

**MID-TERM EVALUATION
OF THE
PROVINCE-BASED WAR TRAUMA TEAM PROJECT
*Meeting the Psychosocial Needs of Children in Angola***

**A PROJECT OF THE CHRISTIAN CHILDREN'S FUND
Richmond, Virginia**

by

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	i
Summary of Main Findings	ii
Problems and Recommendations	iii
Workload	iii
Ongoing Evaluation	v
Lack of Basic Materials	vi
Situational Analysis	vi
Living Conditions	vi
Resistance by UNITA	vii
Logistical-Infrastructural Constraints	vii
Project Documentation	viii
LIST OF ACRONYMS AND ABBREVIATIONS	ix
BACKGROUND	1
The Situation of Children in Angola	1
Cultural Background	2
Psychosocial Stresses	3
Program Background	4
PBWTT Goals and Objectives	5
Scope of Work for Mid-Term Evaluation	7
Evaluation Methods	8
PROGRAM DESIGN AND CONSTRAINTS	9
The Priority of Children's Psychosocial Needs in a War-Ravaged, Poverty-Stricken Country	9
The Appropriateness of the Psychosocial Intervention Model	10
CURRICULUM AND TRAINING PROCESS	13
Selection of Sites and Trainees	14
Follow-up	15
PBWTT EVALUATION AND MONITORING	17
STAFFING	21
Selection, Training, and Supervision of Provincial Staff	21
Staff Development of the National Team	23
RESULTS OF PROJECT INTERVENTIONS	25

Training Targets	26
Impact on Adults	27
Impact on Children	30
The War Impact and Exposure	30
Improvements in Children	31
Spread Effects	31
 TRADITIONAL HEALING	 33
Indigenous and Traditional Treatment of Mental Illness in Africa	33
Healing War-Affected Children	34
 POLICY ISSUES	 41
 APPENDIX 1: IMPACT AND EXPOSURE SCALE	 43
APPENDIX 2: SAMPLES OF CHILDREN'S DRAWINGS	44
APPENDIX 3: ORGANIZATIONAL CHART OF CCF/ANGOLA	45

EXECUTIVE SUMMARY

Several decades of war in Angola, including particularly intense fighting in 1993-94, have taken a heavy toll on the country's children, who comprise nearly half the population. In addition to problems of death and injury, hunger, dire poverty, and the dangers of land mines, large numbers of children have been affected psychologically by loss of parents, displacement, community destruction, and violence. Healing these psychological wounds of war on a multiprovince scale is essential if the Angolan peace process is to take root at the community level. Accordingly, USAID has provided \$2.6 million of support for the Province-Based War Trauma Team (PBWTT) of the Christian Children's Fund (CCF) and an additional \$266,877 in support for the related but independent CCF project on the Reintegration of Underage Soldiers (RUS).

The goal of the PBWTT is to reintegrate traumatized children into families and communities through a process of training local trainers, who in turn train adults who work with children to assist war-affected children. Over a three-year period that began September 1, 1995, the PBWTT aims to train 4,000 adults in eight provinces: Benguela, Huambo, Uige, Luanda, Malange, Bié, Huila, and Moxico, with the work in the last two provinces supported by UNICEF. Each province has a training team that works closely with the PBWTT national team, and the province-based and national teams both consist of Angolans.

The week-long training provides basic information about child development, the emotional impact of war on children, methods of assisting war-affected children, and nonviolent conflict resolution. The seminars present information on approaches to healing that emphasize emotional expression in a secure, supportive environment using methods such as drawing, dance, drama, and storytelling. Using participatory methodology that is respectful of local culture and traditions, the seminars also engage trainees in dialogue about their own war experiences, traditional methods of healing used in local communities, and ways of blending Western and traditional methods to provide maximum assistance to children. Following training seminars, the trainers provide periodic follow-up to consolidate learning and discuss how to handle difficult situations.

Although this mid-term evaluation focuses on the PBWTT, it also examines how the RUS has impacted the PBWTT. The mid-term evaluation was conducted by Dr. Edward Green, an anthropologist and consultant to USAID, and Dr. Michael Wessells, a psychologist and consultant to CCF. Both members of the evaluation team were familiar with the PBWTT project, as they had evaluated the Mobile War Trauma Team (MWTT) project, progenitor of the

PBWTT, in October 1995. They conducted the mid-term evaluation over an eight-day period ending April 7, 1997. During the evaluation they talked at length with the leaders of the PBWTT and visited Huambo province, where they interviewed province-based trainers, trainees, heads of schools and preschools, community leaders, and a traditional healer.

Summary of Main Findings

The evaluation provides convincing evidence that there is a set of simple, low-cost, culturally appropriate and community-based interventions that can be taught to adults in positions of childcare who can then help children who have suffered war-related stresses to improve in meaningful, measurable ways.

At its midpoint, the PBWTT is well on the way toward achieving its training targets in a gender-balanced manner. The PBWTT has conducted 72 training seminars for 1,890 adults, half of them women. The trainees, selected through consultation with local influential's, include teachers, community volunteers (parents and community leaders), social workers, church volunteers or "activists," administrators, health workers, and traditional political leaders. In all but one province, the PBWTT has focused project resources effectively by focusing on areas with the highest concentrations of war-affected children, as determined by situation analyses in each province.

The adult trainees stated that the seminars had helped them to deal with their own trauma and war experiences, to understand that child behavior such as social isolation and aggression may be the result of war experiences, and to acquire specific tools and methods for intervening on behalf of children. The trainees noted the following improvements in children, including their own:

- C Improved child-child and child-adult relationships
- C Improved behavior and cooperation in the classroom
- C Less evidence of war-related games and toys
- C Diminished isolation behavior
- C Greater participation among children in institutions
- C Diminished violence between children
- C Less aggressive behavior
- C Fewer problems with concentration
- C Decreased hypervigilance
- C Improved perspective and hope in relation to the future
- C Improved school attendance.

Because the project addresses real needs and gives adults a means of working personally on behalf of peace, the PBWTT has spread rapidly at the grassroots level. In addition, the prestige of the PBWTT skyrocketed through a joint effort with the RUS whereby the province-based teams of the PBWTT work with local *catechistas* (church volunteers) to demobilize and reintegrate underage soldiers, tasks widely regarded as critical for peace in Angola. Indeed,

CCF/Angola has played the lead role among all organizations in the country because it has provided key technical and logistical assistance in the demobilization and reintegration of 40 percent of the underage soldiers who have been demobilized to date.

Problems and Recommendations

Workload

A general and significant problem for CCF/Angola has been the workload that has developed over the past year, especially since the addition of the Reintegration of Underage Soldiers (RUS) Project in mid-1996. Establishing two projects in seven provinces and providing a great deal of training to volunteers at the provincial level has taken a great deal of time. Indeed, CCF has more provincial coverage than any other NGO in Angola. And as documented in quarterly reports, circumstances surrounding the demobilization of underage soldiers have pulled CCF into logistics, family tracing, and other time-consuming activities that had not been anticipated. In view of this and all the constraints of implementing a project in a war-ravaged country with extremely weak infrastructure, it is to the project's credit that it has accomplished as much as it has and in fact is ahead of schedule in achieving ambitious training targets.

Child caregivers in Huambo who had been trained under the project told the evaluation team they wanted more follow-up. It seems that most provinces are behind in this regard. The choice becomes one of quantity versus quality. Is it better to achieve or exceed the numerical training targets set at project start-up or to plan fewer trainings and thus be better able to provide adequate follow-up to trained groups? Stated another way: How thinly should project resources be spread?

Since it is important to demonstrate that CCF's low-cost, low-tech interventions work (see Policy Issues, below), they must be given a chance to live up to their potential. The evaluation team believes that the PBWTT should opt for adequate quality rather than numbers--although it applauds the conscientiousness of PBWTT staff who have committed themselves to achieving--or exceeding--original numerical objectives (established before the RUS project was factored into the workload). It would be unfair to the model being demonstrated through the PBWTT project if lack of follow-up resulted in significantly weaker impact measurements.

PROBLEM: The magnitude of work has been a major factor contributing to the few weaknesses found in project accomplishments to date: being behind schedule in (1) follow-up to training sessions, (2) documenting traditional healing of war-affected children, and (3) carrying out some components of evaluation (quality of data in general, matching communities that receive PBWTT intervention with those that do not, and defining and testing 5 percent of children with the Impact Scale).

RECOMMENDATION: The following steps should be taken to reduce the workload to more manageable and reasonable levels, thereby ensuring better quality of work accomplished and

affording the unique model implemented by PBWTT maximum chance of having measurable impact:

1. Reset the training target for adults. The original target, established when there were five provinces, was 800 adults per province. If the target number per province were maintained, total target for all provinces would be 5,600. The evaluation team suggests retaining the original overall target of 4,000, reducing both the training and follow-up target per province to 571 adults.
2. Reduce by 66 percent the administration and follow-up of children tested with the Impact Scale (see details and justification below).
3. Add an administrator to each province, thereby freeing existing staff to do what they do best and were trained to do (train caregivers and provide follow-up) and to devote more time and effort to evaluation.
4. Add assistance in the area of research and evaluation, especially related to ethnographic documentation of traditional healing as well as baseline and follow-up measures of children who undergo traditional healing. This type of research is quite different from the psychological-measurement research needed in monitoring and evaluation, and it calls for different research skills. The evaluation team discussed this with the PBWTT, and it was decided that a cultural or medical anthropologist should be hired as a part-time consultant (see recommendation under Traditional Healing, below).
5. Redefine direct and indirect beneficiaries, taking into account the amount of regular contact between trainees and children. Currently, direct beneficiaries are defined as the neediest 10 percent of children and all adult trainees. However, in schools and preschools, where there is regular, extensive contact between a teacher and all of the students in the class, it is justifiable to count all of the children in the class as direct beneficiaries. Other direct beneficiaries include the trainees' own children and other children with whom they have extensive, regular contact. Under this suggested redefinition, the children in classes not taught by a trainee would be counted as indirect beneficiaries. This fits with what the team learned in Huambo, where trainees reported that they occasionally arranged activities for the children in other classes and suggested useful activities to other teachers.
6. By June 1, 1997, at least two pairs of matched communities should have been selected in each province, and work on observation and the PBWTT intervention should begin by July 1, 1997. This allows one full year of data collection on these communities within the funded period.

Ongoing Evaluation

Due to the pressures to conduct trainings and assist underage soldiers, the PBWTT project is behind on several aspects of its plan for evaluation and monitoring.

PROBLEM: The PBWTT has not achieved clarity about how to define the 5 percent of the children who form the target group in a setting in which trainings are conducted. For purposes of acquiring meaningful data and making cross-province comparisons, it is vital that all provinces follow the same rule and procedures.

