

Children in War: the role of child-to-child activities in the therapy and care of displaced unaccompanied children

Paul D Eunson

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Paul Eunson is a Paediatric Neurologist in the Royal Hospital for Sick Children, Edinburgh. He spent 6 years working in Tanzania and Malawi before completing his specialist training. With his knowledge of child health in sub-Saharan Africa, his colleagues in Birmingham gave him leave of absence at very short notice to work in Goma with MERLIN. He continues to have links with paediatricians in developing countries, particularly in training in neurology and child disability.

MERLIN continues to be a very active medical NGO in areas of the world affected by conflict, and natural disasters. This work was awarded the Pierre Strauss Prize in 1995

Introduction

A recent estimate for the number of refugees in the world is 16 million. This figure does not include those people displaced from their homes but not from their country. More than 50% of refugees have fled because of war and violence. Some people have had refugee status for many years - Palestinians in the Gaza Strip, Mozambicans in Malawi, refugees from Ogaden (1). In some situations, refugees have not been able to return home and have become assimilated into the host society or a third country.

Within a refugee community children are present in the proportions of that society. Their numbers may reach 50% of those who fled, or more where the men have stayed to fight or are prisoners. Refugee children have always been awarded high priority for resources whatever the reason for their refugee status. The pictorial

images of hungry, frightened sick and staging children transmitted to donor nations produces an emotional response from the public and politicians alike. That response, when turned into resources, may meet only the immediate and apparent needs of the refugees. Funding for long term programmes for refugee communities is less forthcoming. Amongst refugee children, there will be a small but variable percentage (2% -5%) of children who are unaccompanied.

They may have lost their parents through violence or disease, or have become unintentionally separated in the flight from home. Once centres for unaccompanied children have been established in or near a refugee camp, a small number of parents will leave their children at the centre through motives of safety or better care. Older unaccompanied children may have adequate skills to survive in refugee camps without directed assistance, but younger children are at high risk of disease, malnutrition and emotional disturbances without special care. It is this group of children, highly vulnerable in their predicament who are the focus of this paper.

The case study, Ndoso Centre for Unaccompanied Children in Goma, Kivu Region, Zaire

Ndoso was originally established to provide institutional care for 40 Zairian children orphaned as a result of internal civil violence in Zaire in 1993. In July 1994, nearly 1 million Rwandan adults and children fled from Rwanda across the border into Goma in the space of a few days. It was immediately apparent that there were unaccompanied children amongst them for the reasons given above. As there were no facilities in Goma for any refugees until the relief effort - internal and external - could get under way, these children were extracted from the melee and initially placed in Ndoso. Within one week, 2500 children were being cared for in Ndoso in basic huts and shelters, supervised by Zairian nurses and volunteers.

The centre management requested *Medical Emergency Relief International* (MERLIN) to send a team of medical workers and logisticians to coordinate the medical care of the children. Other non governmental organisations (NGO's) were asked to assist with nutrition, water buildings etc. The centre remained under the original management structure. To assist with the support and monitoring of children, management introduced the 'encadreur' system. Older children among the refugees were delegated to supervise a group of younger children, assisting them in their

tasks of daily living, and facilitating the function of the services in Ndoso.

The MERLIN programme was viewed as successful by the Ndoso management some aspects were considered a model for later centres for unaccompanied children in Goma, and the MERLIN team were able to train and handover to a local team of nurses and doctors. However, we are aware that the programme had some significant deficits. Considerable resources were consumed by the programme initially and the delay before health indicators improved was too long. The programme was designed to meet the immediate physical health needs of the children. The psychological needs were not addressed until weeks after the children arrived.

The numbers of children completely overwhelmed the ability of the staff and agencies to meet any but the most basic needs. Older children in the centre were not invited to take an active role until one month after their arrival; this paper draws from the experiences of the MERLIN programme from July 94 to February 95 and includes an attempt to assess the programme critically.

Institution versus Foster Care for Unaccompanied Children

In certain refugee situations, there will be an excessive proportion of children who are unaccompanied. Undoubtedly, in the movement of Rwanda people to Goma a number of factors strongly contributed to the high number of unaccompanied children who required special facilities. For example, the prolonged flight from home which led to malnutrition, dehydration and death amongst the adults, and cholera already present in Goma, contributing to many of the deaths amongst the 80,000 casualties in Goma. The panic that ensued when thousands of people crossed the border from Rwanda into Zaire separated children from parents. Some older children had already been separated from their families having fled from Rwanda by themselves.

In the chaos that was Goma in July and August 1994, it was not easy for families to become re-united. There was no possible system that could have acted as a contact system for refugees. The adult refugees did not have the resources to care well for themselves. A programme of fostering unaccompanied children at this stage was impractical. After arrival in Goma, many people were later moved to official camp

sites up to 50 kilometres away. Unaccompanied children were taken by aid agencies initially to Ndoso and then to other centres for unaccompanied children as they became established. Where there are small numbers of unaccompanied children, it is usually feasible to consider informal fostering to other refugee families. This allows the child to live during the stressful times in an environment with common language and social practices.

However, the care that children receive, physically and emotionally, will differ from family to family. It will be difficult for the family to care for the child to a standard higher than they can provide for themselves, although the special circumstances of the child may warrant special care. Aid agencies have donated money or material goods to fostering families to assist with the care of the children. This has been viewed as a form of payment. Such measures may be essential as the families themselves are severely disadvantaged. Unfortunately, this has led to refugee children being viewed as sources of income (2) and there have been reports of children being used as child labour and of being neglected, abused, and traded.

The alternative strategy to foster care is to establish centres for unaccompanied children where all services are provided on one site. An acceptable quality of care can be achieved, and the status of the children as individuals and a community can be assessed. Centres for unaccompanied children are also a very effective fund-raising programme for aid agencies. However, when numbers of children become excessive, then the quality of life for children deteriorates as management structures become overloaded. Children who are emotionally traumatised may be lost amongst a large group of children. A long-term commitment to such centres may be beyond the resources of aid agencies. After one year, 500 children remain in Ndoso with no agency committed to paying salaries of staff.

