



Transitional Demobilization and Reintegration Program

The War Within

**A Critical Examination of Psychosocial Issues
and Interventions in DDR**

July 2013

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Contents

- Introduction..... 1
- Part 1 - Identifying Psychosocial Issues in DDR 2
 - 1.1 - Unstable Minds, Unstable Peace 2
 - 1.2 - Psychosocial Impacts of Extreme Violence on Ex-Combatants 2
 - Post-Traumatic Stress Disorder (PTSD) 3
 - Functional Impairment 5
 - 1.3 - Psychosocial Implications for the Community 5
 - 1.4 - The Costs of Inaction 6
- Part 2 – Addressing Psychosocial Issues in DDR 6
 - 2.1 - Surveying Psychosocial Issues in DDR 7
 - DDR Target Group Analysis TGA and Statistics in DDR 7
 - 2.2 - The Challenge of Reintegration 8
 - 2.3 - Approaches to Addressing Psychosocial Issues 9
 - 2.3 - Application of Psychosocial Modules in DDR Programs 13
 - Case Study: Somaliland 13
 - Case Study: Rwanda 18
 - 2.4 - Summary 18
- Part 3 – Conclusions and Lessons Learnt 19
- Part 4 – Recommendations for Future Programming 20
 - 1. Early incorporation of PS into DDR 20
 - 2. Integration of mental health expertise and professional assessment 21
 - 3. Offer variety of specialized, flexible support for mentally vulnerable groups 21
 - 4. Targeting drug abuse and depression 21

Introduction

When DDR work began in Northwest Somalia, also known as Somaliland, in the year 2000, Disarmament, Demobilization and Reintegration (DDR) architects had envisaged a traditional approach aiming at reducing threats to peace through the demobilization of able-bodied combatants only. The approach came with one precondition for any DDR funding: complete registration of all combatants on the payroll of the administration. In the course of the first registration operation in April 2001 of some 80 combatants, the interviewing team alerted the management to the high proportion of physically and “apparently mentally” dysfunctional persons who had reported:

“...Regarding the mental appearance, it could only be noted whether the candidate’s mental behavior is obtrusive or not, as determining reliably the mental condition requires the relevant specialized facilities which are not currently in place...”

The interview team was obviously challenged beyond its capacity. The numbers of “obtrusive persons” who reported for interview were perceived as suspiciously high, and indeed the fact of their turning in was in violation of the project objectives (i.e. to reduce factional strife through demobilization of apt combatants).

A long struggle at many levels followed, starting with a complaint from program authorities over failing to respect the terms of the agreement, to getting an initial indication about the magnitude of psychological challenge confronting combatants. Quarrels over mandate ensued until an initial field study secured facts on the issue, which succeeded in convincing the donor and partner authorities to invert the initial objective from targeting apt fighters only to specifically targeting the mentally challenged for demobilization with a number of sizable pilot interventions undertaken to probe feasibility and develop specific tools. This process took a long time and provided several lessons.

Some of this experience gained was carried along into the World Bank’s Multi-Country Demobilization and Reintegration Program (MDRP), which aimed to demobilize and reintegrate some 400,000 combatants in seven countries in the Great Lakes Region, and operated from 2002 and to June 2009. The MDRP was established on the basis of the regional security dynamics at the time and on the principle that a large group of not-yet-demobilized and reintegrated ex-combatants (regular forces and rebel members alike) posed one of the highest risks to renewed conflict.

This paper will explore a variety of psychosocial issues in DDR impacting on ex-combatants as well as communities affected by violence, and put forth recommendations for improving psychosocial support in future DDR programming. Part 1 presents background information for contextual understanding of the challenges faced by ex-combatants and community members affected by conflict-related trauma, including ways in which psychosocial problems present in the lives of ex-combatants, the short and long-term impacts of trauma on the violence-affected

individual, and the costs of not addressing this critical issue. Part 2 explores key approaches and interventions, particularly in Somaliland and Rwanda, attempted by DDR implementers and the results of such interventions. Finally, Part 3 describes key challenges in addressing psychosocial issues in DDR and puts forth a set of recommendations based on the contextual understanding of the issue and the real-world application of development interventions.

Part 1 - Identifying Psychosocial Issues in DDR

1.1 - Unstable Minds, Unstable Peace

Many of those who have worked on reintegration issues in post-conflict settings share a common bond in terms of experiencing a certain percentage of their beneficiaries appearing to behave in direct contradiction to their own best interest. Those who have worked with former combatants may have even more to say in that respect. A common opinion among stakeholders in the past has been that a certain degree of craziness or even madness spreads among conflict-affected beneficiaries. Oftentimes, staff and managers dealing with such situations do not know how to respond. The general observation may be that a significant percentage of beneficiaries do not adequately respond to well-intended assistance and subsequently lose their benefit.

The case of Somaliland offers some striking examples of such behavior, such as reports of an ex-combatant pouring fuel on mother or sister and setting them on fire when feeling frustrated over economic failure and social pressure to perform or behave. Another report details an ex-combatant “witnessing” former comrades dying “in crossfire” from his own hands in front of his business location and then claiming he did not know what had happened. Some ex-combatants simply exhibit high levels of mental instability, changing their minds frequently over what they think they should be doing to earn a living and the disappearing from their chosen location of reintegration. Some of these individuals even return to armed groups, only to turn up at a demobilization center soon after, often as a “well known case,” a “professional recycist.” Others are unstable in their social relationships, spoil their marriages, are irregular in job placements and get terminated, and so on.

The general attitude among DDR stakeholders has grown into a firm recognition that mental health challenges among ex-combatants and affected communities must be addressed, otherwise such beneficiaries run a very real risk of failing to reintegrate into civilian society, and preventing their immediate social environment (usually a family setting) from recovering and developing. In such cases, beneficiaries become an obstacle for society’s development and its capacity to absorb former combatants, which equates to an impediment for general post-conflict recovery. Further implications could include a standstill or even reversal of social and economic development and return to conflict with armed violence.

1.2 - Psychosocial Impacts of Extreme Violence on Ex-Combatants

Stress is normal for the human body, yet extreme levels of stress can have profound implications for the lives of individuals and society. Massively stressing events are called *traumatic* when they reach a level where the experience and psychological impact are life threatening or present a danger of serious injury or loss of integrity of the body so severe, that the victim is horrified and

feels helpless during and after the experience. Experiences directly related to natural disasters, physical attacks, rape, kidnapping, captivity, torture or war are generally characterized as traumatic. As an effect of such an event, a person can develop different sorts of psychosocial problems or mental illnesses.

Recent studies with ex-combatants in developing countries have shown that the everyday functioning of the returnee is impaired. For example, such individuals are less likely to be married, be employed or be mentally healthy. Studies carried out by VIVO (see Odenwald, Neuner, Schauer, Elbert, Catani, Lingenfelder, Hinkel, Haefner & Rockstroh, 2005) show that 16 percent of former members of the group 'Somalia National Movement' have massive functioning impairments due to mental problems, about 12 years after the end of their liberation struggle. In an attempt to self-medicate their painful emotional symptoms, a high percentage of these young men use a local substance known as 'khat' and are caught up in a detrimental cycle of addiction, psychosis and trauma.