At present, the Kuito province team is measuring the behavior of 5 percent of all children in a community. This conservative approach makes it less likely that an effect of the intervention on behavior will be demonstrated, since only a portion of the children in the 5 percent sample will be direct beneficiaries of the PBWTT intervention. By contrast, the Uige province team is measuring the behavior of 5 percent of the children in schools and preschools where trainings have been conducted. By focusing on children who are likely to have been in direct contact with adults trained by the PBWTT, this approach increases the likelihood that an effect of the PBWTT intervention will be demonstrated.

RECOMMENDATION: All provinces should follow the Uige approach.

PROBLEM: The quality of the data collected thus far is lower than that needed to document the program properly. Some of the data collection has been rather mechanical, and other elements of data collection, notably in the area of traditional healing, have been sketchy and incomplete. Problems of data quality relate to problems of inexperience, excessive workload, and lack of adequate staff training.

The PBWTT national team reports that it took them nearly a full year of training and related work to feel grounded and to acquire the experience with the program needed to collect quality data. It is not surprising that the province-based teams have encountered problems in collecting quality data since they have been running for only one year and are just now achieving the levels of maturity and experience that will allow collection of high quality data. Workload adjustments, however, seem necessary to improve data quality, as the burden of evaluation-related work seems too great.

RECOMMENDATION: At every stage, the national team must reinforce the idea that the collection of quality data is essential for the success of the PBWTT. The evaluation must not be viewed as either an add-on or a matter of secondary importance. To reduce the workload associated with evaluation, the leaders of the PBWTT should increase the use of sampling. Rather than monitoring the behavior of 5 percent of the children in every setting in which the PBWTT works, monitoring should occur in one-third of the settings, based on random selection. To retain balanced representation of types of training settings (e.g., schools, preschools, and communities), of rural and urban settings, and of the types of trainees, sampling should take these groups into account. Recognizing that it is not necessary to collect data on every training seminar, the teams may elect to evaluate only a randomly selected subset of seminars. Other adjustments in the workload associated with evaluation and monitoring may be needed as well, and M. Wessells is available to advise on these.

Lack of Basic Materials

A related issue is the provision of materials to support intervention by trained caregivers. Literally everywhere the team went, it encountered requests for footballs, crayons, pencils, paper, and rope--simple items that are not available. Trainees, community leaders unconnected with the project, and project staff alike agree that provision of a few inexpensive items would go a long way in helping caregivers carry out interventions as intended. Since it is important to demonstrate that CCF's low-cost, low-tech interventions work, they must be given a chance to work as well as they can.

PROBLEM: Lack of simple materials.

RECOMMENDATION: Request funds from CCF/Richmond or another donor to buy such materials and distribute them to achieve maximum impact.

Situational Analysis

There appear to have been some weaknesses in carrying out the situational analyses. One such exercise, identified by the PBWTT itself, resulted in a decision to work in the Benguela provincial capital, where children were not as affected by the war as were children in several areas outside the capital. The drawings of children from war-areas are of fighting, guns, tanks, and planes (see Annex B). Those from Benguela city (the last three in the series) are of boats and basketball games. Benguela city was chosen because of its large number of displaced people and because of comments collected about the effects of war. Fighting in rural Benguela and the killings of local representatives for OXFAM and ADRA discouraged travel to certain areas, which may have hampered data collection during the situational analysis that might have pointed to areas of greater need. In any case, the project has taken steps to relocate interventions where they are more needed.

Living Conditions

The success of the PBWTT project rests largely on the adults whom the project trains. Yet they live under extremely difficult circumstances and must struggle to subsist. Salaries for those employed as teachers, preschool custodians, and social workers are both irregular and inadequate. The highest paid, teachers at a church-supported school, earn only \$25 a month.

Virtually everyone working with PBWTT hopes that volunteering time and effort will eventually lead to some sort of material gain or paid job. Volunteers in rural communities may hope for a tin roof for a school or some other contribution to collective well-being. To the extent that the PBWTT has been able to assist in provision of materials or local construction through its community development initiatives, commitment to the program has no doubt been reinforced

while expectations have been raised as well.

The effort and enthusiasm the PBWTT project has been able to galvanize and direct toward helping children are quite amazing. Major factors have been that children are highly valued and project goals are fully consistent with what Angolans themselves want. PBWTT staff have suggested that providing volunteers with tee-shirts or caps lettered with "CCF" and/or "helping our children" would increase pride, identity, and purpose and reinforce commitment to the project.

RECOMMENDATION: Alleviation of poverty or regularizing salary payment schedules obviously lie well outside the scope of this project. Yet some small steps to reinforce the spirit of volunteerism and identification with a worthy and popular cause would doubtlessly go a long way. The team recommends that CCF or another donor provide tee-shirts or caps, with appropriate identification of CCF or PBWTT, for all PBWTT volunteers.

Resistance by UNITA

UNITA may feel threatened by CCF's promotion of a pacifistic mind set that might question authority, including orders to return to fighting. This can be seen most clearly in the underage soldiers project. UNITA has placed obstacles in the way of communicating with demobilized soldiers, perhaps because it wants to retain control over them in the event that war resumes. UNITA has not responded to PBWTT's requests for permission to enter and work inside UNITA-controlled areas such as Bailundo. Yet some of the areas that have been most heavily affected by war are under UNITA control.

Logistical-Infrastructural Constraints

Angola's long war has led to such disruption to, and destruction of the country's infrastructure that simple tasks are often highly time-consuming. For example, repairing a vehicle or even mailing a letter becomes a daunting task. Due to poor or nonexistent phone and mail service, PBWTT had to develop a system of hand-carried mail before recent establishment of radio communication. Moreover, it has had to deal in cash because there were no banks in the provinces. Recent improvements in infrastructure and project acquisitions (such as radios for communication) have improved the situation, but significant logistical and infrastructural constraints will continue for the foreseeable future.

Project Documentation

More complete reporting is needed to convey qualitative information documenting project achievements to donors and assist the national team in evaluating its work. A similar need was pointed out in the October 1995 MWTT evaluation. At that time, the MWTT staff concurred that CCF quarterly reports should provide more qualitative information about process, content,

and achievements related to important areas such as participatory training, curriculum development, and the community-based approach. Such information was found to some extent in the Portuguese reports but not in the English reports. USAID/Washington still feels, and the evaluation team agrees, that some of the most important project accomplishments are not being conveyed--or are being inadequately conveyed--in quarterly reports. For example, the doubling of the enrollment of a school where several teachers have been trained would be evidence of parents' desire to have their children in a school where teachers are sympathetic and understanding about children's behavioral or emotional problems.

Provincial staff may have little experience in writing and may have even less understanding of what outside donors find important. The national staff must educate the provincial staff in this regard and elicit needed information during bimonthly visits to the provinces. Now that these visits will be for a longer period, there should be adequate time for both activities. It might also be easier for staff to write the quarterly reports in Portuguese and then have them translated into English

LIST OF ACRONYMS AND ABBREVIATIONS

CCF	Christian Children's Fund
MINARS	Ministry of Rehabilitation and Social Rreintegration
MWTT	Mobile War Trauma Team
NGOs	Nongovernmental Organizations
PBWTT	Province-Based War Trauma Team
RUS	Reintegration od Underage Soldiers
UNICEF	United Nations Children's Fund
USAID	United Stataes Agency for International Development

BACKGROUND

The Situation of Children in Angola

For more than two decades following its independence from Portugal, Angola has been at war. Although the war paused briefly in 1991-92, much of the worst fighting erupted following elections in late 1992. It is estimated that more than 100,000 people died from direct shelling or siege-induced starvation and malnutrition in the year following the resumption of armed conflict. At the same time, the number of land mine victims soared to 70,000, estimated by the Economist Intelligence Unit (1995:19) to be the highest number and per capita rate of any nation worldwide. As in many contemporary intra-state wars, the overwhelming majority of casualties are civilians, mostly women and children.

The renewed fighting amplified problems of hunger and poverty throughout Angola and created huge waves of displaced people. According to U.N. estimates, the number of internally displaced people rose from 344,000 in May 1993 to 1.2 million by September 1994. As people sought refuge from the war, the population of Luanda, a city built for 500,000 people, swelled to approximately 3 million people.

Children have borne the most profound impacts of the war. In 1993, some 500,000 children were estimated to have died as a direct result of the war--4,000 a month.¹ Nearly half the 1.2 million displaced people are children under the age of 15 years, and it is estimated that 15,000 children were separated from their families following the renewal of hostilities in November 1992. The fighting amplified economic stress, increasing the problems of family breakdown and hunger and eroding social services. By 1993, UNICEF estimated that nearly 840,000 children were living in "especially difficult circumstances." More recently, UNICEF estimated that 320 out of 1,000 children die before the age of five years and 195 of them die before one year of age. In Luanda, child and infant mortality rates have risen to very high levels, as have the population of street children and the number living in children's homes. Intense strains have been placed on programs for child tracing and family reunification.

¹ Instituto Nacional da Criança (INAC), National Symposium on the Child: Declaração Sobre a Criança Angolana.

Cultural Background

Ethnolinguistic experts have classified the groups in Angola as Central or Southwestern Bantu speakers. The former is a larger group, stretching from the Atlantic to the Indian oceans, occupying an area that lies just to the south of the equatorial rain forest. The economy of the Central Bantu has been based traditionally on swidden horticulture rather than cattle pastoralism, as is typical of groups to the south. Maize, millet, and sorghum are primary crops of the eastern division of the broader group; groundnuts and sweet potatoes are also cultivated. The traditional settlement pattern of the Central Bantu is compact (and formerly stockaded) villages arranged around a central plaza, although groups of the Kwango and eastern Yao cluster live in dispersed homesteads or small hamlets, typical of groups to the south. Each settlement has a hereditary headmen and an advisory council of elders. Age-grades and secret societies are rare. There is a fair degree of social stratification, with most groups distinguishing privileged nobility or royalty from commoners.

With few exceptions, matrilineal descent prevails among the Central Bantu and the resulting descent groups are exogamous, meaning they must marry outside the group. Bride price and polygamy tend to be the rule, and residence is traditionally avunculocal--boys leave their father's home at some age to live with their maternal uncles.

Central Bantu can be subdivided in clusters, a major one being the Kimbundu cluster of west and central Angola. The principal ethnolinguistic groups in Angola are the Kimbundu, Mbundu (or Ovimbundu), kiKongo, Lunda-Kioko, Ganguela, Nhaneca-Humbe, Ambo, Herero, and Xindonga. The word *Ngola* means king in Kimbundu, reminding us in its name that much of Angola was organized into kingdoms at the time of European contact.

