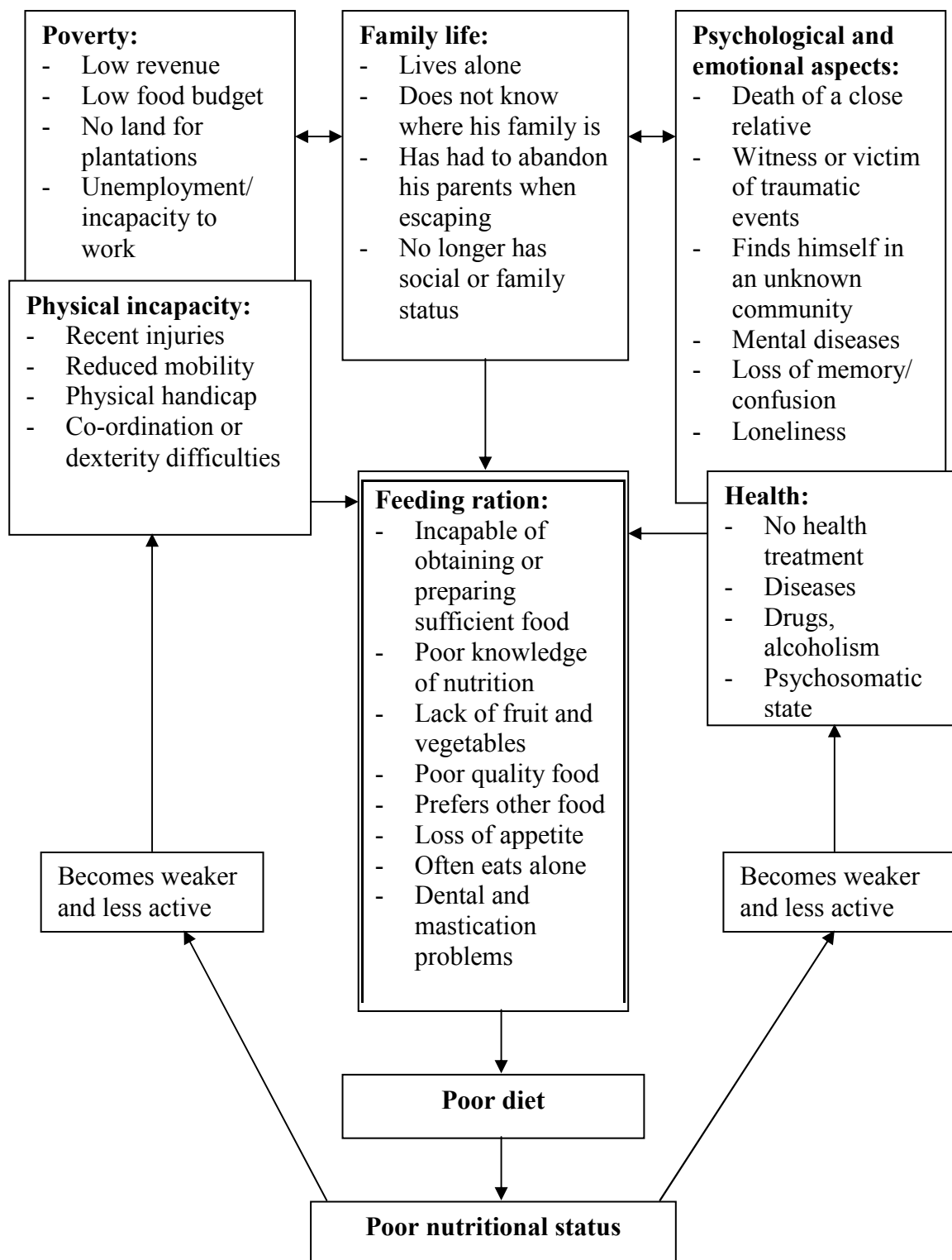
3.2. With an older child and an adult

There is much less data concerning the psychological aspects of adult malnutrition and I therefore do not feel qualified to treat this subject. We know that in psychopathology there are feeding deviancies linked to mental pathologies : anorexia, bulimia, loss of appetite with people who are depressed or suicidal.

Situations in which ACF treat adult malnutrition are emergency contexts where the visible cause is the lack of access to food. But do the psychological consequences of such situations not have an impact on malnutrition? Psychological suffering and traumas disturb the monitoring and efficiency of treatment for adults who are under-nourished or accompanying, as well as that of children. In a situation of war what is meant by *to eat*? What does it mean to a child to want to eat, to want to grow up in a world of horrors, to become like these adults who attack him or who are incapable of protecting him or providing for his needs? What does it mean to an old person to have been left aside by his family because he was too weak to flee with them? Do you really feel like eating, regaining strength and living when you have seen members of your family die, seen your house destroyed or when you have not been capable of protecting your children? In the TFCs where the beneficiaries are prostrate, they continually re-live their exile, commit infanticides or try to commit suicide, what is the point of eating again or of receiving treatment?

To my knowledge, only the NGO called HELPAGE works on old people's malnutrition. Here are some facts that can be found in their guidebook "Assessment and evaluation". Generally speaking these elements concern old people but I think that they can help us to understand the malnutrition of all adults, old or not.

HELPAGE develops the concept of nutritional vulnerability based on a certain number of risk factors that are inter-linked. Without claiming to be exhaustive, the following diagram (that I have slightly modified for ACF) has the credit of showing that many factors are at stake in malnutrition, varying according to contexts and individuals.

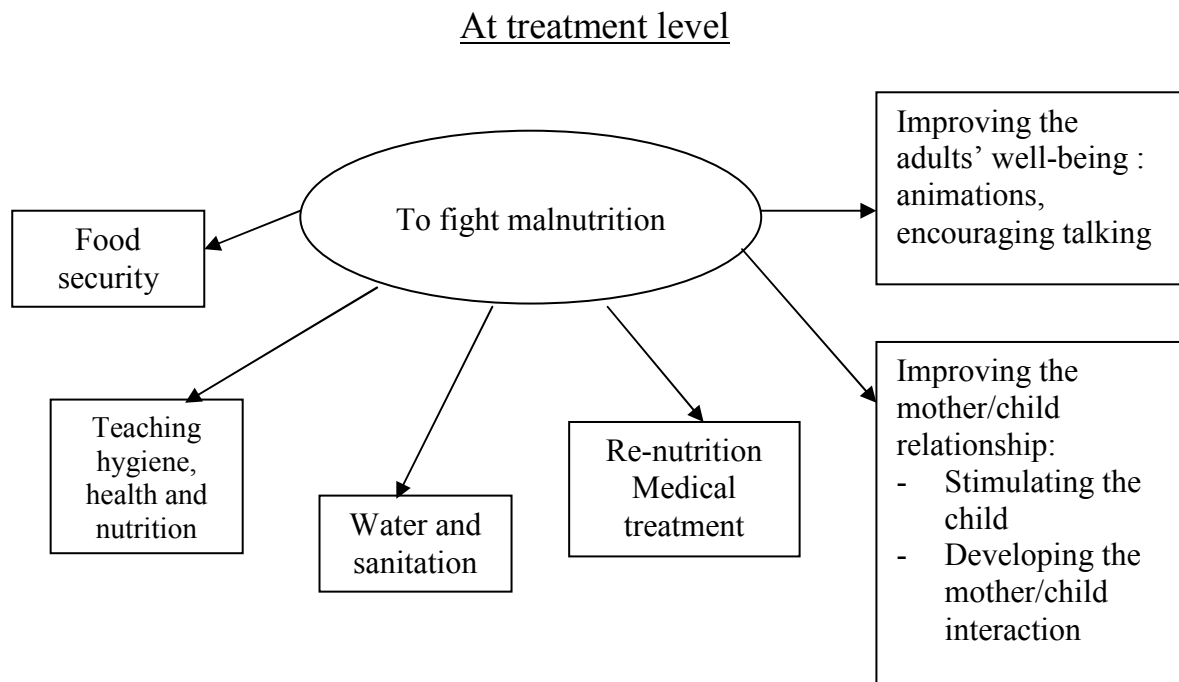


ACF could also carry out research and contribute to the understanding of the causes of adult malnutrition, the links between mental health and malnutrition and later use this information to improve their treatment by a more global approach.

