

Psychosocial Issues in the Demobilization and Reintegration of Ex-Combatants

Introduction

This note is based on the proceedings of an MDRP Technical Coordination Group (TCG) meeting on the psychological effects of conflict on ex-combatants, which took place in Kigali, Rwanda, on June 28 – 30, 2007. Representatives from seven MDRP countries participated in the meeting, which brought together international and national experts and program implementers dealing with the important issue of psychosocial support.

The TCG followed a national conference in Rwanda that looked at the impact of psychological trauma among various vulnerable categories of persons including ex-combatants. The Rwanda conference resulted in a draft national strategy and actions to be undertaken by the Rwanda Demobilization and Reintegration Commission (RDRC).

When ex-combatants return to their communities of origin, they often discover that their prolonged absence and suspected anti-social acts have given birth to a sense of mistrust within the community towards them, even leading to rejection in some contexts. Confronted by difficulties in reintegrating in their communities,

some ex-combatants require psychosocial assistance.

In most cases, the local capacity needed to deal with psychosocial concerns of the community and of the ex-combatants is inadequate. At times, there is also a lack of coordination among service providers. The difficulties that ex-combatants face in their reintegration also affect the local communities - poverty, lack of information and ignorance about the resources available to address psychosocial concerns.

It is clear that the creation of psychosocial assistance capacities or their reinforcement, as well as the coordination of the various entities in charge of psychosocial support, would result in higher rates of rehabilitation of ex-combatants. The process should be designed to instill a sense of confidence in the ex-combatants and positively affect their behavior in society.

Psychosocial interventions require the involvement of every level in the community: government ministries, education and training institutions, the ex-combatants themselves, their families, their communities, international and national service providers, and religious and civil institutions.

International Good Practice: A framework for Psychological Interventions

During the TCG meeting, representatives of Vivo, an international network of professionals specialized in post-conflict mental health issues¹, presented suggestions for building a framework for psychosocial rehabilitation and reintegration of ex-combatants in Rwanda. This could serve as a reference point for similar programs throughout the region.

The Vivo participants provided a historical analysis of the economic, political, social and psychosocial consequences of war, and shared the findings of studies they conducted in Uganda, Sudan, Somalia, Afghanistan and Sri Lanka in the past seven years. Citing a Prigerson comorbidity study from 2001, they revealed that combat trauma bears the highest risk of post traumatic stress disorder

¹www.vivo.org

(PTSD), often characterized by delayed onset, and frequently with significant consequences including unemployment, divorce and domestic violence. A 2002 veteran survey showed that as many as 300,000 veterans of the armed forces of the United States of America (USA) are homeless on any given night and that 60% of the homeless in the USA are male war veterans.

Vivo also referred to the RDRP study² that triggered the current attention to psychosocial trauma among ex-combatants in the countries of MDRP focus – Angola, Burundi, Central African Republic, Democratic Republic of Congo, Republic of Congo, Rwanda and Uganda. **The study suggested that up to 30% of Rwandese ex-combatants with physical disabilities, and about 5% of able-bodied ex-combatants showed symptoms of PTSD.** Previous research conducted by Vivo on ex-combatants in Somalia had indicated similar levels of trauma.

Vivo representatives presented the psycho-biological “defense cascade” as a universal human phenomenon that allows for the physical diagnosis of PTSD and the monitoring of physiological and memory changes in individuals. They also presented the elements of narrative exposure therapy (NET), a treatment for PTSD. Relating these scientific findings to the Rwandan context, Vivo summarized that an effective mental health service structure would have two pillars of interventions: (1) at the psychological-individual level, and (2) at the socio-collective level.

At the psychological-individual level, **the accurate diagnosis of individuals’ mental health is a necessary pre-condition for any effective intervention.** This may first be accomplished through an active assessment and screening of former combatants, and at the same time open access to diagnosis in a health facility for all other severely affected

Box 1: Complementary interventions

The three interventions described below complement the support offered to individuals after their diagnosis. The interventions can be mastered by laypersons :

- (i) Narrative Exposure Therapy – NET, for the treatment of PTSD
- (ii) Interpersonal Therapy – IPT, for the treatment of depression
- (iii) ‘Sociotherapy’ for the strengthening of social capital in general (e.g. trust, community cohesion) and reintegration skills in particular

Master counselors should provide ongoing training as well as supervision to counselors and psychologists. Psychiatrists should ensure adequacy and effectiveness of services provided over time by carrying out action-oriented, ongoing research that feeds information back into the service structure, and thus allows timely and adequate program adjustments. In order to make mental health care accessible to the public, community-based counseling centers should be put in place. Public awareness on trauma symptoms and help-seeking should be created. This would also have an anti-stigmatizing effect.

individuals in the community. Secondly, local counselors need to be trained in different forms of interventions (see box 1).