Traditional healers can be found in all villages of Angola. The World Health Organization has estimated that 80 percent of sub-Saharan Africans rely on traditional healers; the figure is probably higher in Angola due to poor outreach of government health services, lack of medicines in outlying health units, lack of transportation or money to pay for it, and related factors. Traditional healers in Angola are known to play an important role in treating children suffering psychosocial effects of the war and in assisting reintegration into their families and communities of children who have been displaced or who have served as combatants. However, many Angolans are reluctant to talk openly about traditional healing practices because of the attitudes associated with colonialism, socialism, Western medical education, and Christianity.

Psychosocial Stresses

Angolan children have been impacted severely by stress and trauma associated with their war experience. In 1995, the progenitor of the current project--the Mobile War Trauma Team (MWTT) of the Christian Children's Fund--conducted a study of 200 children from Bié, Huambo, and Luanda provinces. These children did not constitute a random sample, since most had been strongly affected by the war. The results of this "worst case" sample were profoundly disturbing: 27 percent had lost both parents, 94 percent had been exposed to attacks, 66 percent had witnessed mine explosions, 5 percent had been victims of explosions, 36 percent had lived with troops, 33 percent had suffered injuries by shooting or shelling, 65 percent had escaped death, and 7 percent had fired guns. The same study indicated that these war experiences exerted a powerful psychological impact on children, who exhibited trauma symptoms such as fright and insecurity (67 percent), disturbed sleep (61 percent), intrusive images (59 percent), frequent thoughts about war (89 percent), and sensory-motor disturbance (24 percent); moreover, 91 percent of the children in the sample exhibited three or more symptoms of trauma.

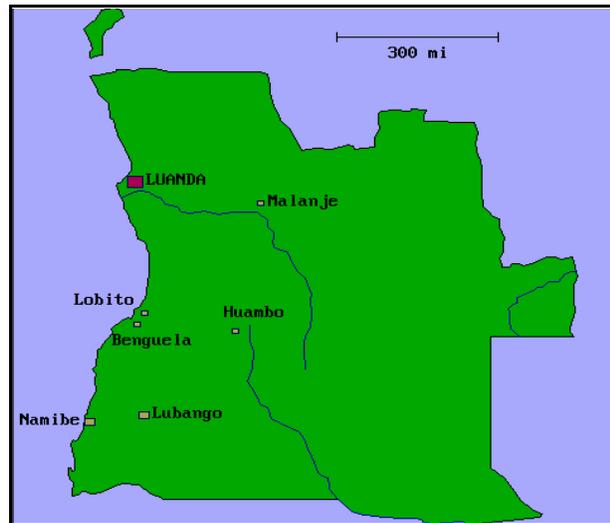


Figure 1: Map of Angola.

Psychological stress on this scale is both a significant source of suffering and a severe impediment to post-conflict reconstruction and violence prevention. The recently completed Graça Machel/UN Study on the Impact of Armed Conflict on Children reported that the main source of child soldiering was children's experiences of victimization in war. In addition, much psychological research has established that children who have been exposed to violence or victimized directly are at risk of future involvement in violence.

Healing children's emotional wounds of war must be a high priority if a civil society is to be reconstructed in Angola. In coordination with the political changes in Angola--notably the Lusaka Protocols, the partial demobilization of underage soldiers, and the impending establishment of the government of national reconciliation--there must be changes in the minds and hearts of people who, because of thirty years of fighting, have never experienced conditions of peace. Constructive changes in people's minds and hearts ought to include healing the wounds of war.

Furthermore, Angola now stands poised, albeit precariously, to build peace and to enter a new phase of its social development as an independent nation. But positive social development will be difficult if children, who comprise half the population, are in poor condition. It is now well

documented that psychological stresses interact with biological stressors such as hunger and disease to damage children's health. In addition, children who experience profound stresses are not positioned to benefit from education, to pursue effective vocational training, or to think critically and act as citizens in a participatory political process. The war-related stresses of children must be addressed if Angola is to break ongoing cycles of violence and poverty and to achieve peace and social reconstruction.

The MWTT initially discussed these results in terms of "trauma." However, the team recognized problems with this construct in the Angolan context. As noted by Straker, Dawes, and others, situations of dire poverty and extended conflict create a multiplicity of continuous, ongoing stresses that do not fit neatly into the conventional category of "trauma." Furthermore, trauma is a predominantly Western concept that does not take into account the spiritual dimensions of stress that are prominent in many African societies.

Significant problems arise also in conjunction with labeling children. To use the term *trauma* is to risk excessive adherence to a medical model and the pathologization of children. In the literature on children and political violence, pictures have sometimes been created of vast numbers of traumatized children, when in fact most research indicates that only a portion of children develop symptoms that meet the diagnostic criteria for "trauma." Even this more moderate view, however, invites the mistaken assessment that children who do not meet the technical criteria for *trauma* are functioning well psychosocially. This is not the case. Children living in situations of chronic war are all affected by violence in one or more of its major aspects: exposure, victimization, or participation. Although the literature has recently swung away from trauma and has emphasized children's resilience, the most reasonable view at present is that all children living in zones of armed conflict are war-affected. The nature and severity of the effects vary according to factors such as the type, frequency, and intensity of war experiences; the child's coping resources for dealing with stress and level of development; and the availability of social supports such as relatively healthy parents or primary care providers. For these reasons, this report honors the terms used by the Angolan team that conducted the research and avoids terms such as *trauma* and *traumatized children* in favor of terms such as *war-related stresses* and *war-affected children*. These terms are congruent with the findings of the recent Graça Machel/UN Study of the Impact of Armed Conflict on Children.

Program Background

The point of origin for the PBWTT was a community-based, culturally grounded project begun by the Christian Children's Fund in 1994. This project--the Mobile War Trauma Team (MWTT)--aimed to address the psychosocial needs of the most severely war-affected children in the capital city of Luanda, which contained large numbers of people who had been displaced by the war, including many unaccompanied children. With funding from ASDI, supplemented by funds from the Bernard van Leer Foundation, an all-Angolan team headed by Carlinda Monteiro

trained 574 adults in Luanda to provide psychosocial assistance to children affected by war. Using a curriculum tailored to the Angolan context and culture and a highly participatory pedagogy, trainings emphasized five elements: child development, the psychosocial impact of war on children, Angolan rituals associated with death, methods of healing trauma (Western and traditional), and conflict resolution. The program collaborated with local communities and with government agencies such as the Ministry of Rehabilitation and Social Reintegration (MINARS) to select for training adults who worked with children and were in a position to have an impact. The trainees included teachers; leaders of communities; staff of children's homes, child-related nongovernmental organizations (NGOs), and programs for unaccompanied children; and government employees. Following the trainings, the MWTT made follow-up visits to provide trainees support and technical assistance.

As documented in the October 1995 report, "Evaluation of the Mobile War Trauma Team" by Edward Green and Michael Wessells, the trainees reported increased awareness of the problems and needs of war-affected children. They also applied a variety of "interventions," such as organized dances, drawing sessions, storytelling, drama and role playing, sports and games, and the establishment of informal schools or preschools. In addition, trainees demonstrated respect for traditional healing methods and receptiveness to the use of both Western and traditional methods of addressing stress. The MWTT reached nearly 15,000 children, who exhibited improved child-child and adult-child relationships; decreased sleeping problems, bed-wetting, stress reactions, and aggressive behavior; diminished concentration problems, psychosomatic illness, and social isolation; and improved future orientation.

The MWTT established an effective method of training, follow-up, and intervention on behalf of children, and it testified to the importance of using an all-national team that respected Angolan traditions and worked in partnership with local communities. Its efficacy suggested the possibility of applying the same kind of culturally appropriate, community-based approach on a wider scale to meet more effectively the needs of war-affected children. The next step was to apply the basic MWTT model in the provinces most affected by the war. The purpose of the PBWTT was to assist children on a nationwide scale, building on the successes and lessons learned from the MWTT.

PBWTT Goals and Objectives

The original proposal dated March 6, 1995, summarized the goals, outcomes, outputs, and inputs to the PBWTT project:

The goal of this program is to reintegrate traumatized children into families and communities in Angola. This includes children who are unaccompanied displaced, former child soldiers, and those who otherwise manifest psycho-social

problems due to war conditions. Reintegration means they will learn to cope successfully with the circumstances of their lives with help from understanding adults.

The outcome is increased capacity of local organizations and adults in six provinces to help children affected by war trauma readjust. Increased capacity includes a better understanding of the psycho-social needs of children and an ability to use a variety of techniques taught by CCF to deal with the stress of exposure to violence and to resolve conflicts peacefully.

The specific objectives included the following:

- C 4,000 adults who work with children will be trained in six provinces during three years and will receive follow-up advice and support.
- C 320,000 children in these provinces will be directly assisted by these trained adults within two years of having received the training.
- C Documentation of specific cases and experiences will be produced and shared.
- C Recommendations for a national policy on unaccompanied children will be formulated with CCF involvement and adopted by the Angolan government.
- C Elements of CCF's training curriculum will be institutionalized as a normal part of social service training programs of the Angolan government.

Initially, the PBWTT aimed to work in Luanda and five provinces--Benguela, Bié, Huambo, Malange, and Uige. A Luanda-based supervisory team of five people would train, support, and monitor province-based teams, each of which would consist of four people who would conduct trainings and provide follow-up assistance and support. Administrative staff were to handle financial management, logistical support, facilitation of evaluations and audits, and submission of quarterly financial and progress reports to donors. This work would be supported by a total budget of US\$ 2.6 million provided by USAID (\$2.0 million), CCF (\$479,000), and other donors such as UNICEF (\$54,000). The project would begin September 1, 1995.

As the project evolved, several modifications were made. First, to focus project resources, a distinction was made between direct and indirect beneficiaries. Of the 320,000 children whom the project will assist, the direct beneficiaries include (1) the 10 percent with the greatest need, as determined by teachers or adult care providers; (2) children with whom the trainees work on a regular basis (as teachers, for example); and (3) the 4,000 adults who will participate in the CCF training seminars. Second, the RUS project made it possible to work in two additional provinces (Huila and Moxico) and to gain access to UNITA-controlled areas, expanding the project's potential impact. To allow the national team to focus its attention on the provinces, the decision

was made not to conduct trainings in Luanda. Accordingly, the PBWTT works in seven provinces: Benguela, Bié, Huambo, Malange, Uíge, Huíla, and Moxico.

Scope of Work for Mid-Term Evaluation

The mid-term evaluation aims to document the current status of the project and to provide information that can be used to improve the PBWTT and maximize its impact in its second half. Documenting the current status is important not only for purposes of accountability and project improvement but also to provide information that will be useful in planning and building support for psychosocial work beyond the life of the PBWTT.