3.3. The necessity for more global treatment of malnutrition in the TFCs

Two complementary elements justify the implementation of a more global approach of treatment in the TFCs:

- The existence of interaction between malnutrition and mental health, of which I hope to have convinced you in the previous paragraphs.
The multi-factor aspect of malnutrition does not permit a unilateral approach. Whether the psychological aspect has played a part or not in the etiology, we must obviously include it in recovery treatment, especially as the only long-term after-effects of severe malnutrition with the child seem to be intellectual backwardness and poor social relationships, according to the intensity and duration of malnutrition.
- The specificity of the TFC beneficiaries, who live or have lived in situations of war or of great violence.



All this theoretical data on the link between mental health and malnutrition exists since the 1960s/70s, but in spite of this it seems that pluri-disciplinary programmes aimed on prevention and healing have rarely been carried out. Why? Will this document also stay aside?

IV. Activities to be implemented in order to integrate the cultural and psychological dimensions in the Therapeutic Feeding Centres

This pilot project concerns the TFCs : access to beneficiaries is easier and ACF's responsibility is very important. If we improve the lay-out of the TFCs, the welcome and living conditions we offer to beneficiaries, if we listen to them, will these few weeks be lived as a dark passage where they are totally dependant (but fed), lost and vulnerable? Or on the contrary will it become a lapse of time where they gather their strength, can talk to people and prepare themselves to lead a new life?

I am not talking here of doing miracles. It is obvious that people with immense psychological suffering are not going to regain pleasure in life in a month, but perhaps we can help them to regain confidence in themselves and in others. We can also encourage those who wish to have places to talk and socialise in order to help them to come out of their isolation and difficulty in living. But we must not try to play the sorcerer's apprentice.

The aims of integrating the psychological and cultural dimensions in the TFCs :

- To reinforce medical-nutritional treatment.
- To decrease the number of desertions and relapses.
- To improve our understanding of malnutrition and its causes and to set up adapted prevention programmes.
- To improve the well-being of beneficiaries and take into account the traumas suffered.
- To prevent psychological after-effects at medium and long term.
- To reinforce our impact concerning hygiene and nutritional education.

1. To improve the lay-out of the TFCs (Stéphane Doyon – ACF logistic dept.)

All the steps to be taken to improve the lay-out of the centres are aimed at encouraging the process of healing by taking into account both the technical and humane aspects.

The construction of a nutrition centre must reply to two types of criteria or standards :

- Construction criteria or standards :

These criteria group together construction standards as well as the equipment of the centre in order to be functional. Hygiene, security, health, fluctuation of people, functionality, etc. are taken into account.

- Well-being criteria :

These criteria group together all the aspects concerning “living environment” or “living conditions”, that is decoration, the installation of resting areas, meeting rooms or relaxation rooms. These criteria must be taken into consideration as soon as construction starts. In this way the centre is equipped according to the standards imposed for constructions, functionality (hygiene, flux, etc) and includes the lay-out of space aimed at decent living conditions.

Construction standards :

To define these standards, we must first of all define the specifications required for the construction of the Therapeutic Feeding Centre.

We must evaluate:

- The capacity of the centre or the number of people who can be taken care of.
- The type of beneficiaries: adults, children, and people accompanying them.
- The type of treatment (24 hours or centre working only during daytime).
- The possibility of referencing the patients (if there is no possibility, in certain cases the centre must be “medicalised” and structures for isolating certain pathologies must be installed, etc.)
- Climatic conditions (heat, cold and rain).

Once the specifications have been defined, the following standards must be applied when constructing the centre:

Surface of a phase = Number of people (including those accompanying) x 3.5 to 4.5 m².

Number of litres of water per day = Number of people x 40 to 60 litres (people living in the TFC) or x 5 litres (people on punctual visits).

Number of latrines = 1 latrine for 20 people.

Number of showers = 1 shower for 20 people.

Washing area = 1 area for 50 people.

These standards are indicators that we must try hard to reach. In emergency or starting up situations, we will often have difficulty in achieving them but they must remain an aim to be reached, as soon as the initial phase has been done.

In order to reply to the criteria of comfort and efficient caring, a centre must not exceed 200 people (400 including those accompanying).

In addition to the different phases, the construction of the following buildings must be foreseen:

- Warehouse
- Kitchen
- Check-in room
- Play area
- Common room that can be used for animations and health education.

All these indications must be part of a plan that we can use as a reference document for the construction of the centre and the choice of location for each structure.

The laying-out of the centre and the conditions for residing

When a patient arrives in a Therapeutic Feeding Centre, in many cases he has just gone through a long period of exile with physical and psychological suffering and traumas. His severe state of malnutrition can be considered as the ultimate consequence of his exile. His stay in the centre will enable him to recover physically and be in good health again with a normal nutritional status.

This period is also a transition stage as the patient has often just gone through a traumatising time, and even if he leaves the centre cured, unfortunately his future remains uncertain in many cases. It is therefore important that this phase allows him to recover both physically and also psychologically.

When the patient arrives in the centre, he becomes an in-patient for an average stay of about one month (25 days on average). During this stay, in the majority of cases, the patient is not able to go out of the centre. He follows a strict treatment that we can compare to a diet since, during his stay, he can only absorb the nutritional products forming his treatment.

It is therefore important to make sure that the patients' living conditions are the best we can offer them. This point must imperatively be integrated in the construction phase or developing phase of the nutrition centre that, in most cases, will be carried out in two stages:

- *The opening phase of a nutrition centre.*
- *Consolidation or developing phase.*

The opening phase of a nutrition centre

In the majority of cases the aim is to open a nutrition centre as quickly as possible in order to take care of patients as soon as possible. The priority is therefore to have a centre with the minimum functions such as:

- The in-patient phases
- Check-in or admission rooms
- Kitchen
- Warehouse
- Latrines
- Showers.

The aim of this opening phase is the treatment of severe malnutrition.

The consolidation phase

As the centre is functioning and replies to the criteria of severe malnutrition treatment, this phase will deal with improving the living or residential conditions, if this has not already been done during the opening phase.

To do so, it is important to integrate this point in the developing or construction phase so that sufficient space can be kept, and the lay-out decided, for building all the installations that will improve the residential conditions.

These various spaces or structures are the following:

- Play areas separated from the phases.
- Common room that can be used for health education.
- Kitchens for accompanying people.
- Play corners in the phases.

Furthermore, it would be advisable to improve the living space by trying to decorate the centre to give it a comfortable and friendly aspect. *Decoration* is more important than we imagine. An austere environment, which looks like a hospital, is not motivating. Old

buildings and constructions with no maintenance can give the beneficiaries a belittling image of themselves. They already have to accept a lack of privacy, proximity, and everyone's noise; let us try to make the atmosphere more friendly and more welcoming by using colours and having good ventilation to protect them from too much heat.

2. To adapt our attitude in the time spent with the beneficiaries according to the different phases

We make a distinction between taking care of the mother/ malnourished child couples and the malnourished adults. Here we talk of the mother in the wide sense of maternal substitute, that is to say the person accompanying the child in the TFC. However, to understand the causes of malnutrition and ensure better care after leaving the TFC, it would be preferable that the person who usually takes care of the child accompanies the child in the TFC.

I have chosen to differentiate caring in the TFCs for beneficiaries who are in chronic situations and those in emergency situations because the psychological process is not the same. I realise that this division is artificial. But the fact is that in chronic situations food is more accessible, security conditions acceptable and that poverty is the main cause of malnutrition. Let us keep in mind that the beneficiaries we meet have also gone through very traumatic events during the previous months or years and the psychological repercussions of such traumas do not easily heal and always guide certain behaviour, even if this is less obvious at first.

2.1. In chronic situations

In this context we mainly meet malnourished babies and small children. That is why we will concentrate essentially on the mother/child couple in this chapter.

We will follow the itinerary of the mother (or maternal substitute) and child couple within the TFC, and insist on the mother/baby relationship, which is a determining factor in chronic situations, as indicated above.