However, there have been very few studies comparing the emotional and physical outcome of refugee children cared for in foster care versus centres for unaccompanied children. In Ethiopia, refugee children cared for in an orphanage did not have an excess of physical, intellectual, or emotional morbidity compared with Ethiopian children staying in their own homes in the same area. (3)

Research from Croatia suggests, however, that children in collective shelters were at greater risk of mental health problems than those with host families (4). It is

appropriate that the decision on the care of unaccompanied refugee children is made based on the specific situation and the resources available.

The main aim of this paper is to illustrate how the care of unaccompanied children can be improved, be achieved more efficiently and be more child-friendly in those circumstances where it is considered appropriate for them to be cared for in a centre for unaccompanied children.

Morbidity of Unaccompanied Children

Research from other refugee situations highlight the vulnerability of refugee and displaced children even when not unaccompanied (5, 6). It may be acute - as in diarrhoeal disease, pneumonia, meningitis - but may also be chronic. Malnutrition rates amongst Mozambican children displaced from home reached high levels in ensuing months (6) and the status of health of children affected by war in Afghanistan has deteriorated significantly. The physical and emotional well-being of unaccompanied refugee children are inextricably linked. Child care workers have recognised for many years that emotionally deprived children may fail to thrive in the absence of organic disease. Severely traumatised children may become mute and uncommunicative, although provided with adequate nutrition adopt a foetal position, engage in repetitive movements, and refuse to eat and drink. A few children behaved like this in the early days at Ndoso. The management of these children is difficult and in emergency situations, they have a high mortality.

The psychological symptoms associated with acute and chronic illness in children are well described - misery, listlessness, apathy and depression amongst others. When compounded by the physical and psychological effects of fear, hunger, malnutrition and loneliness, a community of children is formed who need a therapeutic programme that addresses the whole child. Feeding programmes or play therapy, in isolation will fail.

Structure of current emergency relief programmes

Emergency relief programmes for refugee children have traditionally concentrated on enabling the children to survive. In Goma, mortality rates per 10,000 children per week were the measure by which a programme's success was determined. Food,

water, shelter and medical care are afforded top priority, often through agencies working in co-operation. The medical care combines first response curative services with some public health measures. These may not be appropriate to the needs of the children at that time and the priorities need to be determined by the team in the field. If the programme does not have the capability to be redirected then the children will suffer.

United Nations Children's Fund (UNICEF) and United Nations High Commission for Refugees (UNHCR) recommend that all children admitted to a centre for unaccompanied children be registered, treated and immunised as soon as possible. The attainment of this desired goal depends greatly on how prepared the centre management are, and how quickly and ordered the children come. In Goma, the agencies had no time to prepare themselves and some agencies were still arriving three weeks after the children had fled from Rwanda. In these circumstances, an agency needs to have its strategy prepared in advance and to use all the resources available on the ground.

There are considerable pressures on relief agencies and professionals to run visible programmes that are seen to be saving lives. Pictures of starving and ill children are powerful stimulants for people to donate money. If a team of expatriates are seen on national television resuscitating these children, then the NGO involved will be guaranteed funds for that programme and others. Ndoso, being the first and the largest centre for unaccompanied children in Goma and with grim images of death and disease in its initial period, was inundated with agencies wanting to set up their programme and to take over the management of the centre. The international media have a vested interest in promoting the images of desperately ill children being saved by expatriate agencies. These images guarantee them prime time news coverage, and perpetuate the myth that survival is the ideal, but only, outcome.

Post-traumatic Stress Disorder

Post-traumatic Stress Disorder (PTSD) is a recognised constellation of symptoms that may follow a single dramatic event - physical or emotional - or be the outcome of a period of physical or emotional distress. The traumatic event may be directly experienced by the person themselves, such as being kidnapped or witnessing the death of a family member. Alternatively, the person who suffers PTSD may not be a

direct victim of trauma, an example being symptoms of PTSD appearing amongst school-mates of children killed in a school bus crash.

The symptomatology includes symptoms of re-experiencing events thoughts, dreams and play related to the trauma, symptoms of avoidance or amnesia and symptoms of increased arousal (8) These may be of sufficient severity to produce a disabling illness. Criteria for diagnosis have been deemed in DSM-IV 1994 (9), but this classification is hampered by not taking into account a child's age, or cultural background. This pattern of symptoms is not found solely following trauma, and undoubtedly in unaccompanied refugee children, there are factors other than trauma that predispose towards a PTSD-like syndrome. Symptoms may persist for many years into adult life and inhibit that adult's ability to adapt to and integrate into society. Survivors of the holocaust continued to show symptoms 40 years later. (10) Their children also showed a significant psychological morbidity compared with their peer groups.

Symptoms vary with age, cultural background and personality of the child. There is a recognised pattern of immediate symptoms which develop over weeks or months into those symptoms which may persist for years. The effects of the traumatic episode are compounded in unaccompanied refugee children by separation from parents, fear of the future, and a misplaced sense of guilt. In the setting of refugee camps and centres for unaccompanied children, the physical and emotional environment has implications for the health and development of the child, particularly the younger child. A child starved of physical, visual, auditory and emotional stimuli may fail to thrive or develop even in the absence of organic disease. Children provided with adequate food and water but no emotional care develop social and communicative skills at a slower rate than their peers. The effects of this obviously will merge with PTSD.

Therefore, the children of Ndoso, who had witnessed violence against family, were separated from family and were being cared for en masse with 2000 other children by strangers who did not speak their language, were at high risk of developing PTSD. In the acute stages, this may contribute to high mortality and morbidity rates from organic diseases and the prognosis for the future psychosocial development of the child is compromised.