Documenting the current status of the project requires looking at the project as a whole and in the various provinces. From the outset, the PBWTT has recognized the importance of tailoring project implementation to the needs, conditions, and cultural variations in the provinces. These differences can be a source of strength and vitality within the larger project. At mid-term it is useful to see how the province-based teams have adapted their work to local needs and circumstances and to collect information about the implementation and evaluation process at the provincial level. It is of particular importance to review the evaluation process and methodology to make sure that appropriate data will be available for the final evaluation.

The specific objectives of the mid-term evaluation are:

- C To assess the mid-term status of the project and the extent to which its objectives are being achieved and its accomplishments and problems documented.
- C To identify strengths and weaknesses of project implementation.
- C To review and provide suggestions on the project's methods and processes of evaluation.
- C To recommend how CCF might address problems encountered in the implementation, documentation, evaluation, and management of the PBWTT.

To achieve these objectives, it is useful to consider broader questions: Have project resources been focused effectively? At mid-way, is the project well positioned to achieve its second-half goals? How does the work of the PBWTT contribute to the larger projects of civic reconciliation, political and economic reconstruction, and building peace in Angola?

At the request of the PBWTT national team, a decision was made to also address the impact of the underage soldiers program on the work of the PBWTT as well as personnel issues, particularly workload and staff training and development.

Evaluation Methods

The team spent only a week in-country (4/31/97-5/7/97). Since time was needed for reading a quantity of material and meeting with the national staff, there was time to visit only one province. The team could have split up, making it possible to visit two provinces, but it believed it was preferable to make observations and develop questions and conclusions together.

CCF/Angola should be commended for preparing a great deal of information in advance of the team visit. Time was spent initially in Luanda interviewing national staff, reading reports, requesting and compiling missing information, translating into English key statistical reports prepared in advance, and the like. The team spent two full days in Huambo, visiting sites where trained child caregivers work or live. Here the team made direct observations, asked questions, and looked for evidence of PBWTT efforts and activities. The team asked a set of informal questions: What did you learn during the PBWTT seminar? What was the most important area covered and why? What changes or specific activities have you started as a result of the training? Have you noticed changes in the children under your care as a result of the activities (or other results) of the training? What do children under your care hope for the future?

The team spent the weekend compiling information obtained in Luanda and Huambo and drafting the evaluation report and the final half-day reviewing basic findings and recommendations with the national staff and requesting more documentation in certain areas. The draft report was left with CCF/Angola (and a copy sent to Maggie Brown in the United Kingdom). The team will consider suggestions, corrections, and additions from CCF/Angola and revise the report accordingly.

PROGRAM DESIGN AND CONSTRAINTS

This section focuses on two key conceptual issues: why efforts to address children's psychosocial needs in a war-ravaged country are worthwhile, and whether the model of psychosocial intervention is appropriate to Angola.

The Priority of Children's Psychosocial Needs in a War-Ravaged, Poverty-Stricken Country

One issue that appears central to program success in any country is that many typically do not view the plight of war-affected children as a high priority problem. Often, both governments and local communities are more concerned with immediate biological and economic problems: how to provide food, water, shelter, medicine, jobs, and money. Meeting the psychosocial needs of war-affected children represents the agenda of a foreign NGO. The interest of local people in a child welfare program may stem principally from the hope of translating the connection with a foreign NGO and the acquisition of new skills/training into a way to satisfy these "more pressing" problems.

The Angolan staff implementing the PBWTT face a curious situation. On one hand, they have been sensitized to the seriousness of the problem through their training and backgrounds of working with children. Moreover, the PBWTT program lacks the resources to meet basic biological needs. On the other hand, the staff may agree with their fellow citizens that a way to help children is to enable their parents and entire communities to feed themselves.

Following this logic, some NGOs have decided to work to meet basic biological needs first, leaving psychosocial problems to be dealt with later. This compartmentalized approach overlooks the holistic nature of health and human social functioning. It also commits the error of focusing only on crisis intervention without planning adequately for the transition out of an emergency situation into a situation of stable, ongoing development. Psychosocial assistance can provide important leverage in making this transition, as people who carry a heavy burden of war-related stresses are not in a favorable position to engage in healthy patterns of parenting, participate in community reconstruction, or plan effectively for the future.

Ideally, psychosocial interventions are woven into the fabric of a comprehensive, coordinated relief and development strategy. By design, the PBWTT works toward comprehensive intervention from the start by building linkages with complementary organizations and programs. If, for example, the PBWTT enters a local community and learns that there is no nearby water supply or no primary school or traditional community center (*jango*), the PBWTT identifies partners (other NGOs, government agencies, etc.) that can provide the needed resources. Similarly, the CCF/Angola Representative works closely with DHA and takes part in numerous multisectoral forums that encourage partnership and collaboration among groups and agencies meeting different needs.

The Appropriateness of the Psychosocial Intervention Model

The PBWTT intervention is noteworthy for its community-based orientation, its approach of training adult trainers, and its melding of Western and traditional approaches. The community-based approach is necessary in view of the scale of the need and the limited resources available. In Angola, there are far too few professional psychologists to meet the extensive needs of children. As discussed below, it is doubtful whether an individual-centered intervention would be culturally appropriate in Angola.

By taking a community-based approach of training trainers in local communities, the PBWTT creates awareness and local capacity to meet children's psychosocial needs on a large scale. In addition, the mental health of individuals cannot be separated from the well-being of the community. It is meaningless to talk solely about children's mental health in an environment of destruction in which most adults have been so severely affected by war, poverty, displacement, and other stressors that they are unable to provide security and emotional support for children. By training adult trainers, the PBWTT helps adults come to terms with their own war experiences and position's them to assist children. By establishing in each province a cadre of trainers who know the local people and understand their situation, culture, and needs, the PBWTT builds local capacity to address children's needs without the constant intervention of foreign psychologists.

To succeed, any community-based approach must be accepted by the community. Ideally, it will be adopted enthusiastically and rapidly by many people, including respected community leaders, and integrated into the fabric of daily life. The literature on social mobilization indicates that people engage in large-scale social action when there is a highly salient issue at stake and they see concrete actions that they can take to address the issue. The design of the PBWTT combines all these ingredients. In Angola, no issue is more salient than peace, and people are very concerned about their children. Interest in the PBWTT probably builds by virtue of the connections made between children, war, and peace. The attractiveness of the PBWTT also stems in part from the fact that it not only heightens awareness of children's needs associated with war and peace but also offers simple, usable tools for addressing the needs. Moreover,

adults' enthusiasm for the PBWTT builds as they experience personal psychological benefits from participation in the training seminars. Their enthusiasm is reinforced when they see positive results in the children in a relatively short period of time. People are drawn to the PBWTT, and the program takes root and expands quickly.

An important feature of the PBWTT intervention approach is that it encourages the melding of Western and traditional approaches to healing. The PBWTT incorporates many ideas and practices of the MWTT, which benefited from the involvement of Nancy Dubrow of the Taylor Institute in Chicago. The efficacy of Western approaches has been established scientifically in multiple cultures, though not specifically in Angola.

Most Western approaches emphasize that war-affected children should express their emotions in a secure environment in the presence of others who can provide emotional support, interpret the child's behavior correctly, and enable the child to come to terms with his or her war experiences. Emotional expression may occur directly through talking about what happened and how one felt or indirectly through drawing, play, song, dance, storytelling, and drama. Many African cultures have strong traditions of emotional expression, particularly through song, dance, and storytelling. What distinguishes Western approaches, however, is that expression is not only enabled but also interpreted, and the insights gained through observation of the child's behavior inform the construction of additional structured interventions to improve psychosocial well-being. In the dominant Western approach, a child who draws war-related pictures might be asked to draw more frequently and to talk about the picture and his or her experiences during the war.

During the evaluation of the MWTT project, numerous community leaders commented that the training in Western concepts had improved their ability to assist children. For example, several said that before the trainings, they had thought that children engaged in aggressive behavior were simply unruly and needed to be disciplined; they did not recognize the aggressive behavior as an effect of war-related stress. Similarly, numerous adults commented that before the training, they had thought that a child who spent large amounts of time alone had strong needs for solitude. Following the training, however, they recognized that the withdrawn child might be depressed. Local adults also commented that the Western methods, which the PBWTT adapted to the Angolan context, language, and culture were benefiting the children.

Although the PBWTT does not provide training in traditional healing methods, it encourages traditional healing in several ways. First, the trainers at both the national and provincial levels demonstrate respect for traditional healing. Second, the training seminars encourage participants to discuss local burial rituals and methods of healing related to war and death, practice and discussion of which had often been suppressed by a combination of Western colonization (and overvaluation of Western medicine), Christian missionary disdain for "pagan" practices, and Marxist materialist ideology. This resulted in devaluation of spiritual-religious aspects of Angolan culture. One manifestation of this is reluctance among Angolans to admit that they know about or participate in healing ceremonies and traditional medicine. Third, the seminars

encourage participants to explore ways of using a mixture of Western and traditional methods.

As the MWTT had observed, some of the greatest sources of psychosocial stress in Angola are spiritual and may respond better to traditional treatments than to Western interventions. For example, if a boy had served as a soldier and had killed people, he might believe that he was persecuted by the unavenged spirits of those he had killed. This belief, regardless of its validity, is a powerful source of stress that must be addressed. The culturally appropriate, locally developed intervention is for a recognized traditional healer to perform a cleansing ritual to purge the unavenged spirits, thereby reducing the boy's fear and the community's fear that the boy, left untreated, would bring spiritual discord to the village.

A growing body of anecdotal evidence in Angola and Mozambique suggests that such traditional cleansing rituals are effective in reducing stresses associated with soldiering, supporting the view that traditional healing methods should not be rejected out of hand. However, some traditional treatments may on closer study and examination be found to be damaging. Indeed, caution must be exercised in regard to any therapy that has not been carefully documented. This cautionary note applies equally to Western methods, which have not been scientifically validated in the Angolan context.

The design of the PBWTT reflects the dual needs for openmindedness and caution. Equally important, the PBWTT design calls for the documentation of methods of traditional healing that will enable identification of methods that are useful and those that are either less useful or even harmful. In this respect, the program offers the possibility of generating vital information that may be useful in designing effective national interventions in other countries.

CURRICULUM AND TRAINING PROCESS

The PBWTT curriculum resembles closely that used by the MWTT (for details, see "Evaluation of the Mobile War Trauma Team" by E. Green and M. Wessells). The curriculum is noteworthy in several respects. First, it is a highly original synthesis of scientific concepts and traditionally based methods of healing and concepts about social functioning. Second, the curriculum is adapted to the needs and experiences of each group being trained, for example, particular war experiences or stressors. Third, the curriculum presents topics in a logical progression and covers a broad spectrum of topics, including children's psychosocial development, children's reactions to war, methods of healing, and nonviolent conflict resolution.