On admission:

The mothers are very worried when they arrive with their children, as they feel responsible for their malnutrition. Sometimes they have taken them to hospital several times or have seen traditional witchdoctors, that explains the long period of time between the beginning of the illness and arrival at the Therapeutic Feeding Centre. The mothers feel discouraged and they no longer have much hope of seeing their children live and cured. In order to come to the TFC and to be free for several weeks outside their homes, they have had to organise themselves, find people to look after the rest of the family and leave their shops or their studies.

The first contact with the staff at the centre must be warm and reassuring : describing to the mother and child how their stay in the centre will take place, showing them the entire centre, explaining the technical gestures of treatment, associating the child's symptoms with malnutrition (regression, apathy, anorexia...) For example refusal to eat can be interpreted by the mother as the child's refusal of her breast. If we put this in the context of the illness it shows the reason for anorexia.

Together with the person who admits the patients, there could also be a social or education worker who would be the link between the beneficiaries and the medical teams during the whole length of the stay. In particular he would be in charge of observing the mothers and babies and of individual assistance.

It would also be an opportunity for this social worker to make a first observation of the mother/baby relationship. How does she carry her baby? Do they look at each other? Does she reply to the child's demands? The staff then encourages the mother to stimulate the child, to talk to him even if he does not reply or if he is too young to understand. The atmosphere created by words and stimulation ensures the child's social relationship, his desire to live, develops maternal investment and encourages an increase in weight.

Phase 1

The child's state is critical and the mother is worried.

The national staff's assistance must be informal and warm : to sit with the mother and child, to talk about the child's background, the mother's background, to inquire how she feels, about what she imagines are the causes of the child's malnutrition. Assistance is particularly important at nursing and feeding times. Mothers who force their children need to be helped; they are caught between the fear that their child will die and the necessity to feed him. We must see that she holds her child correctly in her arms (for example making sure that his head does not fall backwards). We must tell them to take their time, that the child must get used to accepting food again and we must highlight the looks and contacts they exchange. These remarks enhance the mother/child relationship, ease the situation and help the mother to regain confidence and to develop exchanges with her child.

Phase 1 favours the observation of problems in the mother/child couple. We can define a certain number of criteria that must draw our attention and justify closer attention :

- Carrying her baby badly as if he was a parcel she didn't know what to do with.
- No smiles exchanged between mother and child.
- No eye-contact between mother and child.
- No play time between mother and child.
- Mothers who often leave their children alone.
- Mothers who carry out daily hygiene care in a mechanical way.
- Mothers who do not know how to breast-feed.
- Very young or isolated mothers.
- A mother's first child.
- A child who has passed into phase 2 and is transferred again to phase 1.

This does not mean keeping a watch on them but spending a few minutes with them to really talk.

Phase 2

The baby has started to take on weight, he is less weak and responds more to stimulation. His mother feels reassured and is receptive to more frequent exchanges.

A good basis for discussion is the introduction of a question paper that is at the same time an important source of information for understanding the causes of malnutrition, gathering useful data concerning food security and getting to know the families better.

The social worker must not confine his work to the questions but take advantage of this discussion to explore the family situation.

In addition to individual assistance, we can add other recreation activities because of the improvement in the child's state of health. Apart from the stimulation of the mother/child exchanges already started in phase 1, phase 2 is favourable for more collective activities. The supervisor and/or the organiser of this phase can propose the following :

- To small groups of children, always in the mothers' presence : songs, games with balloons story telling, objects that can be manipulated, small puzzles... For example this recreation time can take place during the morning for an hour and twice in the afternoon for one hour, at set times with the possibility to come and go. A corner with a mattress on the floor, well aired and with toys available, can easily be installed under the responsibility of a TFC member of staff.
- For the mothers accompanied by their children, joint work groups for the phases 1 and 2 can be proposed:
 - Making toys, dolls.
 - Theatre, songs, dancing.
 - Craft workshops in relation with the current local activities.
 - Gardening that can be set up in partnership with the food security, to give advice to families concerning the seeds, working in fields, etc.

The mothers are encouraged not to leave their children alone, but to put them on their backs during the daily activities.

Phase 3

We can develop even more games and activities and also encourage the exchanges between the children. A mat outside in the shade can become an enjoyable play area.

Returning home will soon take place and the social worker or organiser who has accompanied the mother during her stay in the TFC can tackle the subject of returning home and prepare the mother and child to reintegrate their home.

In the WHO guidelines on the treatment of severe malnutrition, we can find the following points among the criteria for discharge:

- The child has started to play and to smile.
- The person accompanying the child is apt to take care of the child correctly.

These two non-anthropometrical elements seem essential to me and should be integrated in the ACF guidelines, in the same way as mothers with social and psychological problems should be systematically referred to appropriate structures.

And afterwards?

It is difficult not to wonder what happens to the mother/baby couple when they are discharged from the TFC. If we admit that an important factor of child malnutrition is the mother's isolation and depression, we can imagine that when returning home she is faced with the same difficulties as before, and this means that there is sometimes the risk that the child will relapse. Monitoring at the Supplementary Nutrition Centre does not allow individual assistance and is therefore very unsatisfactory for this more psycho-social aspect of the treatment.

I think it would be useful, in all our missions, to take time to consider the ways in which we could check up on the mothers who are in the most difficult situations, using the resources existing in each zone. This could be done by visits to their homes (easier to do in towns and in refugee camps), weekly visits by the out-reachers, referring them to the community health workers, for interventions concerning education, health and nutrition, and also child stimulation?

2.2. In emergency situations

Due to the affluence of beneficiaries and the global insecurity context, we have a tendency to pay less attention to the psychological aspects and concentrate on the more technical aspects. However all the elements described in the chapter on chronic situations remain relevant and we must also add the psychological aspects linked to the contexts. I think we must make a difference between famines due to natural disasters and those produced by human beings. The impact on malnourished people of the way you tackle their relation to food and to others is obviously different in the two contexts. When it concerns the voluntary action of a group on another, combined with a dangerous situation, this certainly leads to an analysis of the phenomenon that is less fatalistic and more difficult to accept.

The population admitted in emergency situations is varied: men and women of all ages are represented. The dynamics are more complex. The people have gone through extremely difficult ordeals. Their behaviour is affected : they are prostrate, in a state of sideration, have delirious episodes ("madness fits"), they cry, are aggressive, are irritable, are frightened, jump at the least noise, withdraw into themselves, have nightmares and often utter somatic moans. Sometimes this behaviour does not show immediately because the beneficiaries are too weak or are too concerned with their immediate survival. This is called a latency period. As their state of health improves, the psychological difficulties and the wish to die are likely to emerge. Sometimes this will happen when discharged from the TFCs, sometimes months or years later. In any case, people never come out of a war unscathed.

All beneficiaries need moral support. What we can do at our level is to give them maximum comfort under the conditions imposed by the context and to listen to them if they start talking about their experiences. To listen and be free to help during these critical phases are more than essential. To receive these words of suffering is not easy and can even be intolerable for certain people or at certain times. One should know one's limits and respect them.

When *malnourished adults* are concerned, we must be careful to make them feel responsible and not to treat them as children, or make them totally dependant. It is essential to talk about our medical gestures, to explain why we are doing certain things or why we are giving certain foods to eat and not others. Individuals feel more important when people talk to them and

explain what is being done to their bodies. In this way we can help them to regain the use of their sick and ailing bodies.

The work surrounding discharge from the TFCs is of the utmost importance. Indeed the beneficiaries have been able to rest, have regained strength but do not know what they are going to find outside. They may be frightened of finding their house demolished, of learning that certain members of their family have died, or of finding themselves again in an insecure environment.

To tackle these difficulties together, to highlight their individual resources, to think about the people who could give them support if needed, helps them to prepare their departure and feel ready to face up to it.

Certain groups of beneficiaries need more sustained and specific comprehension and assistance, even if I remain very careful and refuse to condemn them :

- *Unaccompanied children*: they are very vulnerable. Ideally a member of staff should be chosen for each unaccompanied child and be particularly responsible for him, ensuring a closer check-up and making sure that the child's stay goes smoothly. At the same time it is essential that ACF or a joint NGO tries to find the children's families.