Understanding the consequences of exposure to multiple stressing factors on the returnee is a crucial first step to designing interventions that can successfully assist and treat an individual impacted by trauma. Common consequences can include Post-traumatic Stress Disorder (PTSD) and other associated psychosocial issues such as major depression, suicide, drug abuse and general impairment of functioning.

Post-Traumatic Stress Disorder (PTSD)

Today, it is known that that the experience of war and organized violence causes traumatic stress related illnesses, irrespective of gender, age or ethnicity or other factors. This is due to the fact that traumatic stress impacts on the brain's structure and functioning. During the experience of a traumatic event, among other automatic functions of survival, hormones¹ are released into the body and brain. A large amount of such substances remodels brain areas responsible for our episodic memory; in particular the one responsible for recording of chronological account of our biography.² At the same time others³ boost the activity of a part of the brain⁴ regulating emotional memory, including fear.

A certain combination of resulting psychosocial problems, which is caused by experiencing a traumatic event, is called PTSD. It can be distinguished from other mental health problems by three categories of symptoms:

1. Intrusive symptoms described by chronic re-experiencing of the traumatic event via nightmares, flashbacks, stressful thoughts and emotional and physiological reactivity to reminders of the event;

¹ such as Cortisol, Epinephrine and Norepinephrine

² Hippocampus

³ Epinephrine and Norepinephrine

⁴ the Amygdala

2. Avoidance behavior, which includes active avoidance of any reminder of the traumatic event, like places, people or associated activities, and passive avoidance, like general emotional numbing and a feeling of being detached from other people; and
3. Hyper-arousal symptoms, including sleep and concentration difficulties, exaggerated startle response and an enduring feeling of threat. Drug abuse, somatization (including headache) and depression are commonly associated.

Many studies, which have examined the prevalence of PTSD in war-torn populations, found a persistently high number of affected people. Somasundaram and Sivayokan (1994) show for randomly selected respondents in war-affected North-Eastern Sri Lanka a PTSD-prevalence rate of 27 percent. De Jong et al. (2000, 2001) undertook research in different conflict settings and found high numbers everywhere: 37 percent of the respondents fulfilled the diagnosis for PTSD in Algeria, 28.4 percent in Cambodia; the rate of serious mental health problems in Rwandese refugees in Tanzania was found to be higher than 50 percent in those who had survived and could flee the genocide.

It is also clear that there is no natural resilience against PTSD, and the probability of worsening symptoms is dependent on the number and types of experienced traumatic events (Mollica et al., 1998; Neuner et al., 2004b; Steel, Silove, Phan & Bauman, 2002). This phenomenon, called the *building block* effect, could constitute a reason for the high prevalence of PTSD among refugees as they are exposed to a high diversity of traumatic stressors in their lives (pre-flight, forced migration, unsafe transitional settlements, etc.).

As a consequence of traumatic experiences, those affected by PTSD are likely to also suffer from an array of associated psychiatric illnesses such as major depression, suicidality, and drug abuse.⁵ PTSD is by far the most frequent and therefore important PS problem appearing in this context. Other PS problems with high prevalence are depression, development of drug abuse and development of appetitive aggression.

“Targeting depression within communities remains an untested challenge. First, stigma associated with depression is a significant problem in many cultures (Dietrich, et al., 2004). Depressed individuals, by the very nature of the disease, generally isolate themselves socially. The combined effects of stigma and withdrawal make depressed individuals hard to identify. On the other hand, depression is clearly a treatable disorder and several interventions have been shown to have long-term impact based on rigorous longitudinal research (Sadock & Sadock, 2005; Bolton et al., 2003). For multi-level intervention strategies to be most effective, universal approaches should be theoretically integrated with the targeted approaches (Dishion and Kavanagh, 2001). In other words, without decreasing the stigma associated with depression and helping those most affected reengage socially, the synergistic effects of multi-level interventions will not be realized. This problem has to be tackled from various ends simultaneously, since other societal dynamics are connected. Young adults with depression for example are at increased risk for spreading HIV (Williams & Latkin, 2005).

⁵ See Annex-A2 for further information on psychosocial issues related to PTSD.

Interventions shown to impact depression among ex-combatants in developing countries are yet non-existent. Furthermore, concerns about cost and availability, especially given the potential scale of interventions needed, are paramount. Individuals with high levels of depressive symptoms, particularly those with co-morbid conditions (e.g., PTSD, traumatic grief) may not respond however to other supportive interventions, such as vocational training. One approach, made possible by recent controlled trials of Interpersonal Therapy (IPT) modified for use with adults in developing countries, (Verdeli et al., 2003; Bolton et al., 2003), is to further adapt this intervention for ex-combatants with depression, including those with PTSD or traumatic grief” (vivo).

Appetitive aggression came just recently under research. The executive summary of the paper about to come out states:

“A significant proportion of former combatants reported high levels of appetitive aggression: They reported they enjoyed fighting and liked to see their victims suffer, feeling of satisfaction when harming others (44 percent), having an urge to fight (35 percent), and finding it difficult to resist being aggressive (40 percent). These former combatants clearly not only got used to violence, but, typically “over time”, came to enjoy it and developed a need to be increasingly cruel. Some combatants (8 percent) described combat and attacking others as sexually arousing. Furthermore, a correlation between difficulty controlling aggression and rank was also found: higher ranking combatants reported more frequently that for them it is difficult to stop fighting once started. 44 percent agreed that it could be satisfying to harm others. They did not only fight other combatants or attacked civilians to achieve specific aims, but also for the pleasure of a “man-hunt”; which includes injuring enemies and victims.” (Elbert et al, 2013)

Functional Impairment

What all psychiatric illnesses have in common is the fact that they impair the sufferer in every day functioning: reducing the capacity to sustain intimate relationships and friendships, hindering successful participation at work, lowering scholastic achievements, limiting the ability to participate in communal life and impairing the ability to plan and follow-up on realistic goals for the future. In this way, the mental consequences of war, terror and organized violence on the individual are long-term and psychiatric illness is often chronic. If mental health is not addressed in ex-combatant rehabilitation, the effort of improving social capacities and reducing poverty is clearly weakened (Mollica & McDonald, 2002; Baingana & Bannon, 2003).

1.3 - Psychosocial Implications for the Community

Large epidemiological studies among war-torn populations show that more than one fifth of refugees in camps, and over 50 percent of camp population individuals suffer from trauma spectrum disorders. This impairs not only the mental health and daily functioning on an individual level, but also compromises the reconstruction and development of society (see e.g. vivo’s work in Karunakara et al., 2004; Neuner et al., 2004b; Onyut et al., 2005). High rates of unemployment leave many affected without financial security and an inability to engage in productive activities, such as keeping a household, rearing children, cultivating the field, participating in community decision-making or social events. Such consequences also have a

profound effect on decreased feelings of self-worth. Both types of impairments obstruct social and economic recovery of the social of the country, as they can lead to increased rates of criminalization out of desperation to gain financial support through violent and illegal methods. As a consequence of reduced social cohesion, the basic cell of a society, the family, is weakened, compromising the development of the future generation.