Typically, seminars included 20 to 25 trainees and were conducted during one full week. The curriculum is based on participatory dialogue and active learning. The topics are introduced through the use of active learning methods such as dialogues, role plays, games, and other experiential methods. These active learning methods are well suited to the Angolan context and to adult audiences with little formal education. The participatory process is also useful in stimulating trainees to think about their own war experiences. By asking trainees, "What was the worst thing that happened to you?" for example, the trainers opened a dialogue among the trainees about their war experiences, thereby beginning the process of healing and reintegration. Perhaps most importantly, the participatory methods invited the trainees to talk about Angolan culture and traditions, encouraging participants to blend Western and traditional ideas and approaches in their own communities.

As the PBWTT entered rural areas, it adjusted its curriculum and training process to fit local circumstances. Initially, trainings consisted of five consecutive daily meetings. This approach, however, made it very difficult for teachers to attend the seminars without compromising their teaching responsibilities; a significant percentage of participants in provinces such as Huambo are teachers. To accommodate participants, the PBWTT is piloting in Malange province a modular curriculum conducted one day a month for five consecutive months. The modular approach allows participants to apply what they have learned in a session in their school settings between training sessions by placing greater emphasis in early training sessions on practical activities that participants can use immediately. A five-month field test that will conclude June 15, 1997, offers the opportunity for increased synthesis of concepts and practice and for group problem-solving with regard to difficulties the trainees encounter in applying the material.

Selection of Sites and Trainees

The provinces selected for inclusion in this project were those known to have been impacted most extensively. Within the provinces selected, the trainings have focused on sites where much fighting had occurred and where the most severely affected children were likely to be located. Site selection was guided by information collected as part of the preliminary situation analyses conducted by the province-based teams. By the admission of the national team, compilation of situation analysis information was uneven and, of course, was based mostly on secondary sources of information. Furthermore, the situation in the provinces is changing as the Lusaka Protocols are implemented, soldiers are demobilized, and progress is made toward the establishment of a government of national unity. For these reasons, the national team intends to conduct a more thorough analysis of the situation of children and their communities in each of the seven provinces, and this more current data will guide site selection.

The PBWTT has also made a key strategic decision to work in schools and preschools. This approach provides access to large numbers of war-affected children and the opportunity to institutionalize the PBWTT approach by building it into teacher training. Consistent with the results of the Graça Machel/UN Study on the Impact of Armed Conflict on Children, this approach recognizes education as a fundamental right of children and attempts to strengthen the educational system in Angola.

The PBWTT has also advanced institutionalization of its work by selecting trainees from local churches, which in many areas are a major focus of efforts to help children. This approach, coupled with the collaboration with churches via the *catechistas* in the work with underage soldiers, is helping the PBWTT build a partnership with churches to advance the psychosocial well-being of children. Churches seem to be the only institutions in Angola that organize people above the level of local communities and ethnic groups and that have a large corps of volunteers willing to work on social and humanitarian issues.

The choice of trainees is guided by a mixture of personal, community, and institutional concerns. The MWTT had learned that it would be too limiting to select trainees according to strict criteria such as level of formal education because levels of formal education in the provinces are often lower than they are in Luanda. Following the effective practice established by the MWTT, the PBWTT uses subjective criteria such as a desire to work with children, good interpersonal skills, patience, and self-control. In addition, as the province-based trainers conduct the situation analysis in an area, they talk with *sobas* (hereditary chiefs) and local community leaders, asking them who is well respected and should be selected for training. Consistent with the multisectoral approach established by the MWTT, the PBWTT has sought prospective trainees from MINARS, schools and preschools, national and international NGOs, churches, and communities.

Follow-up

Follow-up visits of two to three hours each provide the main vehicle for further training and learning. Typically, a member of a province-based team visits each trainee once a month in the first three months following completion of a seminar; follow-up are bimonthly thereafter. During these visits trainees to ask questions and team members reinforce learning, maintain trainees' motivation, learn what worked and what failed, and ensure that the methods and concepts covered in the training are being applied in appropriate ways.

In Malange, trainings were conducted over a period of five months via monthly meetings of one day each. Each meeting gave practical assignments for the trainees to complete in sites where they work with children, and the subsequent meeting allowed feedback and dialogue about this activity, its impact, and how to address any problems that arose. In this manner, follow-up is being fully integrated with training.

PBWTT EVALUATION AND MONITORING

The PBWTT was designed with careful, systematic, comprehensive evaluation in mind. Based on discussions with the PBWTT national team and taking into account the lessons learned by the MWTT, CCF consultant M. Wessells wrote a draft evaluation plan that was given to the PBWTT for comment and revision April 10, 1996 (see draft "Evaluation Plan for the Province-Based War Trauma Team Project of the Christian Children's Fund"). The plan was in the form of a "toolkit" from which the national team was to select, adapt, and refine elements to best meet the needs of the project and the Angolan situation and culture. For purposes of convenience, the PBWTT distinguished between ongoing evaluation, which involves extensive input from the provinces, and evaluation snapshots taken at mid-term and the end of the project to provide a comprehensive, cross-province picture of the results achieved. The plan was to emphasize ongoing evaluation as a means of providing information that could guide adjustments in the intervention. By engaging in ongoing evaluation processes, province-based teams would acquire data collection and analysis skills, bringing into the community patterns of observation and recording that could inform future planning efforts.

By July 1996, the national team had prepared a flowchart showing the flow of work and the stream of ongoing evaluation activities. This flowchart reflected the ideas presented in the draft plan and indicates that the team is setting up a comprehensive evaluation of the kind needed to establish the PBWTT as a model project. Briefly, the plan is to conduct a situation analysis as the first step in the work of the PBWTT in a particular area. The situation analysis includes participatory narratives with local groups about what children do typically during a day, their main needs, the context in which they live, and traditional healing in the area. Data from diverse sources on education, health, agriculture, and related areas is used to analyze children's living environment. The goal of the situation analysis is to identify the neediest groups of children.

If conducted carefully, the situation analyses taken together offer the first relatively comprehensive, multiprovincial picture of the current situation and needs of Angolan children; they should prove very useful to many NGOs in organizing work to assist war-affected children. The situation analyses also provide an excellent opportunity to establish relations with the community, including *sobas*, healers, and other local notables. Through discussion with the PBWTT, the local community participates in the decisions about which adults should be included in the trainings.

Once the areas of greatest need are identified, training sites are selected and seminars are conducted. Numerous records about the seminars are kept at the provincial level, and the data are also transmitted to the national office. For example, records are kept on the participants in the training seminars, on trainees' performance on pre- and post-tests, and on participants' evaluations of the seminars. In addition, the trainers conduct a formal evaluation and complete a seminar report for each seminar. This information is used at the provincial level to make adjustments to the seminars and by the national office to monitor the quality of the trainings, ensure comparability of trainings across provinces, and make necessary adjustments in provincial support, leadership, and activity. The Director of Programs (Carlinda Monteiro) and the Coordinator of the PBWTT Project (Julia Antonio) oversee the evaluation effort. Since they know the project best and are in a position to facilitate adjustments in activities in diverse provinces, this arrangement provides the leadership needed for effective self-evaluation. This approach also distributes the evaluation work across the province-based and national teams, avoiding overburdening teams at either level with excessive evaluation work.

Following the seminars, there are detailed evaluations of the behavior of children, particularly those most strongly affected by war. At intervals indicated on the flowchart, follow-up measurements are made of the motivation, knowledge, feelings and work of adult participants in the seminars

Since a pivotal feature of the project is the blending of Western and traditional methods of healing, there should also be ongoing documentation of traditional methods of healing and of social mobilization and activity stimulated by the trainings. Plans were made to hire a well-respected anthropologist in Luanda, Dr. Henrique Abranches, to train the team in the cultures of Bantu-speaking Africa and in basic methods of ethnographic recording and documentation. Members of the national team will record traditional rituals and consult with Dr. Abranches periodically to ensure the accuracy of their reports. Although this arrangement adds to the work of the national team, it will increase the quality of the data on traditional healing.

A key evaluation issue is whether what appear to be effects of the PBWTT intervention are instead due to other variables, such as the passage of time, community use of traditional healing methods independent of the PBWTT, the presence of observation teams in the community or reactive effects of observation, or improvements in local economic or political conditions. To rule out these factors, the evaluation plan calls for conducting a series of comparisons between local communities in which interventions have taken place and similar communities where there has not been an intervention. The evaluation design is as follows:

	Time 1	Treatment	Time 2
Community A	pre-test	PBWTT intervention	post-test
Community B	pre-test	no intervention	post-test

The logic is that since Community A and Community B differ only with regard to whether they received the PBWTT intervention (training plus follow-up), any advantage of Community A over Community B with regard to improvements in children's psychosocial functioning can be attributed to the PBWTT intervention.

The pre-test and the post-test contain a nucleus of common items and measures (such as the Exposure and Impact Scales), making it possible to use the post-test data for Community B as a temporally relevant baseline against which to measure the effects of a subsequent intervention in that community. Following time 2, Community B receives the PBWTT intervention, followed by a post-test (time 3). If the improvements in children's psychosocial functioning owe primarily to the PBWTT intervention in Community B, then relatively little improvement in children's functioning should occur between time 1 and time 2 and significant improvements should occur between time 2 and time 3.

Hopefully, the independent effects of traditional healing can also be measured separately from PBWTT interventions, since at least some of the children living in urban areas may not participate in healing or purification ceremonies. For this reason, it is important to include an adequate number of urban communities in the sample. It will be important to document which children do not undergo traditional healing in order to isolate this potentially important variable.

Since it is important to know whether the intervention effects endure (as well as how long it takes for them to appear), it is advantageous to conduct a series of post-tests, following the intervention. Accordingly, measures will be taken at several trimonthly intervals following the PBWTT intervention. Ideally, the effects of the intervention will appear in the first post-test and will endure with little diminution over time.

Monitoring of children's behavior is an important component of the evaluation system. Having made extensive adaptations of the initial measurement devices used by Nancy Dubrow and Magne Raundalen, the PBWTT national team has constructed Exposure and Impact Scales that are tailored to the Angolan context (see Annex A). The Exposure Scale measures children's self-reported war experiences, and the Impact Scale provides self-report information on psychological impact, for example, on the occurrence of bad dreams. These scales are part of the pre- and post-tests used in the design outlined above. To monitor improvements in children's psychosocial functioning over time, the PBWTT team should administer the scales every six months to 5 percent of the children who form the target group in the community in which the PBWTT is working. In addition, the plan provides for direct observation of the behavior of 10 percent of the children most affected by war in a setting in which the PBWTT is working.