There is a growing body of literature on psychological rehabilitation of children from refugee settings. Small groups have been studied following the conflicts in the Lebanon (11) Croatia (4) and Kuwait (12) amongst others. However, the circumstances of the children from Rwanda differ primarily in their numbers. In the above settings, there were already professional structures which could respond to the children's needs promptly. Neither Rwanda nor Zaire have workers trained in the appropriate techniques who could give the children the intensive therapy provided to children in other refugee settings. Although important in documenting the presenting symptomatology of PTSD and how this develops with time and therapy, the relevance to Rwandan children in terms of management is less clear.

The state sponsored violence and civil war in Guatemala, although never reaching prominence in the world press, devastated a community that has parallels with Rwanda. This conflict was targeted on a rural community, with little resources, many of whom are now in exile. Assistance has come to the refugees from outside Guatemala. A detailed study of the children caught up in the violence confirmed the symptomatology and prevalence of PTSD found in other studies, but concluded that traditional psychotherapeutic practices as used in America and Europe were inappropriate. By using culturally familiar activities of dance, song, mime and play, the children's fears and memories were gently explored in a non-threatening manner. Although the training and supervision of the programme was undertaken by expatriates, the implementation was by adult workers of the community. The author believes that the work was successful because it was constructed in local, political and cultural terms. Other work has confirmed the cultural flavour of psychotherapy is critical to the success of the programme. (14)

Over 8000 children were cared for in recognised (by UNHCR and UNICEF) centres for unaccompanied children in Zaire by September 1994. This did not include those children living in the main adult camps not directly supervised by all NGO. The resources to provide these children was quality psychological rehabilitation similar to that given to the Mayan children in Guatemala are not available. Psychological workers began work in Ndoso six weeks after the children arrived, working through interpreters. By Christmas 1994, only 120 children had been assessed. The chronicity of the adverse environmental circumstances that these children find themselves in is as strong a promoter of PTSD as the original trauma that the child experienced.

As in many other areas of child care in Africa, the resources for therapeutic measures of established PTSD in children are not available. Host governments do not have the capabilities of providing for the needs of the refugees. Non-governmental organisations are not prepared to make a long-term commitment to what may be an expensive programme. Major donor nations were reluctant to commit funds for programmes in the Goma area on the assumption that lack of facilities would encourage refugees to return to Rwanda. It is patently obvious from the experiences of Rwandan refugees in Goma and Kivu Region that the management and rehabilitation of emotionally damaged children is beyond the capabilities of United Nations organisations, NGO's and the Rwandan people themselves. One year after fleeing from Rwanda, the refugees cannot expect a political settlement in the near future. We believe that the environment - physical, cultural and emotional - of centres for unaccompanied children should be designed from the outset to prevent the development of PTSD and related psychological and developmental morbidity.

Child-to-Child activities and active participation by children

The philosophy of Child-to-Child has been developed in recent years and there is now a growing body of literature and resource materials on its use in a variety of situations - primary health care, health education, displaced children and children as refugees. (15, 16, 17, 18a, 19, 20). Allowing children to be involved in decision making in their predicament is a key feature of Child-to-Child activity. This permits the child to be an active partner in assessing priorities and determining what plan of action should be implemented and how this should be achieved. In other situations, such as Child-to-Child projects working with disabled children, this may be a slow process giving each child the time to perceive his or her needs and to articulate them. This process may be hindered further by the child's lack of communication skills and confidence in asserting his or her views as previously the child had a purely passive role in society.

Using the example of Ndoso, where large numbers of children arrive in a few days, it would not be possible to allow this period of assessment and discussion for all Child-to-Child activities. If the children are to be involved in assisting each other and partly preventing and alleviating the problems discussed previously, then they need

to be involved from day one. This therefore assumes that the management of the centre and those organisations assisting with child care are aware of the principles of Child-to-Child activities and the benefits of having children as active partners. In circumstances where it becomes apparent that the life-span of the centre will extend into weeks and months, the opportunity for developing the Child-to-Child process (figure 1) will exist

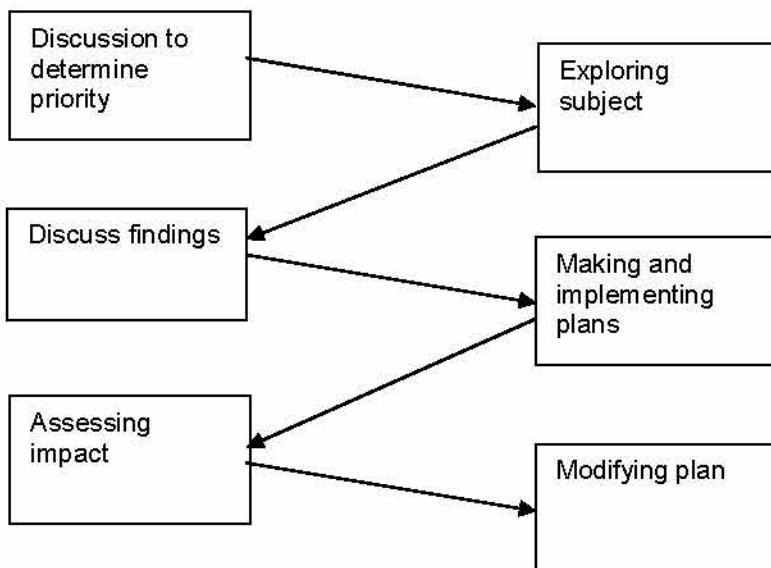


Figure 1. The Child-to-Child process

Once the centre is established and the anxiety levels of the children have somewhat decreased, then they will be able to follow this process. By this time, certain disadvantaged groups amongst the children may have become apparent. These groups are served well by a calm and steady assessment and implementation of Child-to-Child activities.

The initial Child-to-Child activities therefore will be strongly directed by the centre management. This withdraws the principle of children being involved in determining priorities but it retains the principle of children being actively involved in their own care and the care of others. From our experiences in Ndosho, most children are not capable of making decisions for themselves on arrival but were prepared to be directed into appropriate activities. Such was the stress of conditions in Ndosho that the same applied to some expatriate relief workers.