The second pillar of recovery rests on the community. Individual narratives, originating from within the trauma counseling intervention (NET), can become collective narratives by transferring educational information through media and educational programs. A dialogue between victims and perpetrators can lead to more understanding, tolerance, a reduction of stigmatization, and increased openness and trust; this can create a collective new meaning of traumatic events.

Findings of empirical research indicate that coherent values and beliefs can influence trauma symptoms at the individual level and prevent the development of mental disorders. This process of collective analysis and re-writing of history is also believed to mitigate trauma symptoms in the community, enhance the mental health of individuals, increase successful reintegration, and consolidate a new

and coherent collective identity. This process must be closely monitored with a view to measuring effects and adapting it to the needs of the beneficiary society over time.

The Rwanda Experience: Input from the National Conference and Strategy Workshop

In the process of monitoring program activities undertaken in 2005/2006, the RDRC identified a 4.8% prevalence rate of psychosocial stress symptoms among its beneficiary group and a

² Base Line and Impact Assessment on Medical Rehabilitation of Disabled and chronically ill Ex-combatants – Rwanda Demobilization and Reintegration Commission – May 2005

rate of up to 30% among disabled and chronically ill ex-combatants. The RDRRC subsequently entered into discussions with the Rwanda Ministry of Health to discuss options for conducting: (i) a more expansive analysis of the psychosocial situation of ex-combatants; (ii) a mapping exercise for all service providers of psychosocial (PS) interventions in Rwanda; (iii) the development of a model for PS interventions in Rwanda, (iv) a national conference for all PS stakeholders in the country; and (v) the elaboration of a national strategy and a work plan, and the formulation of a standardized training module for PS intervention

training. These elements can serve as an example for other countries where PS interventions have yet to be initiated.

The RDRRC and Ministry of Health presented the results of their assessment of the current capacities in Rwanda. They also discussed other vulnerable groups in addition to ex-combatants whose susceptibility to PS trauma may be similar. They identified stakeholders with whom the Ministry of Health needs to strengthen collaboration and coordination, including the police, the Ministry of Education, the Ministry of Youth,

Sports and Culture, non-governmental organizations and community-based organizations.

Psychosocial Approaches for Child ex-Combatants in Rwanda

Poverty exposes children to psychosocial stress. When conflict is added the ingredients for trauma are even greater. The events of the Rwandan genocide combined the two conditions, submitting children to the effects of violence and subsequently developing physical and mental disorders. Figures for the number of orphans, street children and children in trouble with the law are high. The number of children believed to still be in arms in the DRC is estimated at up to 3,000.

A number of factors lead to the recruitment of child combatants. For some, particularly orphans or children separated from their families, it is a calculated choice for survival, a means of earning a living, a way to self-protect and in some cases a means to exact revenge. Children and adolescents are also actively recruited by leaders of armed groups using ideological or political motivations. Child combatants in the DRC serve as fighters, looters, sex slaves, guards, porters, spies and cooks.

The effects of trauma emanate from children's exposure to life-threatening events like combat, death and wounding of fighters, sexual violence and torture. These children also witness other children being killed or wounded. As for gender, the RDRRC estimates that as many as 150 Rwandan girls may be members of the armed groups in the DRC, serving in multiple military and logistic support roles as well as in the role of sexual slaves.

Box 2: How monitoring and evaluation can guide psychosocial programming. The example of Somalia

Psycho-social interventions and research were undertaken in the context of demobilization and reintegration efforts in Somalia from 2002 to 2004.

Somalia's combatants can broadly be described as having accumulated years of militia experience and exposure to violence; they have high rates of drug addiction (especially khat) and come from rural origins with a poor educational record and limited professional experience. Different militias were associated with warlords, businesses, religious groups, clan self-defense groups and free lance operations.

Preparatory research carried out in Somalia broke the militia groups down by region, category and affiliation. It identified (through more than 7,000 interviews) socio-demographic information, levels of participation in combat, education background, information on small arms, health and drug-related information, levels of PTSD and physical disability, and the combatants' desires for assistance and future economic activity.