It is an understatement to say that this is an ambitious plan for monitoring and evaluation. Its scope and the amount of work involved, however, are necessary in view of the importance of having quality data to document the efficacy of the PBWTT as a model that may be applied elsewhere (see Policy Issues, below). To lighten the burden of evaluation work, a decision was

made to have a consultant (Maggie Brown) who is thoroughly familiar with the program perform the statistical analysis of the data.

One change in instruments since the evaluation process began has been modification of Likert scale questions (a five-point response scale ranging from "strongly agree" to "strongly disagree"). Provincial staff reported that trainees could not understand differences between *degrees* of agreement or disagreement. So response categories were simplified to "agree," "do not agree," and "can't say." This seems to be working well.

Staffing

The PBWTT consists of paid staff at the national and provincial levels and hundreds of volunteers (an organizational chart is provided in Annex D). The national team, based in Luanda, consists of seven professional, or technical, staff (five CCF and two UNICEF), four of whom worked under the MWTT project. Part of this staff constitutes the supervision team; these are the national staff minus the Director of Programs and the Program Coordinator. A major change during the past year was to redefine the role of the Regional Advisor as Director of Programs. This was necessary because the Regional Advisor was situated organizationally outside of direct line management yet had management responsibilities.

Selection, Training, and Supervision of Provincial Staff

Each provincial team consists of a Provincial Representative, two staff for PBWTT, and one for underage soldiers. There are also three guards, a driver, and a cleaner. Each province has a CCF office. The original project plan was for the projects to use one room in the local MINARS office, but this arrangement might have produced competition for resources. Moreover, CCF wants to be seen as an NGO, which would be hard to do if the office were in a government building. The offices have functioned well, considering the relatively low level of supervision from Luanda. Provincial Representatives have quickly shown ability to work independently and take responsibility, and other staff have also worked well. There is good morale and a strong sense of mission at CCF/Angola.

The main selection criteria for provincial staff were some training or experience in social or community work, a 12th grade education, familiarity with local issues, and ability to speak the local language. All positions were advertised and announcements posted where they would be seen by the maximum number of prospective candidates. Typically, 50 to 100 people applied for the Provincial Representative slots. The top candidates had oral exams (concerning personal motivations and characteristics) and written exams (about the effects of war on children). Those selected were offered probationary three-month contracts. Those whose performance is up to standard are subsequently given one-year contracts. This careful selection process has led to recruitment of highly motivated staff with the requisite skills and orientation for the demanding work of the PBWTT. Only two provincial staff members have left since the project began. One

of them, a Provincial Representative, was not suited for the work and was persuaded to quit. In addition, the team met a USAID WID (women in development) evaluator en route from Huambo who concluded that the PBWTT project deserved the highest marks for achieving favorable gender balance, both for its staff and for project beneficiaries.

A staff evaluation is currently under way. Objective performance indicators have been made explicit, so all staff know how their performance is being evaluated.

The key person in each of the seven provinces is the Provincial Representative, who represents CCF in the province and serves as lead trainer, coordinator, supervisor, and administrator for both the PBWTT and the RUS project. The expected addition of an administrator in each province (who will function like an executive secretary) should free the Provincial Representative for training and follow-up activities as well as monitoring and evaluation.

Provincial staff were trained in Luanda during a three-week period in March 1996. Training covered administration, finances, logistics, training procedures, and follow-up to training. During this period, provincial staff also were assessed to determine their own exposure to war (see Impact on Adults, below).

Most international NGOs have relied heavily on expatriate staff, especially to establish a large, multiprovincial presence quickly. Yet CCF has shown through the PBWTT and the RUS projects that an all-Angolan staff can be at least as effective as more expensive expatriate staff. The lesson learned from CCF's success seems to be that for community-based projects that seek to inspire volunteerism and build on indigenous strengths and healing systems, a national, culturally competent staff is a necessary requirement for project success. Respect for the indigenous culture and tradition is another critical element.

Each technical staff member on the Supervisory Team has ongoing responsibility for a particular province. That person along with the Director of Programs has been visiting each province once a month for a two- to three-day stay to supervise, provide ongoing training, solve problems, and so on. It has been decided that these supervisory activities can be better carried out if visits are scheduled once every eight weeks and the teams stay longer. In addition, supervisors will swap provincial assignments to stimulate an exchange of experience and cross-fertilization of ideas.

A meeting of all national and senior provincial staff is held in Luanda every three months. This provides an opportunity for continuing education in financial and general management. Regarding the former, there have been no reliable banks in most provinces until recently. The project has had to send cash to the provinces, and provincial teams had to keep simple records of money received and spent. This system is currently being upgraded. CCF Angola, with the agreement of Richmond, has introduced new accounting software especially adapted for NGO needs. The program director and two program managers (of PBWTT and RUS) have been trained to read and analyze financial reports and budget balances in order that decisions about the

deployment of funds are as closely linked as possible to programmatic needs. Program budgets have been subdivided and distributed to each province, and provincial representatives receive reports on their own expenditure and budget balance to facilitate local management.

Although PBWTT has not overspent its budget, USAID has suggested that PBWTT resubmit its budget to reflect new developments and needs, for example, personnel for the two additional provinces, replacement of a stolen vehicle, and photocopier, and seed money for community projects. Community projects are important because they stimulate (and reward) volunteerism and community participation, encourage initiative, and provide material support, all of which go a long way toward helping PBWTT interventions realize their full potential.

PBWTT conducted a systems audit this year that covered conditions of service and tried to resolve new tax and social security and health insurance issues and establish grievance procedures for personnel.

PROBLEM: It should be noted that Luanda is the most expensive city in the world, according to a survey conducted by U.S. foreign service missions. Salaries need to be increased just to keep up with inflation and rising costs. PBWTT's approach has been to first raise salaries of the lowest paid staff, guards, and cleaners. There have been no recent raises for national staff, nor are they anticipated, creating the risk that other NGOs or international organizations will try to lure CCF's experienced, well-trained and -motivated staff with offers of higher salaries.

RECOMMENDATION: Salaries should be raised during 1997, at least to levels that offset inflation.

Staff Development of the National Team

The following training and development activities were conducted for CCF national staff:

- C Three seminars on supervision, trauma/stress in children, and techniques of group intervention, in collaboration with Medico International.
- C A seminar on anthropology, Bantu culture, and qualitative research methods, conducted by an Angolan anthropologist.
- C A seminar on financial management.
- C A course on Microsoft Access in order to establish a computer database on all incoming data on direct project beneficiaries and related information.
- C A course on organizing and archiving project documents (attended by one staff member).

- C Participation (by three staff members) in a congress on children and war in Mozambique sponsored by a new Mozambican organization that follows and promotes the medical, institutional model of intervention. PBWTT's presentation of the alternative, community-based model was well received and may have influenced the sponsoring organization to consider different ways of helping war-affected children.

RESULTS OF PROJECT INTERVENTIONS

Before consideration of training targets and beneficiaries, the team's main finding should be emphasized:

The mid-term evaluation provides convincing evidence that there is a set of simple, low-cost, culturally appropriate and community-based interventions that can be taught to adults in positions of childcare to help children who have suffered war-related stresses improve in ways that are meaningful and measurable.

The adults who are trained need not have had any formal education, and they can participate as volunteers rather than paid workers. However, the impact might be even greater if caregivers were paid workers.

The evaluation team was impressed with the enthusiasm and speed with which project interventions and orientations have been adopted by Angolans in a variety of settings. It appears that these interventions meet high-priority needs of most Angolans (assisting children in need and taking steps toward peace and reconciliation) and provide caregivers a sense of personal effectiveness in a society where people have long felt impotent while they have been buffeted about by powerful, uncontrollable forces of destruction. Moreover, the interventions are intuitively reasonable and do not involve complex technology or foreign ways of thinking or behaving.

The interventions consist of children's storytelling, drama and role playing, sports and games, organized dances, and drawing sessions and the establishment or rehabilitation of schools or preschools. These largely familiar interventions are seen by caregivers in a short time to have a visible, positive effect on children under their care. Such immediately visible benefits seem to reinforce interest in project participation and lead child caregivers to adopt new behaviors themselves.

A surprising number of informants in Huambo volunteered that the new ways of thinking and behaving taught in PBWTT seminars had helped them personally as well as their children and families. Participants reported that following the seminar, they were not so quick to beat a child for misbehavior; instead, they would take time to understand the child's behavior and then talk with the child. This new way of acting often resulted in a demonstrably better parent-child

relationship, plus a feeling that a mere individual could contribute to prevention of war in country that has become sick of it. These factors together seem to explain why hundreds of impoverished Angolans who are struggling to survive are willing to volunteer their time to the PBWTT project.

Training Targets

In spite of the problems and constraints already reviewed, the training targets set at project start-up appear to be on track. The project objective was to train 4,000 adults who work with children in six provinces during the life of the project.

It is noteworthy that the selection process attempted to respect local rules and hierarchies in communities, schools, preschools, and other settings. Some trainees were nominated by local leaders but all were volunteers. Some were literate, others were not. Motivation and other personal qualities were found to be more important than formal education to success in dealing with child psychosocial issues.

TABLE 1: EDUCATIONAL BACKGROUND OF TRAINEES	
No formal education	11%
4th to 8th class	64%
9th to 12th class	22%
post-high school education	3%

As of March 1997, 1,890 adults had been trained in 72 seminars. Although some 4 percent of data have yet to be compiled from some provinces, 42 percent of trainees were teachers, followed by community volunteers (parents and community leaders), social workers, church volunteers or "activists," administrators (e.g., of preschools), health workers, and traditional political leaders. The organizations or settings with which trainees were affiliated can be classified in descending order of frequency as education, local communities, churches, MINARS, national NGOs, and international NGOs. Finally, the trainees tended to be young, with 67 percent under age 35; balanced by gender (50.4 percent female, 49.6 percent male); and of relatively low levels of formal education, as shown in Table 1.

TABLE 2: PBWTT TRAINEES, BY PROVINCE AND OCCUPATION

	Teacher Worker	Social Worker	Health Worker	Admin. Leader	Trad.	Relig.	Misc.	
Huambo n=339	95	44	4	21	6	0	169	
Bengl. n=218	107	61	0	0	0	92	218	
Bié n=345	137	55	0	3	4	92	54	
Malanje n=175	82	90	0	0	0	0	3	
Uige n=252	43	25	8	0	6	17	153	
Huila n=295	212	23	20	9	14	0	17	
Moxico n=232	112	39	9	14	0	0	58	
TOTAL n=1,856	788	337	41	47	30	128	485	

As shown in Table 2, the greatest number of adults were trained in Bié and Huambo. In addition, 41 adults were trained in two seminars in Luanda before training was discontinued to focus maximum resources on provinces.

Impact on Adults

The Exposure and Impact Scales were administered to approximately 10 percent of adults at the time of initial training. The following tables are based on a random sample of 70 adults, 10 per province. The sample is 50 percent male and 50 percent female and ranges in age from 19 to 63.

