PSYCHOSOCIAL SUPPORT MODEL
for
CHILDREN ASSOCIATED WITH
ARMED FORCES & ARMED
GROUPS IN NEPAL

Transcultural Psychosocial Organization-TPO Nepal
Kathmandu
Psychosocial Support Model for Children Associated With Armed Forces and Armed Groups in Nepal

Peace of Mind
ACKNOWLEDGEMENT

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ACRONYMS

AIDS  Acquired Immune Deficiency Syndromes
ANM  Auxiliary Nursing Midwife
AUC  Area Under the Curve
C4P  CAAFAG 4 Principle
CAAC  Children Affected by Armed Conflict
CAAFAG  Children Associated with Armed Forces and Armed Groups
CAAFAGWG  Children Associated with Armed Forces and Armed Groups Working Group
CBO  Community Based Organization
CHS  Child Hope Scale
CLI  Child Led Indicator
CMA  Community Medical Auxiliaries
CPDS  Child Psychosocial Distress Screener
CPN-M  Communist Party of Nepal- Maoist
CPSS  Child Post Traumatic Symptoms Scale
CPSW  Community Psychosocial Worker
CRC  Convention on the Rights of the Child
DDR  Disarmament, Demobilization and Reintegration
DF  Daily Functioning
DPC  District Psychosocial Counselor
DSM  Diagnostic and Statistical Manual of Mental Disorder
DSRS  Depression Self Rating Scale
FCHV  Female Community Health Volunteers
GAPD  Global Assessment of Psychosocial Disability
HA  Health Assistant
HIV  Human Immunodeficiency Virus
HMG  His Majesty’s of Government
HPW  Health Post Workers
IASC  Inter Agency Standing Committee
ICD  International Classification of Diseases
ICRC  International Committee of the Red Cross
INGO  International Non Governmental Organization
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>IRC</td>
<td>International Rescue Committee</td>
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<tr>
<td>KII</td>
<td>Key Informant Interview</td>
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<tr>
<td>LAMIC</td>
<td>Low and Middle Income Countries</td>
</tr>
<tr>
<td>MHPS</td>
<td>Mental Health and Psychosocial</td>
</tr>
<tr>
<td>MoHP</td>
<td>Ministry of Health and Population</td>
</tr>
<tr>
<td>NFGD</td>
<td>Narrative Focus Group Discussion</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>PA</td>
<td>Physical Aggression</td>
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<tr>
<td>PLA</td>
<td>People Liberation Army</td>
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<tr>
<td>PNGO</td>
<td>Partner Non Governmental Organization</td>
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<td>PRA</td>
<td>Participatory Rural Appraisal</td>
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<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
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<td>PWG</td>
<td>Psychosocial Working Group</td>
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<td>RNA</td>
<td>Royal Nepalese Army</td>
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<td>ROC</td>
<td>Receiver Operator Characteristics</td>
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<td>SC</td>
<td>Save the Children</td>
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<td>SCARED</td>
<td>Screen for Child Anxiety Related Emotional Disorder</td>
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<td>SF</td>
<td>Security Force</td>
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<td>SPA</td>
<td>Seven Party's Alliances</td>
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<td>SPSS</td>
<td>Statistical Package for Social Science</td>
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<td>TADA</td>
<td>Terrorist and Disruptive Activities Control Act</td>
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<td>TPO</td>
<td>Transcultural Psychosocial Organization</td>
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<tr>
<td>UNDP</td>
<td>United Nation Development Program</td>
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<td>UNHCR</td>
<td>United Nation High Commissioner for Refugees</td>
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<td>UNICEF</td>
<td>United Nation Children Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WVI</td>
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**Nepal Context, Psychosocial Principles and Concepts**

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SECTION - I

Nepal Context, Psychosocial Principles and Concepts
Chapter 1 Goals – The goals of this chapter are:

(i) to describe the purpose for this book as demonstration of developing evidence-based psychosocial interventions,

(ii) to provide background context on the People’s War in Nepal, and

(iii) to introduce key concepts: children associated with armed forces and armed groups (CAAFAG), psychosocial, mental health, social ecology, resilience, and war-in-context.

This general overview and introduction of key concepts sets the stage for readers to understand the significance of the research and intervention described in the book.

1.1 Introduction

The objective of this book is to provide an overview of children associated with armed forces and armed groups (CAAFAG) in Nepal focusing on their psychosocial needs, the development of a psychosocial intervention grounded in local research, and the implementation and evaluation of this intervention. Our hope is that this information may be of specific value to those working with CAAFAG in Nepal and also more broadly provide an approach for psychosocial practitioners working in other context helping CAAFAG around the world.

One of the most pressing issues in conflicts around the globe is the exploitation of children by armed groups. An estimated 300,000 children are members of state militaries and other armed groups (UNICEF, 2003, p.4). These children—sometimes referred to as child soldiers—are identified by humanitarian organizations as “children associated with armed forces or armed groups” or CAAFAG (UNICEF, 2007). The dedicated efforts of humanitarian organizations,(UNICEF, 1997) psychosocial workers,(Wessells, 2006) and former child soldiers,(Beah, 2007; McDonnell & Akallo, 2007) have called international attention to this issue. However, there are major gaps in understanding of CAAFAG needs and the design and implementation of psychosocial interventions for
CAAFAG. (Betancourt et al., 2008) This book outlines how we addressed these gaps in the context of Nepal.