With careful thought and planning, there are a wide range of aspects of care of unaccompanied children that are appropriate for Child-to-Child activities. There are three areas on which I wish to concentrate:

1. Activities designed to reduce the mortality and morbidity from diarrhoeal diseases;
2. Activities desired to reduce the prevalence of and alleviate psychological problems, including PTSD; and
3. How the above activities can be used to reduce the dependence of the centre on short-term expatriate workers and to induce a degree of sustainability.

Diarrhoeal Disease Control Programmes

The triumvirate of safe water, appropriate sanitation and health education is not sufficient as an effective control programme unless designed in a way that is culturally and developmentally appropriate for the children. In Ndoso, adequate quantities of clean water were delivered daily by UNICEF and French Army to water tanks installed by OXFAM. Yet the small children did not have ready access to this water due to the difficult terrain and lack of suitable containers. Children died from dehydration in the early days despite there being sufficient water, oral rehydration salts, and intravenous fluids in the store. There was not a functioning mechanism to get the fluids into the children.

Digging of pit latrines is not glamorous and rarely attracts the television cameras, and therefore donated funds. Again, in Ndoso although a number of pits were dug around the camp, the children under five years, the group with the highest incidence of diarrhoeal disease, were unable to get to the pits unaided. It is not sufficient to dig pits, they must be child-friendly and they must be used. Young children must be trained to use them. This requires an understanding of the normal child-toileting patterns of that culture.

Health education of the traditional didactic format with the child being a passive recipient, failed in Ndoso. A group of healthy and alert children not preoccupied with memories of trauma and parental loss may, with the assistance of dynamic teachers, benefit from this method. It is unlikely that this scenario will exist in centres for unaccompanied children. The format of education needs to be culturally appropriate, allows the children to be active, but does not make excessive demands on thought

processing of a fragile child. The learning should be fun, and certainly, with younger children, it is appropriate to encourage some ritualised behaviour patterns through play and song.

I would envisage the encadreurs being responsible for the children having easy access to water all day and night. Each child should ideally have their own cup. Younger children would have supervised drink times during the day. Older children would supervise toileting and bathing with the young children and there should be regular unobtrusive surveillance of the use of latrines. A latrine that is rarely used is functionally defective in its situation, designs or accessibility. With the help of a designated health worker in the centre, the encadreurs would identify children with diarrhoeal disease and continue oral rehydration with that child in the tent/hut. The health workers would work through the encadreurs in stimulating appropriate health education activities with their children. It should be the role of the health worker to enable the encadreur to engage the children in these activities. The encadreur should not be displaced as the mentor of the children by the health worker. As an illustration of child-to-child activities in diarrhoea control, a description from Ndosho follows.

Dysentery Song Contest

As elsewhere in Goma amongst Rwanda refugees an outbreak of bacillary dysentery started in August 1994. Identified as Shigella Sonnei, and sensitive only to Pivmecillinam and Ciprofloxacin, initially it only caused moderate morbidity in affected children. However, once well established reports of deaths of adult patients appeared, UNHCR and UNICEF developed guidelines for treatment as follows:

Ciprofloxacin reserved for:

- 1 children under five years;
- 2 pregnant women;
- 3 severe cases;
- 4 cases with psychotic symptoms; and
- 5 patients in coma.

Treatment with ciprofloxacin was to be supervised and to be reserved only for bacillary dysentery. Supportive treatment was as important as antibiotics. Conditions were ideal for a rapid spread of bacillary dysentery in Ndosho. Although adequate

amounts of clean water were available it was not always easily accessible to the children, particularly those under the age of five years or 12 those who were ill. The programme of building pit latrines lagged behind other developments in the camp and the terrain became persistently soiled with faeces. The children had a tendency to share eating and drinking utensils although this was discouraged. The children were already susceptible to infections due to immunosuppression related to malnutrition and past infections.

Given the above circumstances, we developed our own treatment policy. After careful deliberations with camp management, we decided to treat every child and adult in Ndoso with bloody diarrhoea with ciprofloxacin. The rationale was as follows: 1. Children were crowded into tents and spread of dysentery from one child to another was enhanced. 2. Many children were already weak and malnourished and further infections may prove fatal. 3. There were facilities available to separate children with bloody diarrhoea and supervise treatment and rehydration and 4. As young babies less than one year old were infected we knew that workers in the camp were involved in transmission of dysentery and had the right to treatment.

Health education was included in the remit of a team that visited each tent and hut daily to deal with minor health problems. It was our hope that early and aggressive treatment combined with health education would limit the spread of dysentery. However, these measures were not successful. The numbers of children affected by dysentery steadily increased and coincided with a large outbreak of non-bloody diarrhoea. (Table 1)

Week	Dysentery Cases	Cases of non-bloody diarrhoea
1	141	41
2	118	59
3	93	31
4	155	295
5	69	214
6	27	58
7	22	81

Table 1. New cases of dysentery and non-bloody diarrhoea in Ndoso from August to mid-September 1994

The children had already shown a desire to dance and sing for prominent visitors to Ndoso. Rather than continue with the traditional didactic methods of health education where the child passively receives advice, we wanted to allow the children a more active role and to take some responsibility for their health. By encouraging the older children to care for the younger children, this group would then have a role in the camp which would boost their self-esteem. Health staff fluent in French and Kinyarwanda taught the encadreurs of each tent and hut how dysentery is spread, how it is treated and how it is prevented. Together, they composed a basic rhyme which the young children could learn and the older children would adapt.

Each encadreur then returned to his/her children and encouraged them to produce a song with dance and mime based on the basic rhyme. One week later, each group would perform their song at a concert in front of the whole camp with prizes all round.

The children were tremendously enthusiastic about the concert with some groups managing to produce costumes, others using drums. The concert as a social event and a way of bringing the children together as a community was a success. The children sang and danced and put over their health message in a manner that was natural to their culture and easily understood by the young children. Representatives of other aid agencies attended and the songs were broadcast on the UNHCR refugee radio station to the other camps.