TABLE 3: FIRST-HAND EXPERIENCES OF A SAMPLE OF ADULTS

Experience	Number Reporting:		
	Yes	No	No Answer
Attacks, crossfire	63	7	-
Mine explosion	44	24	2
Aerial bombing	43	24	3
Artillery bombing	58	11	1
Crossed the lines to gather food	40	25	5
Fire	37	31	2
Long marching	51	19	-
Saw dead persons	68	2	-
Saw wounded persons	68	2	-
Saw people being killed	45	23	2
Was kidnaped	12	58	-
Was in prison	13	56	1
Was tortured	23	47	-
Stepped on mine	9	60	1
Saw people tortured	47	23	-
Was wounded	15	55	-
Saw women being raped	32	37	1
Barely escaped death	51	19	-

TABLE 4: WAR-RELATED DEPRIVATION REPORTED BY A SAMPLE OF ADULTS

Deprivation	Number Reporting:		
	Yes	No	No Answer
Lost all belongings	67	3	-
Suffered starvation	53	17	-
Was separated from family	52	18	-
Was displaced	37	31	2
Became sick	41	29	-
Suffered a physical handicap	18	52	-
Participated in combat	23	47	-
Served in the army	17	53	3

TABLE 5: WORST WARTIME EXPERIENCE REPORTED BY A SAMPLE OF

ADULTS

Experience	Number Reporting	Percentage Reporting
Suffered starvation	1	26
Lost all belongings	11	16
Had to quit studies	2	3
Separated from family	3	4
Had to escape during the night	1	1
Endured shelling	1	1
Family members died	21	30
War itself	2	3
Suffering (unspecified)	2	3
South African invasion in 1985	2	3
Was chased/hunted	1	1
Barely escaped death	1	1
Saw people dying of hunger	2	3
Hid in the forest	1	1
Saw people being burned	1	1
Saw people dying	2	3
Long marching	1	1
Searched for food in the Garbage	1	1
Aerial and artillery bombing	1	1
Had to move constantly	1	1

The adults surveyed also suffered a significant decline in socioeconomic status due to the war, as the self-assessment in Table 6 shows.

TABLE 6: SELF-ASSESSMENT OF SOCIOECONOMIC STATUS BY A SAMPLE OF

ADULTS

Status	<u>Number Who Reported the Status:</u>	
	Before the War	After the War
Very good	34	0
Good	36	1
Average	26	29
Poor	1	67
No answer	3	3

According to the impact scale developed by Teresa McIntyre and Margarida Ventura, 44 out of 70 adults(62.9 percent) exhibited PTSD. Seven were in Uige, eight in Malanje, three in Benguela, eight in Bie, seven in Huila, five in Moxico, and six in Huambo.

Impact on Children

According to project statistics, and using the initial counting rules described earlier, the child direct beneficiaries number 7,042. This figure underestimates by a considerable margin the actual number of children who have benefited directly thus far. The PBWTT team is now preparing adjusted estimates using the new counting rule and the revised definitions of direct and indirect beneficiaries.

As the next two graphics show, there was considerable variation by province in children reached, ranging from 27.2 percent of the children found in Bie to 5.4 percent of the children found in Uige. Most children were in kindergartens ("pics") and schools, followed by those in local communities.

The War Impact and Exposure

Scales were administered to a random sample of 100 children. As the tables and graphics show, 99 percent were present in a war area, 88 percent experienced artillery bombing, 86 percent saw wounded and dead people, 85 percent suffered starvation, and 71 percent lost all their belongings. These experiences resulted in various reactions associated with PTSD: 69 percent experienced rapid heartbeat, 66 percent had disturbed dreams, 54 percent had fears that something bad was about to happen, 51 percent had relived bad experiences, and 49 percent had difficulty concentrating etc. Most (26 percent) said hunger was the worst thing that happened during the war, followed by death of parents and relatives; bombing, assaults, accidents, and fire; and living as a displaced person.

Improvements in Children

According to the informal interviews the team conducted with child caregivers in Huambo,

children show positive changes a short time after trained adults begin to implement some of the interventions. Specifically, caregivers reported:

- C Improved child-child and child-adult relationships
- C Improved behavior and cooperation in the classroom
- C Less evidence of war-related games or toys
- C Diminished isolation behavior
- C Greater participation among children in institutions
- C Diminished violence between children
- C Less aggressive behavior
- C Reduction in concentration problems
- C Decreased hypervigilance
- C Greater certainty and hope for the future
- C Improved school attendance

Since most mid-term evaluation interviews were conducted with adults in schools and preschools, the team could not get direct information on bedwetting or other indicators requiring observation in the home. However, direct observation of children's behavior is part of the ongoing process of evaluation and monitoring, and these data will be available for the final evaluation.

A number of teachers and preschool workers commented that they now know what signs to look for in children who are suffering effects of war and how to take appropriate steps to help them.

Spread Effects

Based on two days of interviews in Huambo, the team noted the following "spread effects" of PBWTT interventions:

- C Trainees often reported sharing what they had learned in the PBWTT seminar with colleagues, friends, and neighbors.
- C Teachers have had meetings with parents, especially with caretakers of orphans, to teach them to be sensitive to childrens' needs and help the children in their care. This may occur informally or during formal, scheduled meetings between parents and teachers.
- C Child caregivers in institutions reported improved relationships in their own homes as a result of PBWTT training. One teacher at Collégio de ORA in Humabo commented, "I

have stopped spanking my own children for routine discipline problems. I now tend to talk things through. I realize that I myself was affected by the war, that it made me quick to resort to use of force. I recognized the symptoms we learned about in myself, like jumping at noises."

- C Enrollment at one school increased from 700 to 1,300 between September 1996, when PBWTT training occurred, and late March 1997. School authorities believe this was due largely to the improved reputation of the school as a place where children are treated better, are not beaten, and are not sent home for rule infractions. The PBWTT Provincial Representative agrees with this interpretation.
- C "Moral development" of children has been added to the curriculum of one church school the team visited.

Some of these apparent spread effects are sufficiently important--and of sufficiently large magnitude--to warrant some quick, highly focused research to clearly establish a causal connection. For example, a random sample of parents of children who were transferred to the school of 1,300 enrollment could be interviewed and asked (1) why they transferred their children; and (2) what changes, if any, they have noticed in their children since they have been in the new school environment.

TRADITIONAL HEALING

Before consideration of indigenous treatment for war-affected children in Angola, it might be useful to review general patterns of therapy for mental illness in southern and central Africa.

Indigenous and Traditional Treatment of Mental Illness in Africa

Throughout Africa, mental illness is one of the conditions for which modern medical help is least likely to be sought². Rituals, typically public, are a *sine qua non* of treatment for mental disorders. They may involve propitiation of ancestors or spirits, sacrifice, special costumes, self-flagellation, public removal of substances from the patient's head or body (perhaps involving magical acts on the part of the healer), or purifying the patient with water, blood, or magical medicines. Trance states may be achieved by patient, healer, or both through dancing or swaying to drum beats. There is often symbolism that the patient's family or community is willing to share the sufferings of the patient and accept and reincorporate him into the group.

Observers from the modern health sector tend to agree that traditional healers are especially effective in treating neurotic and borderline disorders, acute transient psychoses, and the secondary or compensatory syndromes associated with schizophrenia. They are probably particularly adept at handling behavioral disorders, untreatable psychosomatic conditions, marital problems, and other psychosocial problems such as those resulting from uprooting and rapid social change. It would then seem that PTSD-type problems should be amenable to African therapies. As G. Foster, a noted medical anthropologist, has observed, "Since patient expectation is an important element in therapy, it seems reasonable to expect that in the absence of organic dysfunction, mental stress and illness can be alleviated by (traditional) curers...."

Healing War-Affected Children

² This summary is condensed from Edward C. Green, "Roles for African Traditional Healers in Mental Health Care," Medical Anthropology, 4(1980): 489-522.

During the MWTT project, it was found that indigenous therapy for ex-combatants or children who have participated in or witnessed bloodshed is provided in and by local communities, in the form of ritual purification ceremonies and related practices. The Children and War project in Mozambique found similar treatments for children.³ Traditional healing for war-traumatized children in both countries seems to consist principally of a "purification" or "cleansing" ceremony, attended by family members and the broader community, during which a child is purged and purified of the "contamination" of war and death, as well as of sin, guilt, and avenging spirits of those killed by a child soldier. These ceremonies are full of ritual and symbolism whose details are distinctive to the particular ethnolinguistic group. However, the general themes mentioned seem common to all groups.

Manifest symptoms associated with PTSD reportedly disappear shortly after these ceremonies, after which indigenous leaders direct attention toward helping to establish an enduring, trusting relationship between the traumatized child and adults of good character and with family members. The need for help in re-establishing normal relationships and activities with other children may not be part--or a major part--of traditional healing. Nonetheless, healers, village elders, teachers, and other child caregivers in both Angola and Mozambique readily understand this concept when it is presented during training seminars.

In Angola at least, ceremonies involving child soldiers have the appearance of what anthropologists call rites of transition. That is, the child undergoes a symbolic change of status from a person who has existed in a realm of sanctioned norm-violation or norm-suspension (killing, war) to one who must now live in a realm of peaceful behavioral and social norms and conform to these. Until the transition is complete, the child is considered in a dangerous state--a marginal, ambiguous state. For this reason, a child is not allowed to return to his family or hut, sleep in his bed, or perhaps even enter his village until the rituals have been completed.

According to interviews by the team with dislocated KiKongo healers and elders in October 1995, the child may be asked about war experiences as part of treatment but is not forced to talk about them. Following the ceremony, the child is symbolically cleansed to put the experience behind him, to help him "forget" (note the symbolism of being forbidden to look back, in the example from Uige, below). A food taboo of fish and fowl must be followed by the cleansed person for one to two months. The traditional healer who officiated at the purification ceremony reintroduces the child to the food.

³ E.C. Green, Jan Williamson, and Paula Nimpuno-Parente, Evaluation of the Children and War Program, Washington, D.C.: Academy for Educational Development/PRITECH evaluation, July 1992. See also the anthropological studies of psychological and social reactions to war in Mozambique by A. Honwana and J. Marrato.

The same basic elements are found in traditional healing rituals and procedures for war-affected children in Mozambique. These are described by Dawes and Honwana as rituals of purification. They may involve the burning of the hut, clothes, and any possessions of the child associated with his former role as a combatant. After describing one such ceremony for a boy named Paulo, Dawes and Honwana comment:

The healing rituals performed for Paulo bring together a series of symbolic meanings aimed at cutting his links with the past, and at cleansing and reintegrating him into the community. While modern psychotherapeutic practices emphasize verbal exteriorization of the affliction, here the past is locked away. This is seen in the burning of the hut and the clothes and the cleansing of the body. To talk and recall the past is not necessarily seen as a prelude to healing or diminishing pain. Indeed, it is believed in this community to create the space for the malevolent forces to intervene.