1.4 - The Costs of Inaction

When the international community intervenes in a post-conflict setting, international actors generally take the common approach of emergency response and recovery. Such an approach is aimed at addressing the most urgent needs and expediting the return of poverty reduction and development activities. Yet, the aforesaid indicates that this may be difficult or even impossible to achieve if psychosocial consequences of violence are not identified and adequately and efficiently addressed. Quite often, proposals for psychosocial work in such settings are perceived as a luxury that can wait. Experience and research, however, have shown that addressing psychosocial issues is not a luxury, but an absolute necessity to successful post-conflict development and long-term peace and stability; and in fact delaying interventions to address psychosocial issues even for a short while can have serious repercussions, as it may be a key factor for relapse of violence.

Due to the experience of massive traumatic stress and its psychosocial consequences, the individual is significantly vitiated in everyday life. Reduced internal stability and general stress (e.g. pressure to perform, long working hours, competitive environment, family problems) are much more difficult to cope with for traumatized persons. They are significantly more often confronted with unemployment, reduced social support, isolation and disequilibrium, which also has tremendous effects on the life of the family, community and society (Zeanah, Boris, Larriue, 1997; Scheeringa & Zeanah, 2001; Dickson-Gomez, 2002). There can be no illusions about the cost of inaction. If mental health problems among ex-combatants are not quickly and effectively addressed, they will try to find ways to cope as they have no other choice. In doing so, the individual runs a very real risk of exacerbating a perfectly treatable malady.

The long duration of war and the repeated occurrence of mass violence in certain locations suggest that these conflicts present a “cycle of violence”. Research is just now awakening to the fact that high levels of war violence lead to higher levels of violence within the family and community (vivo). As high rates of mental health disorders are found in war-affected populations, the psychological factor is suggested to contribute to the continuation of the conflict. Due to the psychological instability, the increased level of aggression and the erratic mood swing, which all can be worsened through drug abuse and other forms of coping through “self-medication,” violent behavior is passed on to others and keeps the cycle of violence going in an already fragile setting.

Part 2 – Addressing Psychosocial Issues in DDR

Progress has been made in DDR programming in recent years with regards to increased understanding around psychosocial issues and incorporation of interventions for those afflicted

in post-conflict settings. Part 2 will explore on earliest point of entry with a survey and a few approaches and interventions piloted and implemented in Africa within the context of DDR frameworks, with a view toward culling key lessons learned for future implementation.

2.1 - Surveying Psychosocial Issues in DDR

DDR Target Group Analysis TGA and Statistics in DDR

Any process of peace and development can only succeed when the individuals concerned assume responsibility for them (ownership). Therefore, any peace and development process must be based on the actual needs of the people affected, and on the scope for action open to it. The persons or groups in society who are to be directly affected by the impact of a project are defined as the Target Group(s). Therefore, Target Group Analysis (TGA) is a basic tool for project planning, which should be applied as early as possible in the project cycle. However, target group analyses cannot substitute for quantitative socio-economic surveys and the elements of those needed to be built in TGA/surveys, where a need is identified.

Typically, TGA's offer qualitative description and analysis of the point of view of the people affected. The TGA for DDR projects should go beyond typical TGA's, as it should include substantial quantitative analyses. Only then it will produce the necessary data to explore strategic features and typical patterns, illustrate these by examples and back them by precise statistical data so that out of these the project's strategic features may be adequately developed, not only in qualitative (a typical TGA-result) but as well in quantitative figures (Socio-economic & health-related data). Concrete planning and budgeting will now be possible.

TGA is a typical instrument to advise an already existing known partner organization how to design the project (the case of the NDC in Somaliland) as it is to advise applicants for implementation tasks, like LINGO's and other bodies (example: the 14th Somali Peace Conference Committee 2, CF and DDR), concerning the clarification of the concrete requirements of a project's concept and its institutional structures (organizational development).

Only a very early on TGA can respond to these needs. Thus, every possible effort should be put into achieving this.

The earliest point of access to the Target Group in DDR programs is the TG Assessment or Survey. If data are not already available from professional records, in the case of formal armies with health services (which they are usually not), pre-disarmament access is the ideal but rare case. Commonly, the earliest possible access is at the moment of disarmament (D1 of the DDR), as before the TG are combatants, not ex-combatants.

In exceptional cases access may be possible earlier (pre-disarmament), but in such situations it is often not possible to undertake a reasonable survey (see Burundi case). If it is feasible this can be considered "The ideal case" (see Somalia case).

Basically, every possible effort should be made to do the survey as early as possible as it is the quality and quantity of the survey that defines the level of success (or failure) of reintegration

support, because early data availability allows for early and good preparation. Some preoperational steps require a lot of time, such as acquisition of funds, establishment of strategic partnerships, recruitment of specialists, preparation and production of guidelines and manuals, training, raising public awareness and sensitization, capacity building in mainstream structures etc.

The quality of the survey which is related to asking the right questions in the right way, and the level of free access to the TGA are paramount to success. Thus, as much effort as possible needs to be put in the development of an adequate questionnaire (copy and paste can only be an initial step, questionnaires need to be reviewed in a participatory manor with well selected representative members of the TG), competence, sensibility, training, instruction and supervision of surveying staff are further elements that cannot get enough attention. The quantity of data acquired mark the accurateness of needs based planning figures to be provided. As a rule of thumb, with less than one percent of the caseload accessed, there is insufficient data, with one percent gives a quite accurate idea of what opinions and ideas are, while five percent can be considered quite safe data. However, this only applies if the selection of TG individuals to be surveyed is random and not biased in any way. It is important to note that the hidden bias and manipulation are often significant problems in the context of DDR. A further key factor to be closely monitored in the course and context of TGA/survey conduct is the security and basic needs environment, as such operations are in many cases run in volatile environments or emergency settings. Crisis management skills of staff are an important asset and need to be considered in training curricula.

2.2 - The Challenge of Reintegration

One of the key issues impacting on reintegration of ex-combatants is the need for the individual to be physically, socially and mentally competitive upon return into the society, if success is envisaged. Besides economic and physical factors, psychological and social normal functioning is paramount for success of reintegration. Thus, psychosocial functioning is an imperative for sustainable reintegration into civilian society.

Over the last decades, the international community, as well as local policy making and implementation bodies, has acquired substantial expertise in disarmament, demobilization and reinsertion steps of DDR which can be implemented in a relatively short time frame, provided that the will of the political leaders and the stability of a peace accord are guaranteed (Gleichmann, Odenwald et al. 2004). Today, however, the reintegration part remains the key challenge to the success of DDR (Mogapi, 2004a), due to a number of reasons including:

1. The process is long-lasting;
2. Financial engagement is long-lasting and often dependent on external donors (UN, Brahimi Report, 2001);
3. The economic development of the country and the attitudes of the communities towards the former fighters play a key role and are difficult to influence (Kingma, 2000; Ayalew & Dercon, 2000);

4. Mental health problems impair the individuals success of reintegration (Kingma, 2000), and;
5. Vulnerable groups, like child soldiers, female veterans or disabled ex-combatants, have a *high risk to fail* in this process (Colletta, 2001).

As a reaction to these growing concerns, in some DRR programs psychosocial tools were developed and implemented to address these special needs. The next sections offer a brief review of these approaches and interventions.