The program demonstrates the importance of a comprehensive package that incorporates:

- socio-economic assistance prefaced by viability studies for different interventions and individual and group beneficiary discussions
- business management training
- a psychosocial package with counseling as well as therapy, nutrition and hygiene training for caretakers of severely mentally dysfunctional cases, with follow-up monitoring and evaluation of progress.

Opportunities for children to leave armed groups in the eastern DRC come uniquely through escape at the risk of capture and punishment, including torture and execution. The effort takes planning and if the children are fortunate, they find their way to MONUC³, which assists them on their way to Rwanda. Once taken in by the RDRC, child ex-combatants are taken to a rehabilitation center where they are provided counseling and offered the chance to regain a sense of childhood through interaction with other children and with center staff. Among the activities carried out in the centers are identification, family tracing and reunification, family mediation, medical treatment, literacy training, civic education and eventually reintegration. In counseling and therapy, various techniques are employed, including: active listening, art therapy, theater and dance, sports, and promotion of life skills.

Psychosocial interventions in MDRP Countries

Angola

Angola relies on the Ministry of Health to screen ex-combatants with symptoms of psychosocial trauma and to provide them with counseling as required. The process begins at the identification stage and is mediated through a national coordination system for psychosocial matters, adapting to needs by providing training for more counselors as increasing numbers of persons in need are identified.

Burundi

Psychosocial interventions for adult ex-combatants affected by trauma have been the responsibility of the Burundi National Demobilization, Reinsertion and Reintegration Program (PNDRR), which has recruited two NGOs to provide medical rehabilitation, and

economic and psychological support. However, considering the short life of DDR programming, additional assistance to ex-combatants suffering from post-traumatic stress disorder should be provided through the establishment of a national structure. This structure should be adequately staffed to provide psychosocial support to ex-combatants beyond the life of the program.

Ex-combatants identified and registered at the time of demobilization are referred to specialized centers in charge of disabled in the PNDRR. However, no study has yet thoroughly assessed the extent or distribution of psychological conditions among this population. Some pathologies associated with war trauma such as schizophrenia, depression, or dementia are more readily recognized than other conditions which are less well documented. Furthermore, the lack of a well established national structure and follow-up systems prevents individuals with special psychological needs from receiving adequate support.

For child ex-combatants reunified with the receiving communities, social workers engaged by partner organizations have provided psychosocial follow-up under the technical direction of UNICEF. These social workers receive training that allows them to diagnose mental and behavioral problems and deal with them to the level of their competence. For children requiring treatment beyond what the social workers are able to provide, they are referred to the Executive Secretariat of the National Commission for Demobilization, Reinsertion and Reintegration (ES/NCDRR) and then on to specialized centers. This follow-up has ceased with the completion of these partners' contracted activities. While this completion is positive overall, there is some concern about what mechanism would support any children who may experience a delayed onset of symptoms. Those former child soldiers who have returned to formal education

may have the advantage of receiving wider supervision, not only from their families, but from teachers and school authorities. However, others may have few options for assistance.

Central African Republic (CAR)

Although a large number of ex-combatants in the CAR have had traumatic experiences that have resulted in depression, sleeplessness, aggressiveness or drug use, their psychosocial needs have not been taken into account.

The CAR has experienced more than a decade of recurrent political and military troubles with multiple militia groups being created and belonging to the respective parties to the conflicts. The project for ex-combatant reinsertion and community support (Projet de Réinsertion des Ex-combattants et d'Appui aux Communautés – PRAC) did not foresee the need for psychosocial interventions even though the realities suggest otherwise. This was quite evident during the identification and verification exercises where the ex-combatants manifested signs of physical and verbal aggression. Given that nothing was done to address these manifestations of psychosocial trauma, the need continues to be a pressing one, not just for the ex-combatants but for the communities where they have reintegrated.

While recognizing the need for intervention, there is a lack of service providers to deal with psychosocial trauma in the country.

Democratic Republic of Congo

The need to organize psychosocial interventions for demobilized com-

³ MONUC, United Nations Mission in the Democratic Republic of Congo, Mission des Nations Unies en République Démocratique du Congo. www.monuc.org

batants was recognized and planned for early on in the National Disarmament, Demobilization and Reintegration Program (PNDDR) in the DRC. Many demobilized suffer from psychological troubles (insomnia, fatigue, anxiety, pessimism, loss of self-confidence and self-esteem, recurrent fits of anger) made worse by the successive wars that plagued the country.

At the end of 2005, a workshop took place to examine psychosocial care for demobilized with the following objectives:

- Identify and train qualified stakeholders in sufficient numbers to cover the vastness of the country.
- Determine the prevalence of psychosomatic problems among the demobilized.
- Define the modalities for intervention.
- Make available the necessary budget for this activity.