- First, CAAFAG are considered to be in need of special psychosocial intervention. However, there is a lack of research in many settings where interventions have been conducted. The specific psychosocial problems and support needs of CAAFAG have rarely been systematically researched before implementing interventions. In addition, there is a lack of research comparing the severity of psychosocial problems among CAAFAG with children living through war who were not conscripted to armed groups. (Betancourt et al., 2008; Dowdney, 2007; Kuruppuarachchi & Wijeratne, 2004; Magambo & Lett, 2004) Without assessing these differences it is difficult to justify special services for CAAFAG as a group rather than aiding children affected by armed conflict with psychosocial problems regardless of their role during the conflict. Unpublished studies of nongovernmental organizations suggest there may not be a difference between the groups. (Betancourt et al., 2008; Blattman, 2006) Therefore, we sought to identify the specific needs of CAAFAG in Nepal and to determine if they differed from other children experiencing the conflict in Nepal.

- Second, there is a risk of a lack of connection between CAAFAG experiences and needs and the interventions provided to them. Child soldiers represent a challenging population for mental health and psychosocial support (MHPSS) as we have little evidence regarding their needs or efficacy of interventions. Despite an increasing breadth of MHPS interventions for children affected by war, very few are supported by evidence (Jordans et al., 2009). Often, interventions are chosen for pragmatic reasons, e.g. they are available and have been used in other settings. In contrast, there is a need for interventions that are appropriate for local context. Therefore, the second goal of our work in Nepal was to transform research into locally specific and appropriate interventions.

- Third, interventions typically undergo monitoring and evaluation, but there is often a lack of scientifically rigorous comparison of intervention participants wellbeing before and after an intervention. At the time our work began in Nepal, there had been no evaluations of the short-term changes in psychosocial wellbeing of CAAFAG before and after a psychosocial intervention. Thus, our third goal was to evaluate the impact of a psychosocial intervention for CAAFAG in Nepal.
The context for this work with CAAFAG in Nepal was “The People’s War,” an eleven-year war between the government of Nepal and People’s Liberation Army (PLA), the military wing of the Unified Communist Party of Nepal-Maoists (CPN-M). Both the government army (the Royal Nepal Army) and the PLA recruited thousands of individuals under 18 years of age into their fighting forces. When the war ended in 2006, the peace accords signed between the CPN-M and government of Nepal called for the reintegration of minors from armed groups into civilian roles in their communities.

To facilitate the reintegration of CAAFAG, UNICEF and other organizations formed the CAAFAG Working Group. Transcultural Psychosocial Organization (TPO-Nepal) participated by contributing research on the psychosocial status of CAAFAG, developing interventions based on this research, training other organizations to implement the psychosocial intervention, and then evaluating the impact of the intervention on psychosocial wellbeing of CAAFAG. This book records these processes.

This book is divided into three sections. The first section provides background on information to place the research and intervention in context. In this introductory chapter of the background section, we present an overview of the Nepal context, introduce the major concepts of the book, and outline the overall process of the research, intervention, and evaluation. In the second chapter we provide additional information on psychosocial concepts of care, social ecology, and ecological resilience. The third chapter of the background section describes the ethical approach and methods employed, including participatory approaches, to understand the experience of CAAFAG in Nepal.

The second section provides three main areas of research findings. The first chapter of the research section describes the conscription of children into armed forces and armed groups. The second chapter describes CAAFAG experiences during association with armed groups, including exposure to war-related traumas. In the third chapter of the research section, we describe the reintegration experience prior to the intervention. This chapter highlights how CAAFAG were supported and or discriminated against upon their return to the community. In the final section of this chapter, we describe psychosocial mapping research in which we identified the existing psychosocial programming in the community in order to identify gaps and areas for augmentation.
The final section describes the psychosocial intervention. First, we outline how the research findings were translated into the intervention design. We then describe the implementation of the intervention. Finally, we describe the evaluation of the intervention and how it impacted CAAFAG and other direct and indirect beneficiaries. The book concludes with a discussion of the lessons learned and pathway forward to meeting the needs of CAAFAG in Nepal and in other settings affected by armed conflict around the world.

1.2 Conflict in Nepal: “The People’s War”

Throughout the past eleven years, both security forces of the Government of Nepal and the Communist Party of Nepal-Maoists (CPN-M) have involved children in political violence. Although children associated with armed groups are often referred to as “child soldiers”, armed groups in Nepal have used children as performers in cultural programs, messengers, porters, cooks, spies, and sentries, as well as soldiers.