2.3 - Approaches to Addressing Psychosocial Issues

MDRP and TDRP of the World Bank

The MDRP was established on the basis of the regional security dynamics of the Great Lakes Region at the time, on the principle that demobilizing and reintegration of the large number of former combatants was critical for renewed conflict. In 2003, MDRP stakeholders held a workshop in Kibuye, Rwanda focusing on the regional coordination of M&E and MIS. Talks identified trauma and psychological concern as a main issue, to be identified with an adequate screening tool, and framework was subsequently integrated at central database levels across the program in all member countries.⁶

Later, the MDRP established a forum for technical expert's consultations, the Technical Coordination Group (TCG). In June 2007, a TCG meeting was held in Kigali, Rwanda, on "Psychosocial Issues facing ex-combatants."⁷

The TCG made progress on psychosocial issues on several levels:

1. An assessment of current levels of knowledge and research;
2. At the regional level, increased information and programming sharing and an agreement on future collaboration, starting from exchange over progress of ongoing or envisaged activities;
3. Government of Rwanda (GoR) – Ministry of Health committed to developing its strategy to respond to psychological challenge on a national level;
4. GoR – Rwanda Demobilization and Reintegration Commission (RDRC) would develop a DDR-specific strategy for the RDRC, with a clear set of recommendations for a plan of actions to be taken;
5. The TCG also took stock of the different types of approaches and levels of achievement in other MDRP partnership countries.

⁶ Schork, Wolfgang & Gleichmann, Colin (2003): Workshop Documentation. Workshop on Monitoring and Evaluation and Management Information Systems in Disarmament, Demobilization and Reintegration Programs, Multi-Country Demobilization and Reintegration Program (MDRP) Kibuye, Rwanda, 10 -13 August, 2003. GTZ, Eschborn.

⁷ Schauer, Elbert, Roth, Bussmann, Neuner and Odenwald (2007): Building a national framework for the psychosocial rehabilitation & reintegration of ex-combatants in Rwanda. Report for Discussion at the National Psychosocial Conference, Kigali, June 2007. Prepared by the NGO vivo, in collaboration with the University of Konstanz, Germany.

Within the MDRP a number of ideas and approaches had been developed since inception, which finally led to a set of recommendations being developed in the TCG (Kigali 2007). Since this was not a policy-making event but a technical meeting, the outcome was a common understanding of technicians on how things should be handled, laid out in a report (see footnote 6). It was left to the participants to determine the extent which they could and would implement these recommendations under the conditions they faced in their countries, as each country faced a dramatically different set of circumstances.

Depending on levels of emergency stress and priorities identified or emergency responsive mode of operations in national programs, recommendations were taken into account and implemented to different degrees and in different ways. For example, Rwanda followed recommendations based on needs and gaps identified and trained large numbers of counselors to help identify and orient ex-combatants in communities and hired supplementary professional staff to work in the demobilization camps with freshly received ex-combatants. Burundi included an assessment tool for psychological problems in its interview at point of entry to the program and developed a tracking tool for the MIS, but lost track on it in the course of the program. DRC did not manage to get anything substantial going, except for basic PS services in transit centers. Angola had already a psychosocial support program ongoing and did not make important alterations as the program was performing. DRC did not manage to get anything substantial going, as it was in a permanent operational emergency response mode. Thus, these experiences show that it essentially depends on the environment what is being done and what is not, leading to very diverse results. Many participants did not get very far with plans to implement, while few made good progress.

IDDRS

Later on, the UN introduced the Integrated Disarmament, Demobilization and Reintegration Standards (IDDRS), which provided guidelines regarding how and when to detect and address psychosocial issues in DDRR programming. The IDDRS is a comprehensive set of policies, guidelines and procedures covering 24 areas of DDR.

Today's standards for the design and implementation of DDRR projects and programs for the United Nations family of agencies are set by the IDDRS. It was developed by a larger group of experts in the field, mainly from the UN. Though, not all DDR actors are bound to it, there is a general tendency to recognize the IDDRS as minimum standards to be observed.

IDDRS Recommendations concerning psychosocial support are as follows:

- Psychosocial support in all DDR programs
- To conduct screening during demobilization
- Start provision of services at demobilization (encampment)
- Avail psychological treatment (therapy)
- Attention to special needs groups (women, children, disabled)
- Psychosocial Support at all stages of DDR

The IDDRS is too young for drawing wider conclusions from experience. However, some impact in the field can be seen as activities are put on the ground. It is certainly not enough to recommend in planning and implementation guidelines to put services in place. The technical capacity needs to be put on the ground early on and TGA cannot happen early enough. One effect of the IDDRS is certainly the presence of psychological experts in the South Sudan DDR program management unit. In South Sudan, as elsewhere in developing countries in post-conflict settings, one of the main challenges is the de facto absence of service providers for psychological treatment. Thus, the DDR-preferred referral to public mainstream structures cannot work, as those are either absent or dysfunctional. Service delivery is only possible through involvement of specialized organizations, such as international or local NGOs. This is currently happening in the Lord Resistance Army (LRA) affected area of the North East of the DRC, where few specialized INGOs provide PS services to escapees and victims and provide some support to a very weak public health structure. However, the response is not needs-based but, as so often, donor driven through budget constraints. The magnitude of the problem needs to drive the operations, not budgetary restrictions. Unfortunately, the reality on the ground is too often the different.

Types of TGA/survey timing with examples:

Historical data from pre-/conflict surveys on Armed Forces or Armed Communities, if available, will not respond to all the needs of a TGA/survey, but they may contain important information. It is always worthwhile checking if any can be achieved.

Pre-disarmament:

Towards the end of an armed conflict it is sometimes possible to access the would-be TG of a DDR program before a cease fire (CF) or Peace Agreement PA is reached or in between the two. This can be seen as the ideal case or best practice, as it would be before DDR planning would have started, and a TGA can provide, what it is supposed to: concrete information for design and planning of a DDR program, based on knowledge about needs and aspirations of the TG (XC). A concrete example is the case of Somalia, in which EC funded GTZ (today GIZ) implemented DRP managed to get access to all armed factions for systematic interview with an estimated 10% of the total caseload.

In Burundi under MDPR program, a similar chance was there, when a CF was negotiated and AG moved into designated areas under UN protection, which made them de facto cantoned, received basic needs supplies (food, shelter items, medication) but remained armed, while negotiations about army integration rates, ranks and demobilization benefits continued. This would have been an ideal opportunity to do a TGA/survey, just like in Somalia. However, AG continued to recruit civilians to boost their numbers and reach negotiated figures they never had. Furthermore, there was a climate of suspicion about espionage and infiltration. Therefore, the proposed TGA did not take off. – In principle, there was an ideal situation, but a non-favorable social environment or climate, which made the implementation impossible.

Immediate post-disarmament registration at demobilization as an entry point with TGA is a typical case. Depending on the environment, it may go well and smooth or it may turn out extremely challenging. Political, Security and socio-economic factors play important roles.

The well performing common case (Burundi):

From a case of a missed opportunity, Burundi developed into a well performing case of good practice. The MIS was developed early on, the questionnaire developed in the course of the MIS programming and the enumerators who had been selected in a competitive process were trained along with UN MILOBS not only on the elements of the DDR program, but also on PS issues and interview psychology.