- *Raped women (and sometimes men)*: first of all we must admit that we do not necessarily know who has been sexually aggressed or not. (A IRC/UNICEF investigation in Brazzaville showed that 60% of the people questioned answered that they knew someone who had been raped, but only 15 to 20% replied positively to the more direct question: have you been raped?) An attack on physical integrity renders any action on their bodies intolerable, especially when done by men. Women can feel shame, reject their bodies, they can refuse to care for themselves and eat. They consider they have been soiled and are impure. We can suppose that abortions, infanticides and abandoned children are sometimes the consequence of these acts of sexual violence.
If a woman has a child to breast-feed, we must be very attentive. Even her milk has been soiled by this act of rape and by giving it to her child she transmits this impurity (see Rigal's article in the reference books).
What happens to women who are pregnant after being raped? How can they love the children who will be born and who will constantly remind them of the crimes committed on them and of the assailants' power on them? How can they make efforts, cherish and love these children?

3. To personalise relationships

So that each person feels recognised as a human being and not just as a stomach to fill, it is necessary to avoid anonymity and to create small groups that help each other and where people are recognised.

Here are a few very simple suggestions :

- To introduce ourselves to people and explain our duties and the part we play.
- To limit the number of people working with each beneficiary so that individual relationship can be developed.

- To try to know the names of a maximum number of beneficiaries whom we are in charge of (which means that the staff must be sufficient to have a limited number of beneficiaries to care for).
- To make up small groups of mothers who will help each other and look after their respective children during the daily activities.
- Never make value judgement. It is not a good way of helping people to express themselves, to exchange and therefore to advance.

4. To establish reference points and routine in the Therapeutic Feeding Centres

The beneficiaries who arrive in the TFCs are often refugees or displaced people who have lost their usual reference points. They are very worried and distressed because of what they have gone through, or have been witnesses of acts of violence, and no longer have confidence in their environment or in men in general. So as not to increase their anxiety and their feeling of dependency, it is very important to establish a routine (easy for mealtimes and taking medicines) that will enable them to control their environment and therefore reassure them. It is useful to install a routine during the course of the day, which will help people to structure their days (activities, discussions, etc.) and to escape from a wait-and-see attitude.

5. To take into account the traumatic aspect of the beneficiaries' stories and of their present situation

To take the beneficiaries' traumas in consideration but not to treat them : there is no question here of doing unauthorised psycho-therapies or debriefings when no-one at ACF is qualified to do so. I insist on the fact that to play at being the sorcerer's apprentice is dangerous, not only for the traumatised people whose protective defence mechanisms may fall and make them totally vulnerable, but also for ourselves. We must be armed to deal with people's sufferings by having an aim, having knowledge on mental health and benefiting from supervision that enables us to work on our emotions, our sentiments and during which we can analyse our practical application.

However I hope I have convinced you that mental health is not independent from the physical functioning of a person and that it must also be a priority in the ACF programmes, for ethical reasons and to reinforce the efficiency of re-nutrition. After understanding the impact of mental health on the rest of life, everyone can understand the point of taking it into consideration and encouraging the well-being of beneficiaries in a maximum way.

It is therefore necessary for each voluntary worker to have a few basic notions of traumas and their symptoms, to be capable of making a difference with stress and to be able to establish partnerships with other NGOs and/or psychiatrists and/or local healers. All the beneficiaries arriving in the centres should be informed of their existence and people who wish can be referred to them.

6. To use active listening

To encourage speech is very positive. However what attitude should we adopt when listening to these words? To listen to someone is not easy and requires initiation so as not to fall into

the trap of pitying the person or passing judgement. It is with the process of active listening games that people (beneficiaries, national staff or expatriates) will feel that they are being heard and understood, more so than with normal listening to people during an exchange. How must we react with the person for a real encounter to take place? It is useless to say that things will be better in the future, that other people have gone through worse situations, that even if the mother has lost a child she still has three left or that she is still young and will be able to have others... To listen is to accept the story told with empathy and without judgement and to try to help the person to carry on the story by rewording it.

To listen is also to observe the attitude and the non-verbal communication of the beneficiaries and the people accompanying them. We can take time to sit next to someone who seems unhappy or who is prostrate, to ask him how he feels, to introduce ourselves and talk to him. Each day, a few words...

7. To enhance the mother/child relationship

Although I may be repeating myself, I will resume the main theories of attachment.

Let us say that roughly speaking a baby is completely dependent on his family, not only to ensure his physiological needs but also for his emotional needs. Many surveys in psychology, especially those of Spitz on hospitalisation or those of Bowlby on attachment, have shown that the relationship with the other person and affection are as important as daily care and food. The mother/baby couple must therefore be considered as one and the weariness in life of one of them will have negative repercussions on the other. Thus a depressed, traumatised or anxious mother may be incapable of ensuring the essential exchanges with her baby and the result will be the baby's de-nutrition or depression.

As we have seen in Michèle Bertrand's diagram, surveys show that for older children the psychological consequences linked to traumas are modulated according to the family (the repercussions have a lesser effect if the parents were able to protect their children).

It is therefore essential to take the children into account as well as the adults in the mental health aspect since the well-being of one has repercussions on the well-being of the other. In addition to these different elements there are the consequences for a mother observing the malnutrition of her child : feeling of guilt, sadness that can lead to rejecting her child, or behaviour that we would consider as indifference as the mother is certain that her baby will die in any case. Of course there are also the anthropological aspects, on which surveys should be made to gather more information per region.

The enhancement of the mother/baby relationship by a sense of humour, stimulating activities and mother/baby groups can encourage a more positive recovery of the beneficiaries' mental life, avoid certain children being abandoned or treatment abandoned and decrease the risks of relapse.

How can the mother/child relationship be enhanced? By putting in evidence the child's initiatives and competence, by encouraging the mother's initiatives, by pointing out the exchanges between them. "He is looking at you. He is listening to you. Oh yes we are talking about you with your mummy. He is smiling at you, he wants you to play with him. How we feel good in mummy's arms. Well done, you can catch the ball. Oh you're not pleased

because your mummy is talking to me and not spending her time with you. There you are, you are talking to him and he stops crying”. All these little sentences out of their context seem a little exaggerated but in the right situations and depending on the way in which they are said, they can have a very reassuring impact on the mother and encourage another way of looking at her child and at their relationship.

8. To implement activities for the children (see animation module annexed)

In situations of war children are going to express their anxiety in somatic ways such as nightmares, jumping at the least noise, aggressive behaviour or clinging to their mothers. If their parents are depressive, the children may take on the role of parents by having a serious attitude and leading the family. For them playing is a way of expressing themselves and replaying what has happened to them helps to progressively control the situation and detach them from it. It is also a means of finding their place as a child again. In post-emergency situations and for children born after the war, we should not under-estimate the transmission of traumas between generations.

In addition to the outdoor play area and spontaneous games, the TFC activity leader (at least one for fifty beneficiaries) must be capable of proposing varied activities to help the beneficiaries to overcome their difficulties and regain pleasure and enjoy life.

9. To develop convivial areas for social interaction

In the case of adults we know that talking relieves people, even if they are not treated. The communities in which we intervene can be of help to the beneficiaries. We can try to group together people who wish, in order to reinforce the social bond and develop social interaction areas that will become places for exchange and talking. We can also imagine activities that are adapted to the local customs and practices, where people accompanying the beneficiaries could participate. The activities do not only concern children. To sing, to dance or to do theatre acting can also be a means of expression for adults and a way of escape.

All ideas and innovations are welcome. To do some gardening can be a social activity where people can chat freely, and at the same time it can be a source of pleasure seeing that life grows again due to the work done with their hands. The food security teams can also give advice. The aim is to create a social bond, to extend the social interaction times to aspects that are not linked solely to nutrition and to re-insert people in the dynamics of life.

10. To run educational sessions concerning hygiene and nutrition (see chapter on a better knowledge of the social cultural environment)

In phases 2 and 3, the days may seem long in spite of the activities proposed and the places for informal exchanges. The activity leader or the person in charge of the phase can gather together a small number of beneficiaries (about 20) for an hour one afternoon per week and lead a participating and illustrated session on hygiene and health education. The advice given will lead to an easier understanding of the rules imposed within the TFCs.