One week after the encadreurs started their education programme (week 4 in table 1), the incidence of new cases of dysentery and bloody diarrhoea began to fall and continued to fall over the ensuing week. Diarrhoeal disease never again reached epidemic proportions in Ndoso.

Discussion

Of course, this is not a controlled study and there is no proof that this method of health education was the only factor that led to a fall in the cases of dysentery. One could argue that the epidemic had reached its peak and was about to decline spontaneously. However, there were still 1000 children in Ndoso who had had no symptoms of dysentery and a percentage of them would have been susceptible.

It is rarely possible in such circumstances to carry out formal studies of health education. Indeed, there is sufficient evidence for the beneficial effect of health education on disease control for its deliberate absence to be considered unethical. Among older children and adults, sufficient numbers will have been exposed to health education in the past to trigger adoption of preventative measures spontaneously. Therefore, the effectiveness of an activity such as the Dysentery Song Contest may only be assessed subjectively. We believe that the dramatic fall in the incidence of dysentery and non-bloody diarrhoea following the song contest is sufficient evidence that it was an elective method of health education.

Prior to the dysentery song contest; the children had confined themselves to activities related to their survival, with food, water, and shelter being a priority for children and staff alike. What play there was occurred between children of one tent or hut and of similar ages. This was partly the result of segregating the children by age group for ease of management of daily needs. However, this is an artificial division and long-term it would be more appropriate to mix the children into "extended-household" groups with children of various ages supervised by a small number of adults. This would be particularly beneficial for the rehabilitation of children under five years. In the weeks following the song contest, the staff in Ndosho observed a change in the pattern of daily activity of the children.

The staff began to notice small groups of children sitting together, drawing in the dirt or on paper provided for the hospitalised children. The activities of these groups were either older children teaching young children basic reading and writing, or peer groups working together on remembered school material. This spontaneous initiation of educational activities by the children strongly reflected the needs of the children. Some had been in Ndosho for over two months and the tragedy of the flight from Rwanda, the loss of their parents and the despair of the cholera epidemic had begun to fade. They were in need of some activity to fill the void in their lives. Perhaps the older children analysing their own situation and the immediate future for Rwandan society concluded that education provided the only escape from their predicament. Whereas previously, a game of football against French soldiers or the arrival of the water truck would attract a large crowd; the children now wanted more active, constructive activities.

Formal education was discouraged by UNICEF and UNHCR in the first three months

following the arrival of Rwandan children in Ndoso. The reasons given were that education facilities for local Zairian children were poor and preferential development of services for refugees would induce some resentment. The children in Ndoso wanted to continue with education, clearly demonstrating their enthusiasm when the director-general of UNICEF presented the camp with an education kit.

When children are separated from their parents, have experienced severe stress, and are in a camp setting, they require stability and a structure to their life. In the event of reintegration into family life not being possible, provision of education has been shown to provide the necessary framework, with the teachers being perceived by the children as the parent substitute. (21) This is a vital step in the prevention of and rehabilitation from post-traumatic stress disorder. Therefore, in Ndoso, when it became apparent that the children would not rapidly be returning to Rwanda, we were keen to start formal education.

In Ndoso, there were a small number of children under two years of age who were naturally dependent on others for all care. They were housed in a stone building in beds with mattresses and blankets. Despite intense supervision of feeding and hygiene, and regular examination by paediatricians, their morbidity and mortality rates were unacceptably high. This was the case in all the camps in the Goma region. The principal causes of death were diarrhoeal diseases, pneumonia and meningitis. Infants were frequently severely dehydrated, hypothermic, and 'hypoglycaemic on admission to Ndoso. Nursing these children in close proximity to each other for 24 hours a day probably contributed to the high rate of severe communicable disease.

In rural Rwanda it would be customary for infants to be in close contact with their mother, elder sister or other female relative for much of the day. This provides the child with warmth, comfort and a wide range of stimulation, all of which contribute to optimal growth and development. Children deprived of these factors, but given adequate nutrition, may fail to thrive or develop. Therefore, the environment in which these infants received care in Ndoso may have been satisfactory in terms of nutrition, hydration and medical surveillance but failed in terms of environmental stimulation and prevention of spread of disease. To counter these factors, teenage girls in the camp were encouraged to come to the infant's house, and to take the infants on their backs to allow the infants to experience the sights, sounds, and

movement of life outside. To prevent inappropriate feeding, the infants' food was prepared and given under the supervision of the staff.

Again, we could not objectively measure the effect that this close contact with one person and experiencing life in the camps had on the infants. In other situations, infants have been placed with temporary foster mothers and families in an attempt to normalise that child's environment. For very young infants, a woman who is prepared to breast feed the baby is the ideal substitute for the mother. In the main refugee camps in the Goma area programmes of identifying wet nurses were successful on a small scale.

The benefits are two way. We believe that the infants benefited from the different experiences and change in environment. We also believe, confirmed by the girls themselves that this provided a role for the girls, and allowed them a certain status within the camp. It permitted them to behave in some ways similar to normal life in rural Rwanda. This is an important part of the process of rehabilitation as demonstrated in studies from other refugee crises and traumatic events. (22)

Measures designed to reduce the prevalence of, and alleviate psychological problems, including PTSD

Following traumatic events involving small numbers of children, a variety of methods have been utilised to determine the prevalence of psychological disorders and PTSD. These methods have also been used to define high risk groups. Such methods include self-report measures, structural interviews, and rating scales, and peer nominations. The advantages and disadvantages of each method in relation to traumatised children have been reviewed elsewhere (23) All have the drawback of not having been validated between different post-traumatic situations and between different cultures. Indeed, it is not yet clear whether the symptomatology of PTSD varies across cultural boundaries. They are also intensive in resources and personnel and are not readily applicable in the chaos of an evolving refugee situation. These factors therefore preclude the use of these tools in communities such as Ndoso.