Struggling with ongoing conflict and operational issues (DRC):

The MIS development started early but became an endless hick-up process, the questionnaire development did not go smooth and subsequently didn't take into account important aspects (for example PS completely omitted), enumerators not selected in a competitive process with many of them lacking the most basic skills, like the language they needed to speak with their clients, enumerator training on the elements of the DDR program in isolation from other actors (UN) without elements of PS issues and interview psychology

Weaknesses:

Delayed registration due to political and security issues, difficulties with access, no assessment and data collection done at the entry point, as there was no developed questionnaire and no trained enumerators, planning and implementation arrangements on extremely short notice, and subsequently very little psychosocial assistance actually delivered.

Post-Demobilization Target Group Assessment:

Rwanda:

Though from a planners' point of view, the approach taken to address the problem is close to the ideal case, practical work has shown need for adjustment, not early on, but over time. With significant increase of exposure to extreme violence in the field (combat and targeted civilian dependents) the number of persons turning in with severe exposure to traumatic events has dramatically risen due to change of combat dynamics on the ground in eastern DRC. While the earlier post conflict setting approach had been working well and appeared fully responding to the need, at the time the change in dynamics of violence produced a new needs profile, which overstretched the system in place. Adjustments needed to be made, moving screening and early intervention to the reception at entry point end. The RDRC responded by boosting staff capacities, recruitment of specialists, screening at point of entry and subsequent provision of services (treatment). UN/MONUSCO-DDRRR boosted response capacity through staff training.

Strengths: pre-screening at intake, fully professional screening process undertaken by a team of medical professionals post demobilization, a fully mainstreamed process (ideal case from DDR perspective) with referral for service delivery by a functioning public health system.

Weaknesses: Late service delivery, little time to adjust and react if needs would rise suddenly at point of entry, time-consuming and cost-intensive process.

Regional Harmonization: The MDRP aimed at establishing a Policy Framework (Regional, national and DDR-specific) through a regional conference organized as a Technical Coordination Group (TCG) meeting in 2007 by the MDRP. Regional harmonization of mental health and trauma concepts was envisaged and agreed on in the course of the meeting, but no formal framework was set up and thus no regular follow up happened. Rwanda benefitted from technical support in the development of national policy on mental health and trauma and the development of a DDR strategy on mental health and trauma.

Strengths: Development-oriented, sustainable, national ownership, fully mainstreamed, DDR supports national policy development

Weaknesses: Time and resource-consuming process, late delivery of services, and it did actually not work except for some level of South-South knowledge transfer between Rwanda and Burundi on handicapped housing.

2.3 - Application of Psychosocial Modules in DDR Programs

This section will describe and examine key interventions for addressing psychosocial issues in DDR. Particular attention is given to Somaliland and Rwanda, followed by a brief overview of interventions and results in other countries.

Case Study: Somaliland

In response to a growing recognition among stakeholders of the critical need to address psychosocial issues in Somaliland, a groundbreaking pilot program was designed and introduced in the region. VIVO⁸ conducted a series of assessments prior to implementation. The second assessment on “War-trauma, Khat abuse, and Psychosis⁹” aimed to clarify whether or not the high number of mentally affected ex-combatants identified in the first assessment was representative and if these findings applied unchanged to the community as a whole.

Study Findings: The survey produced a number of key findings. For example, it was found that a staggering 21 percent of the households surveyed cared for at least one family member with a serious mental health problem; lifetime prevalence for the most severe forms of mental disorders is estimated to be 3.5 percent in the general population, Compared to other countries this prevalence is extraordinarily high. The most significantly, however, findings indicated that 16

⁸ Vivo: Victim’s Voice (www.vivo.net)

⁹ Odenwald, Schauer, Neuner, Lingenfelder, Elbert, Catani, Klaschik, Horn, Hinkel (2002) Preliminary Report of the vivo mission 2 within the EC/GTZ Demobilisation and Reintegration Programme in Somaliland, September-November 2002.

percent¹⁰ of the ex-combatants suffered from a severe mental disorder and that they were four times more likely to suffer from mental ill health than persons without any war experience, and about two times more likely than civilian war survivors (refugees, IDPs); Furthermore, the life time prevalence of schizophrenia in the sample was 2.8 percent, compared with just 1 percent in the rest of the world, the 1.8 percent “surplus” individuals were concluded to have been suffering from another disorder on the schizophrenic spectrum (i.e. 7,200 among an estimated 400,000 inhabitants of Hargeisa); khat abuse was excessive in 80% of the cases with schizophrenic spectrum disorder confirming the hypotheses that there is a link between traumatic stress, khat intake and resulting stimulant induced psychotic disorder.

Pilot Program: Based on the aforementioned findings the project developed a tailored support response according to the specific needs of this especially vulnerable sub-target group by providing packages with the following elements:

A SME micro-project, health and socio-economic assessment, training workshop, home visits and counseling, home and personnel hygiene training, nutritional food cooking and storage demonstration, food distribution and information sharing meetings, and in some cases basic medical treatment and physiotherapy, community awareness and sensitization.

A small enterprise micro project (SME) had proven the by far most chosen and most practically feasible means of economic support towards self-sustainability. To allow a good choice to be made, with a good perspective for economic viability, a health assessment needed to explore levels of mental and physical fitness and a socioeconomic assessment shed light on capacities, experiences, assets and access to networks. Participants in the program would undergo training to learn basic business skills, including literacy and numeracy where necessary, simple accounts etc. Counseling in the decision making process with home visits allowed a hands-on coached selection of an adequate economic activity. Personnel hygiene status of mentally challenged XC were found catastrophic in many cases and families totally incapable to respond to the most basic needs and without any skills to handle and care for their challenged family members, A trial of training on the most basic things like washing, hair and fingernail cutting and evacuation of feces and urine from a living area showed a quick improving impact on the mental health status of XC. As the revelation of body mass index (BMI) in the course of the registration process showed severe nutrition problems in XC, food security was identified as an urgent issue to be addressed and support from WFP allowed food rations to be allocated. Soon, it was found that care takers lacked basic skills of food storage, food preparation and hygiene. Thus, basics of nutrition, cooking and food storage were taught in situ, enriched by information sharing. Basics of medical care and physiotherapy especially for those who had spent years in chains showed quick impact. Community awareness and sensitization was paramount to success of any intervention. Without them nothing would have worked, as communities are driven by suspicion and jealousy.

¹⁰ This applies mostly to those unfit for active service. Among the active servicemen the earlier study identified further problems about the mental well-being.