For all the programmes

Aims	Advantages	Limits	Activities to install
<p>1. <i>A good knowledge of the social cultural environment and to respect people in every way</i></p>	<ul style="list-style-type: none"> - Appropriateness of programmes - Understanding the beneficiaries - Considering the beneficiaries other than by their biological bodies and the staff other than by their professional competence 	<ul style="list-style-type: none"> - To take time at the beginning - May seem incomprehensible at first - Difficulties linked with the language, with the different cultures - Lack of time - Number of staff 	<ul style="list-style-type: none"> - To interest the staff at headquarters - To interest the voluntary workers on their first mission - Extension of the role of the Medico-Nutritionist Co-ordinators and Heads of mission so they can capitalise the anthropological data and installing people capable of being cultural mediators in the field and in Paris - Capitalisation of the anthropological data at headquarters
<p>2. <i>To train expatriates in encountering others</i></p>	<ul style="list-style-type: none"> - Better communication with the national staff and the beneficiaries and less conflicts - Encounters with the beneficiaries are more gratifying - Better communication within the expatriate team 	<ul style="list-style-type: none"> - Depends on individual sensitivity and good will - Beware of things becoming systematic - What do we make of what we have gleaned? All the same keep your distance with the staff in order to manage the teams. 	<ul style="list-style-type: none"> - To interest the staff at headquarters - To train voluntary workers during the first departure preparation - To train the Medico-nutritionist Coordinators - To interest the Heads of mission - To introduce a paragraph on the anthropological data in each end of mission report - Selection criteria for voluntary workers (motivation)

Aims	Advantages	Limits	Activities to install
3. <i>Use participating methods</i>	<ul style="list-style-type: none"> - Better efficiency, installation, continuity of programmes - Creates a social bond 	<ul style="list-style-type: none"> - Use existing methods and invent others according to needs - Takes more time 	<ul style="list-style-type: none"> - To interest staff at headquarters and each department must work on methods adapted to their needs for training expatriates and developing the technical departments - Take advantage of people like Professor Chevrolet to train the expatriates and help the technical departments - Train expatriates and the national staff, especially by using active educational methods during the training courses and possibly use these methods in the field
4. <i>Reinforce our partnerships</i>	<ul style="list-style-type: none"> - To take advantage of the experiences of others - To respond to the beneficiaries' needs in the best way 	<ul style="list-style-type: none"> - Not always easy to work with others - Change in working habits - To be aware of one's limits 	<ul style="list-style-type: none"> - To interest the staff at headquarters and on the missions - To formalise partnerships (CEDRATE, ERM, HI..) - Information to be exchanged and put on the network

A new look on nutrition and malnutrition : beyond the technical aspect

Aims	Advantages	Limits	Activities to install
1. <i>Overtaking the body/spirit dichotomy to improve the fight against hunger</i>	<ul style="list-style-type: none"> - A more global and innovating approach of beneficiaries - Better understanding of the cultural realities of individuals and illnesses 	<ul style="list-style-type: none"> - Unusual at ACF and with regard to western medicine 	<ul style="list-style-type: none"> - To interest the staff at headquarters and on missions - To integrate this aspect in the guide-lines - To train the Nurses nutritionists and the Medico-nutritionist Coordinators
2. <i>Integrating the psychological aspects in our understanding of nutrition</i>	<ul style="list-style-type: none"> - Better understanding of the impact of malnutrition, as a reflection of nutrition - To extend our comprehension of the stakes of nutrition 	<ul style="list-style-type: none"> - The present staff is not trained 	<ul style="list-style-type: none"> - To train the Nurses nutritionists and the Medico-nutritionist Coordinators - To integrate this aspect in the guide-lines - To interest the staff at headquarters and on missions
3. <i>The psychological aspects in the triggering off and/or aggravation of malnutrition : beyond the technical aspect</i>	<ul style="list-style-type: none"> - To understand the stakes of nutrition for development beyond the psychological aspect - To avoid value judgements and errors linked to ignorance - Taking into consideration suffering linked to malnutrition - Taking into consideration the anthropological aspects of food and to compile them 	<ul style="list-style-type: none"> - The present staff is not trained - We feel reassured by the technical aspect of nutrition 	<ul style="list-style-type: none"> - To interest the staff at headquarters and the Heads of missions - To train the Nurses nutritionists and the Medico-nutritionist Coordinators : nutrition is a relational act beyond the psychological aspect - To integrate this aspect in our nutrition protocols - To use the Mental Health report as a module for the nutrition department

**Activities to install in order to integrate the cultural and psychological dimensions
in the treatment of malnutrition**

Aims	Advantages	Limits	Activities to install
1. <i>To improve the lay-out of the TFCs</i>	<ul style="list-style-type: none"> - Does not cost much - Easy to carry out - Improves the daily life of beneficiaries 	<ul style="list-style-type: none"> - Is not always considered in terms of priority - No guide-lines for the construction of the TFCs where we could integrate these elements 	<ul style="list-style-type: none"> - To integrate a plan in the nutritionists modules concerning the lay-out of the TFCs
2. <i>To adapt our presence with the beneficiaries according to the phases</i>	<ul style="list-style-type: none"> - Improvement in the services offered - A better knowledge and monitoring of beneficiaries 	<ul style="list-style-type: none"> - Employment of sufficient staff - Understanding that the treatment of malnutrition must be done otherwise than technically 	<ul style="list-style-type: none"> - To interest the staff at headquarters and on the missions - To train the Nurses nutritionists and the Medico-nutritionist Coordinators - To train the staff and integrate this dimension in their job description - To integrate this dimension in the guide-lines
3. <i>To personalise our relationships</i>	<ul style="list-style-type: none"> - To create an environment in which beneficiaries feel secure - Better organisation of teams - Better follow-up of beneficiaries 	<ul style="list-style-type: none"> - Employment of staff who are receptive to this aspect of treatment 	<ul style="list-style-type: none"> - To interest the staff in the field - To train the Nurses nutritionists and the Medico-nutritionist Coordinators - To integrate this dimension in the guide-lines

Aims	Advantages	Limits	Activities to install
<p>4. <i>To install reference points and routine which help the beneficiaries to control things and become active</i></p>	<ul style="list-style-type: none"> - Fairly easy to install - Appropriation of the programme by the beneficiaries 	<ul style="list-style-type: none"> - The beneficiaries are not always competent - Difficult to maintain when there are unexpected events 	<ul style="list-style-type: none"> - To improve the welcoming aspect - On admission, we must explain how the days are going to pass - To make a tour of the centre - To use the ‘leader’ mothers - To plan the days and their organisation with the members of the community - To maintain regularity
<p>5. <i>To take into account the traumatic aspect of the beneficiaries’ stories and their present situation</i></p>	<ul style="list-style-type: none"> - Improvement of the services offered - To avoid the installation of psychological problems - To encourage people to talk 	<ul style="list-style-type: none"> - Difficult to listen to the psychological suffering of others - It is essential that everyone must be party to the project 	<ul style="list-style-type: none"> - To interest the staff at headquarters - During their initial training, to interest expatriates in traumas, as much for themselves as expatriates as for the national staff and the beneficiaries - To tackle the problem of death and work on bereavement during the initial training - To train the nurses nutritionists and the Medico-nutritionist Coordinators - To interest the Heads of missions - To take time to listen - To develop a network of partners to whom people in need can be referred

Aims	Advantages	Limits	Activities to install
6. <i>To use active listening</i>	<ul style="list-style-type: none"> - To be able to take position regarding the beneficiaries and to listen attentively to their stories - A better communication - To have considered our limits 	<ul style="list-style-type: none"> - Takes time - Talking can be considered as less essential than action - Increases vulnerability - The beneficiaries do not want to leave the TFCs 	<ul style="list-style-type: none"> - To train expatriates during their first departure preparation - To train the nurses nutritionists + the medico-nutritionist nurses + the Heads of missions
7. <i>To enhance the mother/child relationship</i>	<ul style="list-style-type: none"> - Necessary in order to avoid relapses - No need for equipment 	<ul style="list-style-type: none"> - Takes time to observe - The present staff is not trained 	<ul style="list-style-type: none"> - To interest staff at headquarters - To train the nurses nutritionists + the medico-nutritionist co-ordinators + the Heads of missions - To integrate this aspect in the job description of the nurses nutritionists - To encourage relationship during meals, during games and activities, in the mother-baby groups - To develop early-learning games - To integrate this aspect in the guide-lines - To send out specialised expatriates (paediatric nurses, ergotherapists and educators for young children)?