However, it is vital to be able to identify the distressed child early, for the sake of that child and also for the community of children as a rising prevalence of psychological

disturbance indicates an environment not conducive to the children adapting to their predicament. I do not propose that children be asked to search for specific symptoms of PTSD in their peer group. It is essential to have a simple set of criteria that can be used by all in the centre to help identify the children at risk. The criteria do not have to be strongly discriminating for a defined disorder as the management of the child will be non-specific in the first instance - gentle encouragement to talk, more physical contact with an adult or older child, special care in its broadest sense. Those supervising the care of the children should be aware of the significance of:

- sleep disturbance
- outbursts of anger
- mutism or reluctance to talk
- reluctance to eat or drink
- inappropriate attachment to one adult
- withdrawal from all activities

Even in situations where resources and personnel are available, not all victims can be reached one-to-one. In a population the size of Ndoso, the responsibility for identifying children most at risk has to be delegated to those who may be untrained but have more prolonged contact with the children. In Ndoso, it was a not infrequent occurrence for a cook or a laundry worker, or a carpenter to bring to the attention of the medical staff a child who was always crying, or not eating, or limping. Elsewhere, parents and teachers under-report psychological problems compared with children.

(24) When portrayed as a task of mutual self-help, it is an appropriate role for children to assume.

The exploration of problems such as memories of the traumas memory loss, recurrent dreams should be left to suitable experienced adults trained in culturally appropriate therapeutic techniques. I would view the child-to-child abilities as a "holding operation". It identifies and draws into the community children who are severely stressed and cocoons them until more specific help is available.

As I have discussed previously, there is strong evidence that the provision of an environment that bears a resemblance to the home culture - similar language, foods religion, daily activities - may hinder the development of serious psychological morbidity. Work with Rwandan refugees in Tanzania suggests that abilities commonly employed in youth organisations such as the Scouts and the adoption of

the encadreur system encourages communication and socialisation amongst the children (25) From Thailand, Reesler commented on the beneficial effects of Cambodian children experiencing the cultural and religious practices of their homeland (22). Within a community of unaccompanied children, the memories and resources for providing this cultural structure lie with the children themselves.

I would propose a series of structured and semi-structured activities during the day supervised by the older children.

The exact nature of these activities depends on the culture, the resources, and the age structure of the children. This has to be left to the discretion of the decision makers which includes the children. There will be times when children of all ages mix, and times when peer groups are separate. This does not obviate the role of the adults carers but allows them greater flexibility and more opportunity to concentrate on the more disadvantaged groups.

Time	Activity	Comment
Morning	Breakfast	<i>Older children collect food and utensils supervise feeding of young children identify children who are not eating</i>
Morning	Personal hygiene	<i>Young children supervised</i>
Morning	Health issues	<i>Education activities with health team</i> <i>Oral rehydration encouraged</i> <i>Ill children taken to dispensary</i>
Morning	Education	<i>Basic skills taught to younger children</i> <i>Older children work together</i> <i>Songs and games with children under five</i> <i>Story telling - competition and small groups</i>
Noon	Personal hygiene	<i>Supervised before meal</i>
	Mid-day meal	<i>As for breakfast</i>

Afternoon	Rest period	<i>In tent with encadreur</i>
Afternoon	Games	<i>As appropriate for age of children</i>
	Communal work	<i>As appropriate for culture of the children e.g. girls - play with and care of babies boys - garden activities</i>
Afternoon	Personal hygiene	<i>Supervised before meal</i>
Evening	Evening meal	<i>As for breakfast</i>
Evening	Hut/tent activities	<i>A time for talk and socialising</i>
Daily	Religion	<i>Culturally appropriate activities</i>
Daily	Special groups	<i>Rubbish collection</i>
Weekly	Medical	<i>Scabies control Delousing</i>
Weekly	Nutrition	<i>Assessment of vulnerable groups</i>
Weekly	Communication	<i>Between adult workers and encadreurs</i>

This timetable is not exhaustive and will vary depending on the peculiar circumstances of that situation. It is designed as far as possible to mimic the life of children in rural Rwanda. The communal activities and responsibilities are certainly common features of school life in many parts of Africa and will not be an alien concept to the older children. The rest time is crucial for the younger children and it is during this period that they can have the warmth and stimulation of close contact with adults that is essential for their future development. When one considers the wealth of stimulation that a young child in Rwanda would receive, on the mothers back and participating in all the abilities of the extended family, it is not difficult to imagine the emotional bleakness of the traditional orphanage environment. All of these abilities can be child-led and provide the child with a variety of stimuli throughout the day. The opportunity to mix with many children and adults yet retain the comfort of belonging to a small group with a recognised home and mentors.

Time and the arrival of new resources will demand adaptations to the timetable. I would argue for an early introduction of formal education. This is one of the rights of

the child and has been recognised as a crucial support structure in a community where the family network is absent (21) The teacher may be the adult to whom a child can turn to for affection and support where the parents are absent.

As it is improbable that definitive research will ever be done on control and prevention of psychological problems including PTSD in situations on the scale of Ndoso, then we need to analyse smaller studies and extract the relevant lessons. The message that one gets from these studies are as follows:

Communication is crucial	<i>Between children between children and care-givers Between care-givers between caring agencies</i>
Early intervention is effective	<i>Trained psychotherapists are not essential for beginning the healing</i>
Introduce familiar items and practices to reduce feelings of alienation	<i>Personal objects for each child Communication in their own language Religious activities of their culture and family</i>

A child's anxieties will decrease with time if their predicament is stable. Uncertainty about the fate of family members will prolong anxiety. However, apparent adjustment may not indicate resolution of stresses, and psychological problems may continue to develop. There are correlations that may be drawn from studies of children affected by war but not separated from parents and families. The following issues have relevance for child-to-child activities.