In the development of the PS Pilot Module (XCs, 2001), the following areas were targeted:

- Psychological Rehabilitation (NET)
As PTSD had been identified as the key mental health issue amongst XC with significant rates of dysfunctional individuals (16%), Narrative Exposure Therapy, a treatment for trauma resulting from organized violence using ... "A form of exposure for clients with PTSD which encourages them to tell their detailed life history chronologically to someone who writes it down, reads it back to them, helps them integrate fragmented traumatic memories into a coherent narrative, and gives that to them at the end as written testimony..."¹¹
- Medical Rehabilitation
As a rule of thumb, it should be expected to have to expect some 10% of XC to be suffering from physical impairment of some kind, not always directly war-related, but always impacting the individual. Medical rehabilitation is therefore a precondition to successful economic reintegration, as economic factors override social short term engagement, such as a DDR program. The project therefore referred physically dysfunctional XC to mainstream medical services and produced solid results, though the local standards of medical are not amongst the highest.
- Social Reintegration & Community Sensitization & Participation
Early on, it was realized that no single intervention in a community can be done without sensitization of this community. As the whole community is effected by the problem (every one out of 5 households care for a mentally impaired veteran), the community is highly interested and as competition over access to services and resources is high on the agenda, it is not possible to perform any work in the community without their buy-in. thus, community absolutely need to be kept informed about what is going on and they need to perceive this as something they benefit from. Thus, meetings with communities were held, discussion and self-help groups initiated, fliers, radio programs, tv events and a newspaper (milk & honey) created to keep the communities at every possible level in the loop and involve them.
- Economic Reintegration Support & Food Security
Typical D&R packages were offered, but tailored not only to local but also to individual needs. Since the TGA had reported poor BMI, food item packages were handed out. Both produced improvement in the mental health status of the XC.
- Inter-Agency Coordination & Collaboration
When understanding the magnitude and scope of the problem, it became immediately clear, that the project would require support from other organizations. This had been the approach envisaged by the donor from the onset. Thus, the project focused on identification of partner organizations for service delivery. It needs to be said, that the

¹¹ Neuner's full definition, further information. [Paul Burns]

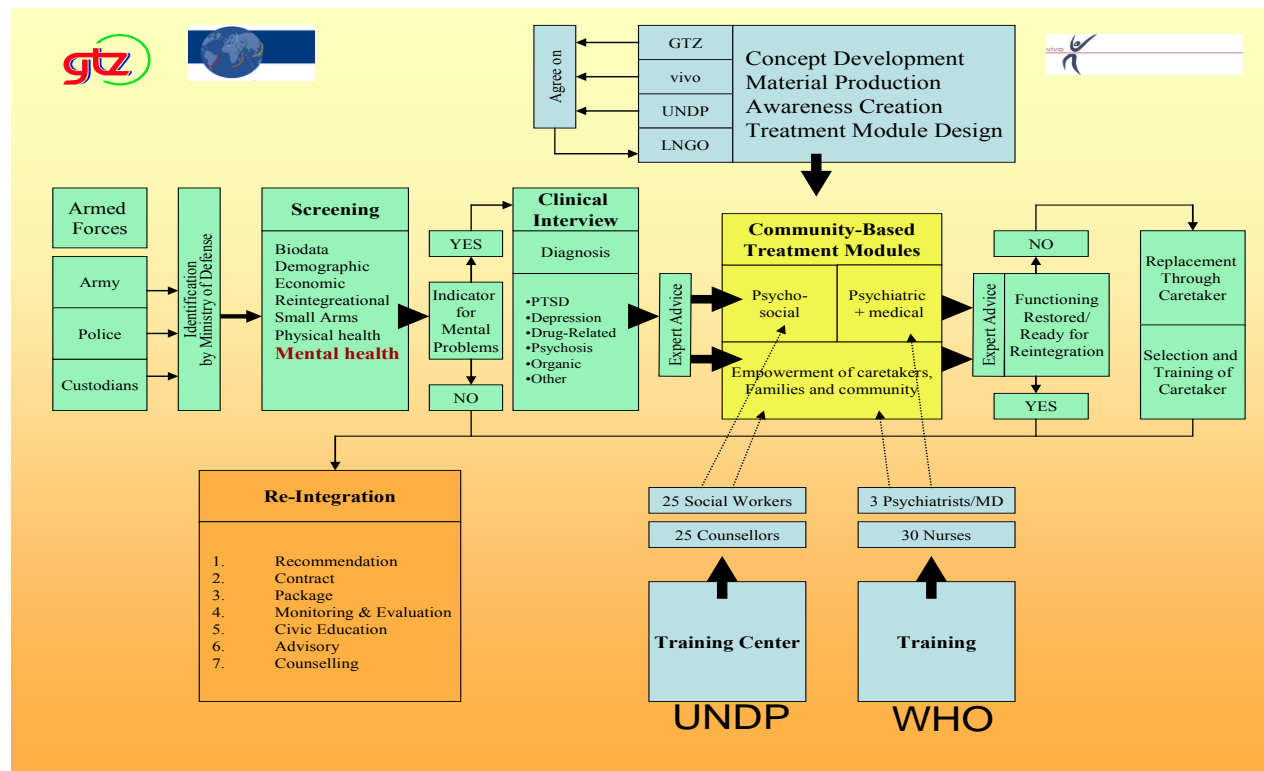
response was rather insignificant. The Target Groups reputational record of tendency to violent reactions made it extremely challenging to identify organizations ready to take tasks on. Nevertheless, some did respond and contribute or collaborate. There is a chart given below which results from this experience in proposing a structure that could function.

The first pilot took on 38 caretakers of mentally sick, while the second assisted 23 families with 41 mentally sick beneficiaries and 158 dependents. 14 packages of this type were granted to severely physically disabled persons.

Pilot Results: An impact assessment revealed good results (improved BMI and general health, decreased number of chained etc.). A pilot on NET (Narrative Exposure Therapy) produced encouraging results with high healing rates. Another pilot on medication treatment was done later and results are published.

Research impact on planning: Proposal for an integrated inter-agency and community based psycho-social assistance system

Led by the VIVO team on the ground and in close cooperation with other actors in the field (COOPI/GRT, UNA, WHO, the EC Somalia Unit, UNIFEM and UNDP), the project developed a proposal for an integrated inter-agency response (see attached chart) to the quantitative challenge encountered. Unfortunately, this approach was not followed on, as there was an attack on international project staff by a group of terrorists, which led to the withdrawal of the agency from the ground.



The key elements of this approach are designed around measures to build and strengthen community capacities to cope with the problems and to strengthen these through involvement and rehabilitation of basic local health facilities. COOPI's long standing experience with support to Berbera mental hospital (and others) and its out-patients support net through the local NGO Garvo had a major influence on the proposed scheme. Therefore, the COOPI/ GRT approach and experience merit attention.

Reintegrating ex-combatants and war widows in Somalia through awareness-creation by means of media proved to be a successful concept in the pilot projects. The monthly demobilization newsletter "Nabad & Caano", flyers and wallpapers played an important role in the successful reintegration of ex-combatants in Somaliland (highest edition printing in the country). Radio programs on practically every field activity have proven to facilitate implementation a lot. TV covered activities equally, but reaches only a low number of potentially more influential people.

Budgeting and Costs: In the two pilot phases, costs of packages turned around 900 USD per capita. For an estimated statement of costs for reintegration support to former Somali militia, the program proposed Handicapped (25% mental and physical) 300\$, as part of an overall package cost of 1,780 \$ US, including food aid to 40% and TSN payments to all.

Strengths: The PS assessment and pilot program in Somaliland demonstrated several strengths. The intervention was implemented at the earliest possible entry point, which proved very beneficial to DDR planning. The assessment benefited from a well-developed questionnaire and well-trained enumerators. The holistic approach of the pilot proved to be very beneficial.

Weaknesses: Major weaknesses of this intervention included institutional weakness of national demobilization bodies and local administrations, weak capacity of local staff, unstable- or undecided beneficiaries, poor health status of beneficiaries and drug abuse, and violence against international staff. In terms of the assessments, accessibility proved very difficult, and planning was only based on estimates of actual numbers of combatants for central and south Somalia. Finally, but certainly worth noting, the Somaliland intervention was only a pilot and therefore implemented on a small scale and short time frame, falling short of addressing the high level of need in that region.