Aims	Advantages	Limits	Activities to install
8. <i>To install activities for the children</i>	<ul style="list-style-type: none"> - To restore the wish to live - Notion of pleasure 	<ul style="list-style-type: none"> - The regular team can be open to this aspect of things but lacks time : employment of additional staff and organisers 	<ul style="list-style-type: none"> - To interest staff at headquarters - To train the nurses nutritionists and medico-nutritionist co-ordinators on the importance of games for the development of children + the Heads of mission (ERM) - To develop animation and games - To integrate this aspect in programmes - To respect the child's life as a child - To employ competent organisers or to train them - To develop local and inter-NGO partnerships
9. <i>To develop social interaction areas</i>	<ul style="list-style-type: none"> - To use the local traditional resources - To create a social bond - To break the beneficiaries' isolation 		<ul style="list-style-type: none"> - As regards construction, make provision for an activity area for the people accompanying beneficiaries, and take time to think about space for the different phases - To install workshops for the adults - To encourage their participation and their implication in the running of the TFC

Aims	Advantages	Limits	Activities to install
<i>10. To lead educational sessions concerning hygiene and nutrition</i>	<ul style="list-style-type: none"> - To improve prevention - To decrease the relapse rate - To improve these sessions 	<ul style="list-style-type: none"> - There is no type of education session that works in all countries - It is essential to understand the anthropological facts and to use participating methods 	<ul style="list-style-type: none"> - To take advantage of the beneficiaries' free time to make demonstrations to small groups - To start from the beneficiaries' cases - To be acquainted with the cultural beliefs and manifestations - To train the nurses nutritionists and the Medico-nutritionist Coordinators

For the staff : a certain number of elements described above will also have positive repercussions on the national teams. However we can still imagine specific systems for them, in addition of course to correct material conditions. This must be dealt with in the field (See II of the second part).

Third part

Expert evaluation mission in Liberia

1. Scope of the mission

For my reflection concerning the integration of psychological and cultural dimensions in ACF programmes, it was essential for me to go into the field for a discovery and evaluation mission. We do not actually know what choices will be made by ACF concerning the continuation of this project. Therefore I have not set up actions where we would perhaps be unable to ensure the continuity.

Aims of the mission :

- To grasp and understand the functioning of a TFC with ACF.
- To evaluate the beneficiaries' mental health in the nutrition centres.
- To take advantage of the experience of national teams and expatriates concerning these questions.
- To evaluate the operational feasibility of certain mental health sections within the existing programmes.
- To gather anthropological elements concerning the system of kinship in the country, the manifestations linked to disease, feeding, death, insanity and traditional methods of healing.
- To meet the NGOs and local associations who look after people suffering from traumas.
- To write down this experience in a little booklet, for use in the departure preparation of the TFC's nurses.

Liberia was chosen for several reasons :

- A TFC centre functioning for post-emergency cases.
- The team has been there for a certain length of time and Leila Bourahla, the MN co-ordinator, has been in the area for 4 to 5 years.
- A receptive team, ready to put a lot of effort and thought into the mental health problems.
- Easy for transport, as the TFC is situated near the capital.

The mission took place between the 15th January and the 12th February 2001.

2. Progress of the mission

2.1. Organisation of my time:

After the usual beginning of mission briefings, we organised my time into two half-times:

- Monday mornings, Tuesday afternoons, Wednesday mornings and Thursday afternoons in the TFC in VOA. Observation of the way in which the centre functions and the mother/child couples, discussions with the mothers and children, informal discussions with the national staff, accompanying the social worker during the distribution of question papers on food security/nutrition.

The rest of the time was divided into visits to the local and international partners intervening in the mental health field, in writing reports, in visits to the out-reachers in order to have a better knowledge of the Monrovia context and the work done before entering the TFC, and in some additional selective visits to the TFC.

2.2. Restraints and limitations

a) I arrived in Monrovia at the same time as Leila, who had been in France for a month, and Carole, a nurse, who was starting her job in the mission. In spite of the fact that they often made themselves free for me, I did not want to take up their time excessively as there were other priorities than my stay for the mission to run smoothly.

b) The language problem : this experience confirms that I am not gifted for languages and in particular Liberian English. It was very difficult for me to have any conversations with the mothers and children in the centres, either by making myself understood or by understanding them. We very rapidly needed a translator to come with me during my visits to VOA. Unfortunately, although she was very willing, she had neither the adequate training, nor any particular sensitivity concerning the psychological approach. I was therefore able to talk with the mothers a bit more, but in several stages. Bad translations or additions to my own words, given directly by the translator, broke up the dynamics of the exchanges. I was therefore limited in the discussions I had.

c) Because of the short length of my stay, I deliberately defined a very strict method of discussion. I did not want to engage any therapeutic process, or work on unconscious mechanisms and stop half way through. I therefore gathered fairly general information and was not able to validate or invalidate the relation of a more or less direct cause between traumas happening during the war and the present situation of families. We started to talk of the thematic of war with certain mothers and with the national staff but without ever making a direct relation with today.

On the other hand, war has entailed a general lowering of the social-economic level and the destruction of local infrastructures. Great poverty is the background to difficulties of all natures : priority is given to survival, families are dispersed, women are isolated, the mothers are very young, there is violence in the couple that aggravates the relation of conflict and the psycho-emotional problems.

d) I did not carry out any research in the strict sense of the word, that is to say discussing with a certain number of mothers per day, adding up certain data, following a number of mother/child couples from the beginning to the end of their stay in the TFC. However I noted a certain number of recurring elements or, on the contrary, exceptional elements, which we can compare with Leila's statistic data, in order to analyse their relevance. It is obvious that it would be interesting to elaborate a social-economic survey, including precise psychological data that would enable us to understand the context of malnutrition in Monrovia in a better way.

e) The scope of my intervention was very clear: evaluation during 4 weeks and not an operational mission. I did not want to intervene directly with the national staff but I worked in collaboration with Leila by transmitting my observations and remarks to her. By their observation of my behaviour in the TFC, my informal exchanges with them, and the

information from the accompanying adults with whom I discussed, we wagered that they would become aware to the approach I was developing.

We also organised a session with the TFC medical staff on the link between mental health and nutrition and the recommendations I could propose.

f) I had never been to Liberia before this mission and it is not in a month that I could discover the cultural aspect. But the team who has been there for a certain length of time has a lot of information that Patrick David, the head of mission, has promised to compile in a file before his departure.

g) As I did not know how an ACF TFC functioned before this mission, perhaps not enough time has passed for me to be able to judge and generalise things to other contexts and in particular to emergency situations. (Would a field visit of 10 to 15 days on this type of mission be possible?). The TFC admits about one hundred beneficiaries. How can these recommendations be applied to a much bigger TFC? I leave you to judge and await with interest your remarks and comments.

3. Observations and analysis

I am not going to recall here the history of Liberia, but refer you to the SITREP. Let us say that we are in a post-emergency situation. There has been rapid urbanisation after deadly conflicts that made people flee and broke up the families bonds. There are a lot of illiterate people, great poverty and many unemployed, as well as a very Americanised culture that is not really a social support and an important number of churches.

The TFC is located on the outskirts of Monrovia (Montserrado County) in a town context, in a refugee camp. The number of beneficiaries (mainly children under three) is constantly increasing. Malnutrition is similar to what I have described in the second part on “chronic situations”, with a prevailing factor linked to poverty and the subsequent difficulties.