Issue	Child-to-Child correlation
Social support by family members buffers psychological difficulties of war. Interventions should be multifaceted	<i>Form small groups of children under care of encadreurs with close links to named adults to create a cohesive community environment which addresses all issues of child life.</i>
Education components normalise feelings and children need to develop war-related play, writing and talking to manage their anxieties	<i>Develop programme of small group play and games appropriate for developmental age of child and larger drama/song/dance activities for whole centre - but do not explore anxieties on a one-to-one basis until trained professionals are available.</i>

<p>Research is difficult because of lack of resources, suspicion, government disapproval and the emotional state of the children.</p>	<p><i>Document activities and provide means whereby the children can record their reactions to what is being asked of them.</i></p>
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Psychological morbidity is a dynamic ebb and flow of related problems. A point prevalence of global psychological morbidity or of individual symptom complexes is of limited use. From other studies, there is a range of prevalence of up to 50% of PTSD and related disorders in children who experienced the trauma of conventional war. (26) One would expect the prevalence in unaccompanied children who have experienced the extraordinary traumas of the Rwandan civil war to be near the top of this range.

If a group of children are able, through child-to-child activities, to communicate with peers and adults, then they may be better able to express themselves when they are able to meet therapists compared with children from an environment where communication was not facilitated. It will however be near impossible to assess the effect child-to- child activities has on the prevalence and severity of PTSD and related disorders. A child's symptomatology may change from day to day with changes in their predicament and as they adapt to it. Rather than make an assessment of the effect child-to-child activities have on one facet of child life, it is more rewarding to assess its impact on global quality of life in centres for unaccompanied children.

How child-to-child and self-help activities may reduce the dependence on short-term expatriate workers and induce a degree of sustainability

Throughout primary health care, there is an aphorism that states - "Do not do any task yourself that you cannot train a junior person to do". It applies very well to the role of expatriate relief workers and local professionals in emergency refugee care. It cannot be taken to its utmost extreme as there are circumstances where the responsibility of performing an apparently routine and mundane task needs to be taken by the senior person.

Ndosho employed more than 350 adult workers to care for a maximum of 2500 children. This number included cooks, laundry staff, guards, sanitary workers, and

medical staff but did not include those employed by UNICEF and NGOs for specific programmes with the children, nor the encadreurs. Among this number were 29 Zairian and Rwandan nurses and paramedical staff paid by MERLIN. The MERLIN team consisted of a maximum of 5 expatriate staff (2 nurses, 1 doctor, 2 logistician) with 10 local support staff wage. Budgets as percentage of total budgets are itemised below.

Budget item	Monthly wage	% of total monthly budget
MERLIN local staff	\$4840	11.7%
MERLIN expatriate(allowance + perdiem	\$2183	20-34% (MERLIN budget)
All Ndoso staff	\$41,234	100% (Ndoso budget)

It is difficult to estimate the total cost of running Ndoso for a given period of time as many items and services were donated without an attached monetary value. However, a project proposal prepared to run Ndoso for 6 months, including education, came to \$500,000. Food and salaries per month currently is \$30,000. These are beyond the budgets of virtually all NGO's and requires UN or government funding. Although there are attractions for an NGO in running a centre for unaccompanied children, the cost precludes long-term support. Therefore, each NGO should be analysing their involvement with the children to ensure that services will continue after they withdraw. As well as looking for a replacement funding agency, this involves encouraging the camp management and the children to be more self-sufficient in their physical and emotional needs.

As the health of the children improved, and some children were reunited with families, whilst others were moved to centres in Rwanda, the number of staff required for care of the children dropped. At the time of writing, 500 still remain in Ndoso, many of them under 5 years, and funding is still insecure. The initial demand for staff due to the dire circumstances of the children, and the gratifying response by Goma residents perhaps stifled any measure of self-help activities at the beginning. The management and workers saw their role as providing total care for the children who passively accepted the care. The element of sustainability was missing from the beginning. In the fickle world of aid appeals, workers salaries do not carry the same

weight as food, medicines, or clothing. Not only would child-to-child and self-help activities reduce the numbers of salaried staff required, it would free some staff from routine work and allow them greater contact with the children and to meet their needs or to take on tasks that needed their greater skills and maturity. Examples of delegated tasks for workers are given below.

Cadre of worker	Task delegated	Task taken on
Nurse	Oral rehydration	<i>Tutor encadreurs in principles of health</i>
Education		
Cook	Preparation of basic ingredients	<i>Preparation of porridge for nutrition unit</i> <i>Preparing a more varied diet</i>
Nursery worker	Play and stimulation of young babies	<i>Feeding of ill children</i> <i>Work with children with development delay</i>

The net effect will be a community of children more independent in their skills of daily living, backed by the support of the social structure of the camp and by the close proximity of adults, they know and trust. The longer term viability of the camp to exist until its raison d'etre disappears will be more assured. NGO's and other donor agencies did see a viable project which they can support in full or in part. This project meets the needs of the children as they perceive their needs because they have an active role in decision making.. Most importantly, the centre will be where a good quality of life for unaccompanied children is the attained goal, rather than mere survival.

Assessment of quality of life in centres for unaccompanied children

From the onset of the centre, the aim should be to ensure quality of life for the children. It is an understandable goal to strive to save every child brought to the centre, but in retrospect, the MERLIN staff are aware that all our works and resources were consumed by curative medical care in the beginning. In most of the recent large refugee crises precipitated by war – Mozambique, Ethiopia, Liberia, Bosnia, Rwanda - people do not rapidly return to their homes. Therefore, vulnerable children may be cared for in centres for months and years at a crucial time in their emotional development.

As each refugee situation has features unique to it, it is not possible to compare directly the result of one programme with another. The chaos and uncertainty of a refugee crisis is not conducive to objective research methods and research is not viewed as of high priority by refugees or aid organisations. Yet with vulnerable groups, there is a need to set attainable goals of standards of care. If mistakes are made; there may be dire consequences for the individual child and the community of children. Managers of centres for unaccompanied children should have a set of guidelines which can be modified to meet the peculiar features of that situation. Within the management structure, there needs to be the resources for assessing progress in developing services or the children, assessing not merely the presence of these services but how they function and meet the needs of the children.