Unfortunately, none of the activities materialized for lack of financial means.

Psychosocial support extended to child soldiers has been well done during the transitional period. All social workers responsible for the supervision and documentation of the children were trained by a national team of trainers on themes such as recognition of children seriously traumatized, dialogue and listening to instill confidence, peace education through educational games, training on human rights and on children's rights in particular, and training on the objectives of the PNDDR.

The care was conducted in two phases:

- During the transitional period, from the verification of the child's status as a child associated with armed groups through social reintegration (family reunification

or autonomy); and

- During the period of economic reintegration (training, income generating activities, education).

The training of national trainers was provided by UNICEF and delivered by international consultants who were well experienced in working with vulnerable children and those affected by armed conflict. In two years, more than 1,010 child soldier counselors were trained throughout the DRC. So far, 30,219 children have received psychosocial assistance.

The PNDDR in the DRC continues to feel a strong need for the organization of psychosocial care in order to reinforce the chances for successful reintegration of demobilized ex-combatants in the DRC.

Republic of Congo

In the Republic of Congo (RoC), the importance of a comprehensive approach for dealing with the social and economic reintegration of ex-combatants is recognized. It begins with the sensitization of political authorities, civil society, local and international communities and the ex-combatants themselves.

The identification process includes a preliminary health assessment that informs assistance in the reintegration phase. The program treats social and economic reintegration jointly. As part of the socialization process, medical and mental health concerns are taken into consideration; civic and moral education, as well as professional orientation, is provided to ensure a well-rounded approach to reintegration.

With respect to psychosocial interventions, the RoC set up a medical center with psychological clinicians trained in trauma counseling by the Ministry of Social Affairs with assistance from UNICEF. Systematic medical visits are followed by treatment where required with specialized assistance

to the disabled. Group counseling is followed by individual counseling in cases where PTSD is manifested. However, long term care is not available due to a lack of personnel specialized in such treatment.

The International Labor Organization (ILO) provides reintegration assistance to child ex-combatants, utilizing the expertise from ministries and UNICEF, well equipped to handle psychosocial care. This includes identification, socio-economic reintegration and psychosocial care. Psychological debriefing for various militia groups is also provided, which allows the identification of individuals with PTSD. Their symptoms include fear of persons with weapons, irritability, persistent sentiments of revenge, hypersensitivity to helicopter sounds, refusal to reintegrate into the family sphere, difficulty sleeping and bulimia among girls victims of rape.

Uganda

In Uganda, the various sources of psychosocial trauma include: poverty, hunger and famine, killings, unemployment, imprisonment, stigmatization rape, defilement, domestic violence, child abuse and divorce. Among the symptoms of trauma in children are nightmares, daytime flashbacks triggered by various stimuli, inability to concentrate; for male adults, symptoms include anxiety, excessive drinking and drug abuse, aggressiveness, stress, isolation; for girls and women, symptoms include denial of children's needs, stigmatization and worries about the future of their children.

The trauma suffered by girls and child mothers is usually stronger because of rape. Many may have had children not out of their will but as a result of their trauma, which can cause bitterness and longer healing periods.

Activities promoting psychosocial support are embraced by many in the communities of return. This can have

a positive impact on the psychosocial wellbeing of the children if counseling, sensitization and assistance are continued. Some activities may support psychosocial development in which the affected are encouraged to participate. There are also programs where members of the community are trained to identify those who need support. This can then be complemented by trained psychosocial providers, by training of teachers, and by integrating psychosocial curriculum in formal and informal learning institutions.

The identification of children can be

conducted in reception centers or in schools or camps and they can then be referred to appropriate service providers for care. By promoting awareness at all levels of Government and in society, more can be done to identify and assist those who suffer from trauma. Involving the media as well as cultural leaders in sensitization programs can also be a great asset.

Conclusion

All participants in the TCG meeting agreed that the dual individual and

community-based approach described by Vivo offered a realistic model for addressing the identified needs and the magnitude of intervention. Thus, this stepped-care system is the recommended response to the challenges that all MDRP countries face in psychosocial support.

A more expansive analysis of the psychosocial situation of ex-combatants in MDRP countries is needed, beginning with a mapping exercise for all service providers of PS interventions. This initial step will help to establish a foundation for other interventions.

For more information on the work of the Psychosocial Issues in the Demobilization and Reintegration of Ex-Combatants, please visit: www.mdrp.org



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