The cleansing process and the practice of closing the way to malevolent spirits, is associated with the notion of social pollution. Individuals are believed to be potentially exposed to pollution in their contacts with other social groups and environments...Social pollution may also arise from being in contact with death and bloodshed.⁴

The close similarity in the child healing practices in Angola and those in Mozambique suggests that war-affected children are treated in much the same way in south-central Africa, at least among Bantu speakers. This further suggests that any ethnographic observations or attempts to measure the impact of such traditional healing would have *regional* implications.

In its evaluation of the MWTT Project, and in the Evaluation Plan of the PBWTT Project, the team recommended that the project compile systematic ethnographic documentation of traditional healing for war-affected children. It was also suggested that case studies be made of particular children who had undergone traditional healing, using direct observation and measurement of progress at regular time periods. It was recommended that CCF staff receive training in ethnographic research methods and/or rely on the assistance of an Angolan or Mozambican anthropologist.

There were several reasons for these recommendations.

First, when and if a child improves over time, we cannot know how much of the improvement is

⁴ A. Dawes and A. Honwana, "Children, Culture and Mental Health: Interventions in Conditions of War." *Rebuilding Hope: Congress on Children, War and Persecution*. Maputo, Mozambique, December 1996, pp. 8-90.

due to project interventions and how much to traditional healing. As it is, those who control or influence the allocation of development (relief, rehabilitation) funds may argue that a child will improve over time simply by removing him from a violent environment. With the availability in Angola of apparently effective traditional healing for war-affected children, the argument may be strengthened that psychosocial projects for children are not needed.

Second, as a community-based project that tries to build on existing practices and strengths, PBWTT takes the position of encouraging traditional healing and believing that its psychosocial interventions complement it. This position is less tenable if information about traditional healing remains anecdotal.

Finally, the more that is objectively known about traditional healing, the more effective the complementarity between it and PBWTT's efforts can become, thereby maximizing PBWTT's impact. This might mean some modification of PBWTT's approach or emphasis or development of a closer working relationship between PBWTT and those involved in traditional healing.

Although there was some training of national staff in Bantu cultural patterns and qualitative research methodology, progress in learning about and documenting traditional healing has been limited. Reasons given are that it has taken a great deal of time and effort to establish the project in seven provinces and the RUS project has taken time away from the PBWTT project. Progress in evaluation and monitoring is also behind schedule, but perhaps more so in traditional healing. The national staff believe that provincial staff may feel inhibited about investigating an area that has been discouraged or at least devalued by colonialism, socialism, Western medical education, and Christianity. Moreover, direct investigation requires knowing in advance when ceremonies will take place and then traveling to villages or peri-urban areas. It was hoped that national and/or provincial staff would make direct observations. However, adults trained by PBWTT in the provinces are more likely to live in areas where ceremonies take place, and PBWTT staff has asked them to document these.

The following are two of the better examples of observations recorded by project trainees.

(Huila Province) Two ethnic groups in Southern Angola, the Ovimbundo and the Vakakonda, do not allow child soldiers returning from the fighting forces or quartering areas to rejoin their villages until they have undertaken a ceremony entitled "Okupiolissa."

The community and family members are usually excited and pleased at the homecoming. Women prepare themselves for a greeting ceremony: they dress in raffia skirts, bead their hair, paint their foreheads with flour, and make belts of empty gourds with seeds inside. Some of the flour used to paint the women's foreheads is thrown at the child, and a respected older woman of the village throws a gourd filled with ashes at the child's feet. At the same time, clean water is thrown over him as a means of purification.

While the purification rituals are taking place, the women of the village dance around the child, gesturing with hands and arms to ward away undesirable spirits or influences, sending them behind and away from him. Afterwards they each touch him with both hands from head to foot to cleanse him of impurities. The dance is known as "Ululando-wé-wé-wé".

When the ritual is complete, the child is taken to his village, where villagers celebrate his return. A party is held in his home, where only traditional beverages ("Tchimbombo," "Macau," and "Canhome") are served, principally to the village chiefs. The child must be formally presented to the chiefs by his parents.

During the party, the child sits beside the chiefs, drinking and talking to them, and this act marks his changed status in the village. The chiefs tell the child stories of his family's history, explain the roles and functions of different members of the community, and inform him of behavioral norms. In the course of the explanation, they also cover details of the relationships between the young people of the village and any marriage commitments. The older women mock him for not yet having a wife and vie with each other to offer him a fiancée.

During the celebration, the younger children of the village respectfully step back for the young man to pass and offer to assist or serve him in any way possible.

Later, the village elders make plans with the young man about his future. They discuss whether he wants to stay in that village, what he would like to do in terms of work, if he would prefer to remain living with his parents or would rather build his own home, and whether the elders should allocate him some land to cultivate.

Following these rituals, the young man has earned the right to visit sites of historical significance in the village, together with friends.

(Uige Province) When the child or young man returns home, he is made to wait on the outskirts of the village. The oldest woman from the village throws maize flour at the boy and anoints his entire body with a chicken. He is only able to enter the village after this ritual is complete.

After the ritual, he is allowed to greet his family in the village. Once the greeting is over, he must kill a chicken, which is cooked and served to the family. For the first eight days after the homecoming, he must sleep on a rush mat on the floor. During this time, he is taken to the river, where water is poured on his head and he is given manioc to eat. As he leaves the site of the ritual, he must not look behind him.

A second type of ceremony conducted in Uige Province is known as "Kutumbula." The child is taken to the river before sunrise, along with his closest family members and three witnesses from the village. Three branches of a Mululua tree are dampened in the river and passed across the child's head three times, after which the child is bathed in the water. The branches are left to float away on the current, while the child returns to the village.⁵

These examples of observations notwithstanding, the PBWTT has not yet documented traditional healing for war-affected children to the extent needed. It appears that no paid staff of PBWTT have observed these practices (although some provincial staff may have witnessed these in their own families and communities, before or apart from their work with PBWTT).

PROBLEM: The PBWTT project is significantly behind schedule in documenting traditional healing practices for war-affected children through ethnographic observation and case studies accompanied by measurement at regular time intervals.

RECOMMENDATION

1. Since special expertise is needed for this work, the team recommends that the PBWTT team enlist outside assistance. After discussion between the evaluation and PBWTT teams, it was decided that a cultural or medical anthropologist should be hired as a part-time consultant. He/she should be (1) experienced with children and war psychosocial issues (the Angolan anthropologist who has provided some training during the past year lacks this); (2) expert in Bantu languages and cultures; (3) Portuguese- speaking; and (4) preferably from southern Africa. A candidate with all these qualifications was decided upon and she will be contacted by the end of April.
2. A guide has been prepared to assist the process of ethnographic information gathering. [Nb Ted will discuss with USAID whether this is still needed, since if an anthropologist such as Alcinda Honwana is hired, she would develop her own guidelines and instruments.
3. Since this activity has been sidelined while PBWTT staff at all levels focused on activities that seemed more central to project goals, a time schedule with appropriate benchmarks is also being provided.

⁵ Written by CCF Provincial Teams and translated by Maggie Brown, Representative.

POLICY ISSUES

The interminable, bloody conflict in Angola has ravaged the economy and ruined social and health services, among other consequences. At the start of the project, the plight of traumatized children was not viewed as a high-priority problem by either government or local communities. For both, there are the more immediate problems of food, water, shelter, medicines, jobs, money, security. However, the goals of the PBWTT and the simplicity of the interventions have proven easy to explain and promote at the local level. CCF/Angola has made strategic institutional links with MINARS, UNICEF, Save the Children, and other influential organizations. It has spent considerable time giving interviews to the press so that PBWTT and the underage soldiers project have become better known nationally and internationally. There has been less time for awareness-raising and information dissemination through international conferences and publications, although there are concrete plans to remedy this.

It seems that two approaches to war-traumatized children have developed in both Angola and Mozambique. One is institution-based, chemotherapeutic, relatively high cost, and relies on Western individualized psychotherapy. The other is community-based, "low-tech," and low cost and consists of simple, sustainable interventions. The first either has no knowledge or opinion of indigenous healing for war-affected children, while the second recognizes that such healing is widespread and beneficial to children. The "low-tech" approach seeks to complement what people are already doing for themselves by creating a safe, stable living environment for children and helping them cultivate stable relationships with other children through organized activities and exposing them to good adult role models.

USAID has favored the second approach, followed by both the Children and War project in Mozambique and the PBWTT in Angola (the C&W project is now funded by the Bernard van Leer Foundation). This approach merits being characterized as culturally appropriate, while the first approach is modern-Western in orientation and relies on imported technology. Judging by the experience of PBWTT and its predecessor project, as well as the Children and War project, the interventions of the second approach appear sustainable because they are simple, low-cost, easily taught and learned, quickly adopted, easily disseminated beyond those directly trained, meet felt needs, and relate to a core cultural value (care of children) and therefore are well supported.

CCF as well as the evaluation team believe that the first approach is unsuitable in Angola because (1) institutional therapy is not affordable where large numbers of children have been war-traumatized; (2) Western psychotropic drugs are expensive and would have to be dispensed by providers with inadequate training; moreover ongoing, accompanying psychotherapy would

not be feasible; (3) Western psychotherapeutic treatments of PTSD or related syndromes have not been properly validated in African settings; and (4) the approach is not sustainable.

The first approach, however, may have appeal to donors and to medical authorities (e.g., ministries of health) because the interventions are familiar in the West and to the Western-educated in Africa. To Africans supporting this approach, assistance amounts to increases in institutions (hospitals, orphanages), high-level training, and provision of the latest drugs. Understandably, this is appealing. Those supporting this approach may not believe that the "low-tech" approach works, and they may be unsympathetic to approaches that they regard as unprofessional. To the extent that community-based approaches are associated with traditional healing, they may be criticized for condoning or encouraging superstitious practices. As mentioned, Western education, Christian missionary influence, imported political systems (i.e., Marxism) and other forces have all combined to devalue traditional healing, whether or not intentionally.

There is evidence in both Angola and Mozambique of competition for donor funds to address the psychosocial problems of war-affected children. It is therefore of great importance to the future of such programs that the impact of the community-based approach of CCF be demonstrated through objective measurement. It is also important that what Angolans were already doing for themselves and continue to do--namely, traditional healing of war-affected children through purification ceremonies and the like--be documented and the effects measured. Without evidence related to both interrelated approaches, donor funds could be attracted to institutional approaches in the future.

APPENDIX 2

APPENDIX 3