Summary: In the Somaliland case it was the discovery of the existence of an unexpected problem (mental health) that led project management with donor backing to seek for a specialized partner to look into the problem by doing a first assessment. The results of this first assessment were so surprising that they encouraged doing a second and more profound one. The problem identification by the assessment led to the design of a pilot intervention (trial) to see if it would be realistically feasible to address the problem. Positive experience with the trial allowed a second pilot to refine modules, which finally led to a complete review of the project objectives and change of focus, with services to be delivered to the sub-target group in severe need that was supposed to be excluded from program benefits in the first approach envisaged.

Case Study: Rwanda

Like the VIVO program in Somaliland, several studies conducted in Rwanda pointed to a growing need to address psychosocial issues among ex-combatants. A study commissioned by the RDRC¹² in 2005 revealed that disabled ex-combatants suffered from post-traumatic stress symptoms at a rate of 28.6 percent.¹³ A second study, published in March 2007, carried out interviews with former soldiers and the staff of the commission's medical department as well as several hospitals in order to identify service institutions in the country, which could provide support for people with mental health problems.¹⁴ This study identified a massive lack of resources and adequate training, effective evaluation, assessment and intervention approaches and identified lack of knowledge about mental health issues in both, decision makers as well as the general population.

The studies recommended the drawing in of expertise in order to improve mental health services for ex-combatants in Rwanda. Aside from general recommendations, like the involvement of more psychologists and psychosocial workers, the importance of interdisciplinary interventions, the development of specific services for mental health problems, and permanent psychosocial care during the entire demobilization process, the development of public awareness and educational programs concerning mental health, among other is suggested. Sensitization programs were also recommended to aim at communities as well as former combatants, and were thought to help develop an understanding in the society for mental health problems and for the fight against social stigmatization. The studies also suggested that training programs cover a wide variety of aspects of the psychosocial intervention, especially the therapeutic relationship, grief, the posttraumatic syndrome, stress and anger; instruments for evaluation and different approaches of intervention.

As a consequence of these findings, the TCG was invited to be held in Rwanda, a strategy to address the problem was developed and subsequent action taken, including a training handbook developed, health workers at several levels were trained, especially within the communities of reintegration, and more professional staff were hired to provide pre-medical screening and initial mental health services in the camps before discharge.

2.4 - Summary

The Rwanda project initially foresaw the identification of persons with needs for specialized mental health services by a medical assessment team composed of professionals and their subsequent referral to the existing and functioning public health system. This is usually seen as the ideal case. A sudden increase in exposure to extreme violence on the field of combat in DRC led to a dramatically deteriorating increase in the needs for care and treatment of the TG upon arrival. The UN, in its transit centers and the Rwanda Demobilization Programme reacted adequately, by boosting training of staff to be able to detect (UN) and also address PS issues

¹³ Karegeya, D. K. (2005), RDRC Base line and impact assessment – medical rehabilitation of disabled and chronically ill ex-combatants.

¹⁴ Muhorakeye, C. (2007), Le programme Rwandais de Démobilisation et de Réintégration – recherche psychosocial.

upfront in the Demobilization Centers. This represents a change in the approach as the adequate reaction to a sudden change in needs of clients.

Part 3 – Conclusions and Lessons Learnt

Psychological dysfunction is an effect of violence and its effects on humans can impair them temporarily or permanently and thus hamper their ability to reintegrate into a civilian society. Depending on the type and length of armed conflict, numbers of psychologically effected amongst exposed is significant and may be as high as 50% or beyond. For the type of conflicts with informal and proxy wars and armed groups fighting with very cruel operational modes and terrorist groups targeting randomly, numbers of psychologically suffering may be very high amongst civilians but also combatants.

Psychosocial issues are not necessarily easy to detect, though, depending on the type, people may have a well-developed sense for behavioral characteristics that are beyond the norm. Having the feeling that “something is not alright” with a person and knowing what exactly is the issue and needs to be done about it are two very different things. It is important to be aware of the fact that psychosocial needs vary according to individual experiences and context. Attention and programmatic flexibility are paramount to success.

Important challenges frequently encountered stem from a lack of awareness and understanding by actors, stakeholders or target group of a particular problem and its key issues. Often this is connected to a belief that the problem can be effectively addressed later or that it is “none of our business”, that “this” is a difficult but insignificant sub-fraction of the TG and it can therefore be put aside, that “this task” is development work to be taken on by specialized agencies and that addressing PS issues is long term engagement which can not be addressed in a post conflict or emergency settings. All of it is untrue! In reality, however, and particularly with regard to psychosocial issues in post-conflict settings, lack of awareness and understanding can be a costly and even deadly misstep for DDR stakeholders.

It is important, that programmers and implementers are aware of psychosocial issues, competent and equipped to identify and address them. Certainly, not all cases of unsuccessful use of reintegration support are due to psychosocial challenge, but many are. And many are not understood as such and attributed to absence of will and thus failure being the “deserved punishment.” DDR Programs must be prepared to address their needs and provide not only psychosocial assistance but also treatment (rehabilitation) as reintegration into civilian society is at risk to fail otherwise.

There should be no hesitation to draw in expertise in order to improve mental health services for ex-combatants. General recommendations provided to improve programmatic response to PS problems turn around the involvement of sufficient numbers psychologists and psychosocial workers, the importance of interdisciplinary interventions, the development or improvement of specific services for mental health problems, and permanent psychosocial care during the entire demobilization process, the development of public awareness and educational programs concerning mental health. Further, sensitization programs should aim at communities as well as

former combatants, and are designed to help develop a better understanding in the society for mental health problems and for the fight against social stigmatization. Training programs should cover a wide variety of aspects of the psychosocial intervention, especially the therapeutic relationship, grief, the posttraumatic syndrome, stress and anger; instruments for evaluation and different approaches of intervention” (Vivo). At times the shortage of empirical evidence data is felt as obstacle, as it might be difficult to make the case, especially towards donors. Experience with pilot implementation like the Somaliland case and integration into routine DDR like in the Rwanda cases may be helpful in that context.

Rwanda and Somaliland cases show that TGA probing for PS issues is best done very early on. From Somaliland, it is learned that it is possible to effectively and efficiently address (treat) the key psychological violence related impairment, the PTSD in a standalone DDR Project in a post conflict setting with no functioning mainstream structure for referral available. Another lesson is the importance of adjustment of reintegration support tools to local conditions and inter-agency cooperation and complementation. Copy and paste from other programs, following guidelines like the IDDRS are good for the initial steps of planning, a profound TGA/survey must provide data for more concrete planning, and pilots need to test and adjust the tools developed. Flexibility in packaging is important; best is tailoring to the individual level. Further, no activity at all can be done without sincere sensitization and public awareness. Stigmatization needs to be addressed by all means to allow social reintegration to happen. From the current Rwanda case it is learned that constant monitoring of the intake is very important. The recent developments in eastern DRC, directly impacting the repatriated XC to Rwanda make once more clear, that monitoring and evaluation of results is not enough, that it is also of high importance to constantly screen for changes in the needs of the intake caseload. Programs must permanently monitor the condition in which their clients report and must be able to adjust to changing needs. Once again programmatic flexibility is of high importance.