A lot of my observations are written in the second part of this document on mental health at ACF and I will not come back on them. In this paragraph I will deal with a few impressions gathered from my discussions,¹⁵ in order to outline some outstanding points that would be worth going into more deeply, by carrying out a more precise survey:

- All the mothers with whom I started a dialogue talked very freely. They were very open to exchange and seemed to be pleased to spend a few moments with me. Concerning only two of them, I had to come back three days running and after seeing me discuss with their neighbours they then accepted to talk.
- A few children aged 2 or 3 were frightened by my white skin and did not allow me to approach them and play with them, even after having seen me for several days.
- Sharp observation allows you to spot very quickly the mother/child couples who are not functioning correctly and the presence of underlying problems. This was confirmed at

¹⁵ This does not concern a representative example since I had a tendency to go towards the mother/child couples who I felt were not functioning correctly.

each discussion. Often young mothers with their first child were concerned, or people who had taken in an orphan. The age of mothers admitted in the centre¹⁶ was less than 16 years old for 5%, 12% from 16 to 20 years old and 64% from 20 to 34 years old. I therefore think that the young women in my example were over-represented. I make the assumption that they are in greater difficulty as still adolescents and not mature, often living with their own parents and that they have difficulty in assuming their status of mother and coping harmoniously with their baby's requirements.

- I did not see any difference in the mothers' attitude between boys and girls. The same number of admissions concerning girls and boys confirms this. I think that in certain countries, on the contrary, this can be a revealing indicator.
- When I questioned the mothers on the causes of malnutrition, most of them did not know what was at the origin of the disease that had started by vomiting and diarrhoea. A few of them made the link with personal causes such as the death of their own mother before the child fell ill, or the husband's jealousy that obliged the mother to wean the child too early, or abandoning the child or seeing a pregnant woman die. I think that if I had been able to really carry out deeper psychological interviews, I would have obtained very interesting individual and cultural explications. However we can note that the causes given by the women are all linked to relational family dynamics.
- 90% of them had already been at least once to the clinic or hospital before arriving at the TFC, without any improvement in the child's state of health. We can therefore see the necessity of training the nursing teams of the local structures in malnutrition and its treatment, which would avoid a certain number of severe de-nutrition cases.
- Mothers and children quickly realised the type of intervention I was carrying out and made a difference between the medical team and me, for example by calling me "the person who plays with the babies and makes them smile".
- Introducing games, songs and balloons at once changes the atmosphere and encourages exchanges between the mothers and also between the children themselves.

Amongst the mothers I questioned, we can see certain outlines:

Very young mothers with twins or a first child (73% of them are the oldest of the family) live with their parents who themselves have young children to cope with). They lack maturity and have difficulty in grasping their children's need in an adequate way (they do not carry their child properly, do not breast-feed their child correctly, introduce diversified feeding too early...)

Mothers, who are at the head of families (30% of the mothers admitted are in this situation) are often more or less depressed and tired and isolated. They get little help from the group to bring up their child and must go to work each day, leaving their baby with the older children.

4. Meeting the local institutions and the international NGOs

¹⁶ Leila transmitted to me the figures that she obtains through the analysis of a question paper that she has set up in the TFC.

At the present time there exists no survey on the needs for psychological treatment in Liberia. Save the Children Fund has done research on the children's representation of war in the country. The conclusions obtained by Leila were amazing : the children considered war as a positive episode. Unfortunately we did not have access to this document, as I would have liked to check the method used.

4.1. UNICEF

UNICEF works mainly as a support to the Social Affairs Office of the Ministry of Health and is not directly implicated in mental health. The only programme that has a link with ACF's aims concerns support to pregnant adolescents. We can assume that this type of approach encourages the prevention of malnutrition through specific support to young mothers with their first child (when in fact this population is over-represented in the TFC). But we must question this point as, according to the director of UNICEF, this programme does not obtain very good results. He hopes to work with YMCA and no longer with the government on this problem.

4.2. WHO

Although WHO declares that in 2001 one of their main aims is to treat mental health (and this has even been in the Liberian newspapers!), we were unable to see anyone concerning this question in Liberia, as there is no project in this field.

4.3. Don Bosco (Mother Pattern College - Health Sciences)

This organisation has been established in Liberia for many years and has a good knowledge of the context. According to them there were already many problems before the war, and they are more accentuated today particularly due to poverty. They deal with different social-psychological projects:

- Training of social workers in order to help people who have been traumatised by the war, with community support. They also train employees of the Ministries, of Don Bosco Homes and Save the Children Fund.
- Programme concerning violence on women. Household violence seems to be very frequent and at all levels – men on women and children, women on men and children, children on their parents – apparently linked with the context of poverty and social-economic difficulties. The programme works with small groups of women and traditional midwives, using participating methods and discussions. Do they accept violence in life? How can they implicate themselves in the community? Intervention models? They also encourage social integration of these groups through work in order to make them financially independent.
- Child to child programme : organisation of play activities for the children concerning health education.
- Programme to help traumatised children : this project is starting. It concerns the training of voluntary teachers from several schools on traumas, on maintaining and on resolving

conflicts. They spot the pupils who are in difficulty in their schools and offer them more specific support. A social worker is the referent in each school.

We could think about working with Don Bosco at several levels. I think they have a good experience of participating methods. They could perhaps train ACF staff in this approach (wat/san, food security or TFC, either in the constitution of communities or in health education for example), by showing the benefit of open discussions, of forming a group and giving support to find the means adapted to each group, individual or context. Why not also tackle the question of violence, for instance in the TFC either by displaying posters or by selective discussions?

If we want to implicate ourselves in the future with people who are traumatised and in the resolution of conflicts, it is obvious that they could adapt their training programme to our needs. I only know about the themes evoked, that seem very interesting to me, but we would need to check the contents more thoroughly.

4.4. Save the Children Fund

SCF does not intervene in Monrovia but in the counties on the integration in the communities of children who are ex-soldiers or children living in the streets. They develop an approach that is to try to form small groups of children, to increase solidarity and help integration. They are faced with a lot of difficulties like the young people's aggressiveness, the abuse of drugs and alcohol, prostitution, HIV, violence between them and on their children, no schooling and of course the fact that the communities reject these young people.

Generally speaking there is an important need for a social-psychological network in Liberia. A few populations in certain counties are aimed at, such as the ex-soldiers or the street children, but nothing is organised for the population as a whole or for people traumatised by war. It is therefore difficult to refer the beneficiaries who we could pick out in the TFC. There is apparently a psychiatrist, Dr Grant, working with JFK, who mainly prescribes medicines, and a clinical psychologist, Mr Danken. I did not have the opportunity to meet them. Moreover I am rather puzzled about the various approaches developed (apart from that of Don Bosco). In fact I am not convinced that working with small groups of ex-soldiers and street children is the most judicious approach. Amongst all the NGO teams there is no specialist in mental health, either as a technical referent or to ensure individual monitoring.

There are also discussions concerning the community approach adapted to all cases. Is it adapted to the Liberian context? Is there an already existing organisation in each community or are we talking about communities that we will form for a joint project? Is there any sense in wanting to integrate ex-soldiers in communities? And in which communities?

5. Conclusions

This mission was very useful in helping me to grasp the functioning of a TFC and to understand more clearly in what malnutrition consists and its treatment. This was made easier by the TFC's small size but also because of Leila and Patrick's open-mindedness to the mental health dimension. The month spent in Liberia enabled me to confirm the feasibility and relevance of certain of my propositions and to improve them due to a more realistic vision of the TFC.

It is evident that the mothers are ready to talk and are pleased when we sit down with them for a few moments.

Leila is redefining the community worker's timetable:

- Her presence during admissions so that she can make a preliminary observation of the relations with the child and so that the accompanying adults can spot her as soon as they arrive.
- Distribution of the question paper on food security/nutrition on entry in the second phase with indications on the importance of going deeply into certain questions.
- Having discussions with the mothers who seem to have the most difficulties.

Beyond these basic replies, certain mothers could take advantage of psychological care, even at short term. Unfortunately the human resources are not present in Liberia for the time being.

As far as activities are concerned, the staff is insufficient and in charge of too many beneficiaries. There is little time left for activity sessions. We are trying to develop a relationship with the beneficiaries that is more on the listening side and less moralising, and insisting on the fact that stimulating the child and play activities are an integral part of the treatment. The play activity and stimulation function could be indicated in the job descriptions.