There is not a single criteria or statistic by which the centre can be judged. Just as the emotional and physical health of the children are closely linked and affected by each other, so the assessment of these problems cannot be taken in isolation. Only by constant monitoring of all facets of centre life can an indication of progress be obtained. Such an assessment will therefore be a composite report. Where various agencies are working in parallel in a camp, traditionally their reports have concentrated on the ability of that agency in isolation to justify funding. The value of such a report is questionable, and its production testifies more to the rivalry between agencies than to the desire to monitor progress. Reports are of most value to camp management in analysing the situation of the children and the frequency of the assessment and its content has to be made at centre level. Reports should contain most of the following as a minimum.

Sector	Measurement	Comment
Health	Weekly mortality	<i>Deaths/10000/week</i>
	Weekly morbidity	<i>Cases/10000/week</i>
	Specific disease morbidity	
Nutrition	Weight-for-height scores	<i>% with <-2 standard deviations</i>
	Weight-for-height scores	<i>% with <-3 standard deviations (indicators of moderate and severe malnutrition)</i>

	Mid-upper-arm circumference	<i>Children 1-5 years – a quick method of assessing malnutrition but does not describe the same group as weight for height score (personal data on file)</i>
	Night blindness rate	<i>Indicator of Vitamin A deficiency</i>
	Anaemia rate	
Sanitation	Number of Latrines	
	Ease of access to latrines	
	Frequency of use per day	<i>3-4 visits/child/day less suggests need for better access and education. More suggests diarrhoea.</i>
	Epidemiology of diarrhoeal disease in camp	<i>Identification of case clusters</i>
Emotional health	Incidence of psychological problems	<i>Sleep disturbance Aggressive behaviour Not eating or drinking Excessive attachment to adults Failure to thrive in absence of organic disease Withdrawal from communal activity</i>
	Developmental progress	<i>Document developmental status of children under five years and the attainment of new skills</i>
	Reports from encadreurs and adults	<i>Via regular weekly discussions</i>

Ndosho management had little control over the rate at which children arrived and in what state the children were in on admission. High death rates initially may not be a reflection on the centre's ability to care for children.

Statistics are only a part of the assessment. Workers experienced in care of unaccompanied children describe a subjective feeling when the centre changes from

crisis management to planned progress. The children change from being passive in the face of their predicament to being active, boisterous, and demanding. Their characters emerge and they begin to assert themselves as individuals. The children have mood swings, and still suffer psychologically. They now have some control over their situations can be active participants in decisions about themselves, and therefore have a much improved prognosis for emerging, still scathed, but adjusted.

There is no gold standard in care of unaccompanied children. The aim is to provide children with an environment - physical and emotional in which they can continue to develop in their own culture. The outcome should be children or young adults who can fulfill their potential and reintegrate into their extended family, foster family ,further institutional care or wherever. That move away from the centre may be after some months or even years. From experience elsewhere, the ultimate success of care of children who experience psychological trauma of war is how well they participate as adults in society. The philosophy of the centre should be centered round the long-term nature of their responsibility for the child.

Implications for agencies involved in the care of unaccompanied refugee children

Before agencies and their personnel adopt the principles of child-to-child and self-help activities, there needs to be a change of attitude to the care of refugees in general. No longer should refugees be deemed as helpless victims waiting passively for succour, but as individuals who can help themselves if provided with the appropriate support. Within the community of refugees, there are tremendous resources. Mozambican refugees in Malawi established road-side markets selling their own grain and vegetables to Malawians and even to UNHCR who were supposed to be supplying the refugees. Within a few hours of the establishment of a refugee camp, small markets appear, and small boys start selling cigarettes.

Children can be active participants in decision making and have inner resources of their own. Those working with them need to be aware of this and need to have the skills to encourage and communicate with children. Emergency relief teams traditionally consist initially of nurses and doctors experienced in curative care. Communicators, health educators, and primary health care workers have usually come in the subsequent programme. I would argue that the emphasis of team

composition should be altered to provide a better balance between first response workers and those who via help develop broader based care for the children.

Local and expatriate professional workers need training in the principles of child-to-child abilities and communicating with children before they arrive in the centre. This training should be an integral part of the initial orientation that workers receive when employed by an agency or accepted onto the register of available personnel. In a two week course for health emergency staff employed by *Medicin Sans Frontier*'s six hours are allocated to communication skills while in their four day primary departure course, communication skills are allocated five hours. Not all agencies are able to provide this depth of training and orientation. For those personnel who are to work with unaccompanied children a more targeted training is essential. I accept that it will be difficult to provide this training for local staff recruited urgently. I would propose that the following issues be covered in some depth:

- communicating with children at different developmental stages
- emotional responses of children to stress
- stimulating play and other social activities techniques of child friendly health education
- case studies of the use of child-to-child abilities with disadvantaged children

Conclusions

I would hope that the need for centres for unaccompanied children the size of Ndoso would be a rare event. Providing good quality of life on that scale is expensive and difficult. However, when the situation demands, the relief agencies need to be prepared and have the personnel trained in management of these centres. In refugee crises related to war, recent experience suggests that refugees do not return home within weeks. Therefore, the longer term care of the unaccompanied children needs to be considered from the onset.

By using child-to-child activities, the children develop a sense of responsibility for their own care and can participate in decision making. This promotes a general sense of well-being amongst the children and can have a beneficial effect on diarrhoeal disease control and psychological disturbances. The dependency of the children on adults and the dependence of the centre on outside agencies is reduced, enhancing the long-term viability of the centre.

One year after their arrival in Ndoso, 500 children are remaining. They are utterly dependent on the centre for all their needs. Funding is insecure. Although they have survived people who have been involved with them cannot yet claim a successful programme as only time will reveal how well they have adjusted to the traumatic experiences of 1994. If they are permitted an active role in their lives, a range of experiences and stimulation and a quality of life comparable with their pre-war expectations, then their prognosis is good.

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