Regional programming and harmonization of programmatic approaches are good ideas and would improve regional social equality and reduce cross-border jealousies. However, as legal bases, cultural considerations, socio-economic and security conditions often drastically differ, implementation of such approaches remains challenging. For the MDRP attempt, results were beneficial to single country programs, but joint regional programming and harmonization of approaches did not materialize. However, later on in the course of project implementations, knowledge (and experience) transfer happened between Rwanda and Burundi (on handicapped housing).

Part 4 – Recommendations for Future Programming

1. Early incorporation of PS into DDR

It is recommended to start as early as possible in the program/project, or the program/project to be designed. The ideal case is a pre-disarmament assessment, in which armed belligerents, either encamped or not, are visited by assessment teams, undergo voluntary interviewing, and, in the ideal set of all cases also registration. It depends on the kind of conflict, type of armed participants, mindset, ideology, experience etc., if, or if not, they will be open to such an

exercise. The fact that it was possible to do this with 8,132 active militia belonging to 39 known factions and additional unknown armed groups in the Somalia of 2003/4 should be encouraging to give it a try anywhere else. The data concerning war-related trauma, drugs, other psychological problems and gender-related questions of reintegration were analyzed proved to be rich and enormously helpful as what concerns planning of activities and budgeting.

There is a clear need emerging to take psychosocial needs into account from the very beginning of planning of interventions, as have done the world bank in its large African DDR, and as the IDDRS also recommend. Planners need to bring along a good understanding of the issues. A thorough assessment needs to be done as early as possible, best before the concrete planning starts so that the data acquired can help direct the planning. Certainly, this will be challenging in some settings. But, it was done in the past. Thus, proof is at hand that it can be done. Best practice is pre-disarmament assessment and registration, which delivers qualitative and quantitative data. Intervention planning is best if based on concrete data. Psychological and social assistance require qualified staff and training of local paramedical and medical professionals, which means time to prepare beforehand.

2. Integration of mental health expertise and professional assessment

Normal is that roughly one percent of any given population is suffering from psychological conditions, equally shared between females and males. Any finding beyond this would be an indication for something beyond the norm. In most cases, there will be knowledge about a conflict history and reports about violence exposure. Typically, there will also be anecdotal record of abnormal behavior patterns amongst population or certain groups. The way to find out more is through professional assessment that will capture facts, identification of persons with special needs, their registration for tracing and follow up, referral to competent service providers (if in place) or setting this up, professional treatment and follow-up, best practice will establish and assure care takers providing assistance. Society preparation, sensitization and participation are crucial for success.

3. Offer variety of specialized, flexible support for mentally vulnerable groups

On the well performing end, Rwanda was amongst the programs that had triggered the TCG with important studies indicating the need for something serious to be done, and it was amongst the programs that implemented a number of recommendations. It also had its DDR specific strategy framework developed in the course of this event. wSome of the Rwandan beneficiaries with identified psychological needs managed to draw from a whole set of specialized support for vulnerable groups: pension, handicapped housing, physical medical rehabilitation and psychosocial support and mental health treatment, besides the usual economic reintegration assistance support.

4. Targeting drug abuse and depression

Drug Abuse should be part of any discussion on mental health. Substance abuse, such as alcohol, hashish, khat, tablets and cigarettes, is by far the most predominant cause of preventable premature illness and death in society. Ex-combatants in different countries around the globe have a higher than average prevalence of substance abuse. Consequences of traumatic

experiences, in combination with the impact of drugs, may produce psychosomatic symptoms and reduced intellectual skills, making the concerned even more vulnerable for unemployment and poverty.

Annexes

A1. Terms and Definitions¹⁵

Psycho refers to the inner person – one’s thoughts, feelings, attitudes, values and beliefs.

Social refers to the person’s external relationships with his/her environment.

Functioning refers to the daily tasks; behavior and duties people have given individual roles, context and background.

Resilience refers to individual resources and experiences; everything a person can, has and is.

Trauma is a Greek word for “wound” applying both for body and soul.

Psychological “trauma” is the experience of events that are life- threatening or include a danger of injury so severe that the person is horrified, feels helpless etc.

Traumatic events might cause a medical condition that requires treatment (therapy) most frequently PTSD, but co-morbid with other disorders

A2. Further Information on mental health issues connected with PTSD

Major Depression

A long-lasting feeling of sadness, weakness, guilt and hopelessness indicates Major Depression. People with serious depressions say they see their lives as pointless. They feel slowed down, burned out and useless. Some even lack the energy to move or eat. They doubt their own abilities and often look at sleep as an escape from life. Many think about suicide, a form of escape from where there is no return. Other symptoms that characterize depressions are sleeplessness, loss of self-esteem, inability to feel pleasure in formerly interesting activities, apathy and fatigue. Given the high rates of PTSD (see above) it is understandable why Rwanda also has a relatively high prevalence of depression (~15 percent), at least among adults (Bolton et al., 2002). These estimates are based on careful research using culturally appropriate measures (Bolton, 2001a).

Suicidality

Major Depression Disorder is associated with high mortality. Up to 15 percent of individuals with severe Major Depression Disorder eventually commit suicide. Even though Suicidality is not a psychological disorder in itself, it is often associated with depressive symptoms, but also with symptoms of posttraumatic stress or grief. Suicidal persons have the wish to die or to be dead; this wish might be indefinite or very concrete (with suicide plans). The wish to be dead might manifest itself in different ways e.g.: being so sad that one believes it is impossible to bear the feeling any longer; having no interest or energy to take part in life any longer; seeing no meaning

¹⁵ The Basics: Definitions (taken from Hinkel & Winkler, 2012)¹⁵

in life, having no positive thoughts about the future; wishing to be reunited with a deceased person; having the feeling that life is too difficult to deal with it, such as in circumstances of domestic violence, abuse, war, poverty etc.

Drug Abuse

Drug Abuse should be part of any discussion on mental health. Substance abuse, such as alcohol, hashish, khat, tablets and cigarettes, is by far the most predominant cause of preventable premature illness and death in society. Ex-combatants in different countries around the globe have a higher than average prevalence of substance abuse (Kulka et al., 1990, McFall et al., 1992; Odenwald et al., 2005). In studies in Somalia, the NGO vivo (Odenwald, M., Lingenfelder, B., Schauer, M., Neuner, F., Rockstroh, B., Hinkel, H. and Elbert, T.; Screening for Posttraumatic Stress Disorder among Somali ex-combatants: A validation study. (2007) has shown that ex-combatants with PTSD also have a different drug abuse profile, e.g. longer duration, higher quantity of abuse, separation from social group during drug intake. The drug habit in psychologically affected persons often begins in the belief that one can use the substance to “self-medicate” the painful emotional and bodily feelings that accompany mental illness. This belief is mistaken, because substance abuse only relieves short term, in the long run original symptoms worsen, for example posttraumatic symptoms exacerbate (Savarese, Suvak, King et al., 2001) and the drug itself introduces its own range of emotional and physical anguish and side effects. Consequences of traumatic experiences, in combination with the impact of drugs, may produce psychosomatic symptoms and reduced intellectual skills, making the concerned even more vulnerable for unemployment and poverty.

Appetitive Aggression

Former combatants may enjoyed fighting and like to see their victims suffer. They not only got used to violence, but, enjoy it and develop a need to be increasingly cruel (Elbert et al in prep).

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