The presence of an activity organiser within the TFC seems to me to be absolutely essential in order to:

- Organise activities and play with small groups of say 5 mothers and their babies, who have been spotted as being in difficulty, for about a quarter of an hour (the babies' concentration capacity is limited).
- Discuss with the mothers and their babies. There again in ten to twenty minutes they can tell a lot of things. We do not need to have discussions once a week for an hour. Exchanges twice or three times a day are much more profitable.
- Propose activities to larger groups for mothers who wish, with their children, once or twice a week (for a maximum time of an hour).

The activity organiser's personality is very important because his dynamism, his creativeness and his faculty to listen to beneficiaries will bring liveliness to the centre (in addition of course to the right attitude adopted by the nursing teams). In this way we will also encourage talking, improve the well-being of beneficiaries and the mother/child relationships.

Fourth part

**Means to be used for
ACF's mental health project**

Means to be used for ACF's mental health project

I assume that generally speaking my propositions seem to interest ACF.

How can we implement them?

The setting up and follow up of this project necessitates two additional aspects:

On the one hand, the acceptance of this approach by all ACF members by interesting and training them so that taking into consideration the psychological and anthropological aspects of the beneficiaries becomes an ACF collective project.

On the other hand, I think it would be very useful for a mental health professional to intervene in the TFC so as to initiate this specific dimension at a local level in the existing programmes and to start interesting the staff. If we consider the continuity of this project on a long-term basis and to compensate for the turnover in the field and at headquarters, that entails a loss of information, it is necessary for this person to be also the technical referent at ACF's headquarters. His role there would be to pay attention to this aspect of the programmes, especially to ensure the training courses linked to mental health and to prepare answers adapted to each mission. This project could be covered by a request for finance made for example to the Fondation de France.

My suggestions mainly concern a change in attitude towards the national teams and the beneficiaries. Once the training modules have been set up, they will be integrated in the present training courses and will not entail any extra expense. As far as the missions are concerned, the expenses are not very high : an activity organiser must be recruited for about 100 beneficiaries, an area for play and social interaction must be set up, small material mainly composed of salvage equipment and the purchase of a small article per child admitted in the TFC. I think I have sufficiently developed my reasons to justify with the sponsors the importance of integrating this dimension in the treatment of malnutrition. I also think that it is a matter of motivation and presenting these elements in our proposals, that *considering the anthropological and psychological dimensions is not something that comes in addition but is an integral part of malnutrition treatment at ACF.*

Furthermore I wonder if we do not have a somewhat prevaricate opinion of the sponsors because mental health and traumas are in fashion and take a considerable place in the quality approach that is advocated today by our sponsors.

1. A collective project

1.1. Shared responsibility

First of all we must interest the ACF staff at all levels as this extension of ACF's competence can only be acquired if the salaried staff and voluntary workers agree to this project. Most of the salaried staff is already interested, perhaps because I am present, but it would be useful to imagine more specific meetings and exchanges with each department.

The suggestions I propose in this report form the basis of a more humane and more global approach of beneficiaries. It is a long-term process that will necessitate each person's contribution and constant vigilance. We are taken up by the lack of time and the technical

factors and it is each person's responsibility to keep a watch so that this more global vision of the beneficiaries is not lost.

1.2. To interest and train staff in dealing with mental health and anthropological data

The elements I develop are aimed at interesting and training ACF voluntary workers in mental health in the hope that they will carry this project in the field, be capable of integrating it in their programme and transmitting it to the national teams.

Therefore in each training course we must think about putting factors into practice and transmitting them to the national teams.

a. With the voluntary workers :

- ◆ *For all the voluntary workers during their first departure training course (in collaboration with the Human Resources Dept.)*

To deal with the following questions : meeting others; active listening (in fact this is already taking place); a few basic notions concerning traumas, mental health and an global approach to nutrition; talking about mourning and loss and their cultural aspects; developing participating methods and reflection on the humanitarian cause and working in inter-cultural situations.

- ◆ *For the administrators*

Information on the purchase of small equipment for the death of beneficiaries.

- ◆ *For the nutritionist nurses (in collaboration with the Nutrition Dept.)*

These are the most important people, with the Medico-nutritionist Coordinators, for the pilot project since they are the interface with beneficiaries, national teams and the other members of ACF.

- During their technical training :

- * Leading a module on traumas and mental health linked with nutrition and all the proposals ACF has retained on these points, that is to say establishing landmarks in the TFCs; underlining the importance of the welcome on admission and the beneficiaries' conditions of life; the enhancement of the mother/child relationship; the necessity for areas for play and social interaction and the essential role of activity organisers.
- * Leading a training module on the importance of anthropological data, gathering it and compiling it.
- * Thinking about applying it and training the national teams in the field.

- Concerning the job descriptions :

- * Extending their role to animating the places for social interaction and talking in the TFCs and supervising the play activities for the children and the mother/baby groups.
- * Extending their role to gathering anthropological data.

◆ *For the medical-nutrition co-ordinators (in collaboration with the Nutrition Dept.)*

These are the most important people with the nutritionists nurses for this pilot project, since they carry this project with their teams and motivate them concerning the proposals.

- To help them to go beyond the purely technical aspect of the programmes and particularly the nutritional approach :
 - * Leading a module on this subject during their training course.
 - * Helping them to enhance and supervise this aspect with their teams and to work around the mother/child relationship and the importance of play.
- To interest them in mental health (in collaboration with the debriefing group?) :
 - * Leading a module on this subject + active listening during their training course.
 - * Thinking about the consequences of taking mental health into account in their programmes and for their teams. Interesting them so that they reinforce their availability and time for listening to their teams and that they obviously integrate this aspect in their programmes.
 - * Extending their job description to creating and animating a reference network for the most traumatised people.
- To interest them in the anthropological data :
 - * Leading a module concerning this subject during their training course.
 - * Extending the job description to gathering and compiling anthropological data, especially on feeding, manifestations of disease and treatment practices, bereavement rituals, the system of kinship and the creation and animation of a network of reference people concerning local culture.
- Training in participating methods concerning the inter-cultural field :
 - * Leading a module on this subject during their training course (using Jean-Claude Métraux's works for example).

◆ *For the heads of mission*

- To help them to go beyond the purely technical aspect of the programmes and particularly the nutritional approach :
 - * Leading a module concerning this subject during their training course.
- To interest them in the notion of psychological traumas :

- * Leading a module on this subject + active listening during their training course.
- * Thinking about the consequences of taking mental health into account in their programmes and for their teams. Interesting them so that they reinforce their availability and time for listening to their teams and that they obviously integrate this aspect in their programmes.

◆ *For the national teams*

- a. First of all we rely on the expatriates to interest their teams in the different aspects of mental health (which means that each training module will contain a part dealing with the transfer of information to the national teams). However we could envisage training courses in the field by mental health professionals : imagine.....
- b. Use the mental health report as the fifth volume to be added to the guidelines on nutrition.
- c. Use the report (mental health project arguments and how mental health can be taken into consideration in all ACF programmes) for the initial trainings.

1.3. Organisation of my work (and planning?)

In order to carry this project through successfully and to integrate it in the existing programmes, I must work in collaboration with different departments:

- Establishing meetings *by department* to advance together on global reflection
- With the *nutrition department* on the training of nutritionists and medical-nutritional coordinators, on the integration of this dimension in the protocols, on the functions and training of the national teams and the activity organisers
- With the *training /human resources department* on first departure training, interesting the heads of mission, the participating methods and training on traumas
- With the *wat-san or logistic department* on building a play room and a social-interaction room
- Eventually with the Technical Director to present the project and think about how and to whom we can sell it (Fondation de France).

2. Financing a pilot project

The problem with reports is to make them exist, a question that is all the more difficult when there are four head offices and missions throughout the world. To introduce this approach at ACF I think the project should be set up and financed over two years.

We must decide if we choose a pilot zone or the missions with a TFC as a whole and define a job description for the person responsible for this pilot project with various aims : introducing this approach in the different TFCs, participating in the training courses on these themes, being the technical referent on these questions for the headquarters, selective help on specific programmes...