Nepal is a landlocked country north of India and south of the Tibetan autonomous region of China, with a population of almost 28 million. Nepal’s history represents a legacy of political, economic, and cultural processes that have marginalized large sectors of the population who recently have become the backbone of the Maoist revolution. Nepal ranks 142 on the human development index—near the bottom of the medium human development category (UNDP, 2007). This rank conceals strong inequalities by region (e.g., in agricultural production), gender (e.g., in literacy), and urban versus rural areas (e.g., in infant mortality) (Government of Nepal, 2007). Thirty-one percent of the population lives below the poverty line. Moreover, Nepal has the highest income gap between rich and poor in Asia with the Gini coefficient having increased from 0.34 to 0.41 in the past decade (World Bank, 2007). Nepal’s population comprises more than 60 ethnic and caste groups, with a long history of hegemonic dominance by the Hindu high castes (Bahun and Chhetri) of minority ethnic groups (Janajati, who are predominantly Buddhist and shamanist) and also of those deemed to be low caste (Dalit). Although

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some of Nepal’s ethnic groups have rejected caste ideology, no group has remained uninfluenced by it.

Nepal was unified as a Hindu monarchy in 1769. Against the backdrop of the autocratic Rana regime, the Communist Party of Nepal (CPN) was founded in Kolkata, India in 1949. From the 1960s through 1980s, the CPN split into multiple factions, which were involved in the fight for a multi-party democracy. In 1990 Nepal became a multiparty democratic Hindu monarchy. The CPN (Unity Center), which formed in 1991 and included Prachanda and Babu Ram Bhattarai, rejected the November 1990 constitution promulgated by the king, referring to it as an inadequate basis for a genuine democracy. They continued to demand a constituent assembly with a plan for drafting a new democratic constitution and eventually the formation of a People’s Republic of Nepal (Karki and Seddon 2003). In 1994, CPN (Unity Center) divided into two parties: the CPN (Unity Center) and the Maoist party CPN (M). The latter Maoist party headed by Prachanda boycotted the elections.

Table 1.1 Overview of Nepal’s Political History and the People’s War

<table>
<thead>
<tr>
<th>Period</th>
<th>Events</th>
</tr>
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<tbody>
<tr>
<td>1740–1769</td>
<td>Prithvi Narayan Shah conquers disparate fiefdoms, establishing the kingdom of Nepal. The country is subsequently ruled as a hereditary Hindu monarchy of the Shah dynasty.</td>
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<tr>
<td>1846–1950</td>
<td>Rana family seizes power, and takes on an autocratic hereditary prime minister role with King from Shah family as figurehead.</td>
</tr>
<tr>
<td>1949</td>
<td>The Communist Party of Nepal (CPN) is formed in India.</td>
</tr>
<tr>
<td>1950–1951</td>
<td>Armed insurrection by the Nepali Congress with support from the fled King Tribhuvan leads to peace negotiations which end Rana autocracy. Multi-party democracy is established in Nepal.</td>
</tr>
<tr>
<td>1960–1990</td>
<td>King Mahendra seizes power and introduces the Panchayat system in 1962, which bans political parties. Political parties go underground often mobilizing through student organizations.</td>
</tr>
<tr>
<td>1990–1996</td>
<td>Parties unite and start the first People’s Movement (Jana Andolan). Start of politically unstable multi-party democracy</td>
</tr>
<tr>
<td>1995</td>
<td>The Communist Party of Nepal (Maoists), CPN(M), is formed when Puspha Kamal Dahal (aka Prachanda) splits off from the Communist Party of Nepal (Unity Center).</td>
</tr>
<tr>
<td>Period</td>
<td>Events</td>
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<tr>
<td>1996</td>
<td>CPN (M) issues 40-point demand to His Majesty’s Government of Nepal. When the demand is not addressed, the CPN(M)’s military wing, the People’s Liberation Army (PLA), under the leadership of Chairman Prachanda begins the “People’s War” on February 13th with PLA attacks on police posts and a state-owned agricultural development bank in five districts.</td>
</tr>
<tr>
<td>2001</td>
<td>Majority of royal family is killed in the Royal Massacre. Official reports blame Crown Prince Dipendra; however, public suspicion of conspiracy by king Gyanendra is widespread. Government imposes a State of Emergency in November, after a series of Maoist attacks on police and army targets. Army deployed systematically for first time and armed violence intensifies greatly.</td>
</tr>
<tr>
<td>2002</td>
<td>His Majesty’s Government (HMG) of Nepal institutes Terrorist and Disruptive Activities Control and Punishment Act (TADA) restricting civil liberties throughout the country, followed by massive disappearances throughout the country and widespread use of torture by government security forces; The United States Congress approves US$12 million to train RNA officers and supply 5,000 M-16 rifles.</td>
</tr>
<tr>
<td>2005</td>
<td>In February, King Gyanendra dissolves parliament and enforces curb on independent media. Scores of senior political leaders, journalists, trade unionists, human rights activists and civil society leaders are arrested in the following days. Government cuts telephone and internet connections. In September, the CPN (Maoists) declares a three-month unilateral ceasefire in an attempt to forge ties with opposition political parties. In November, after negotiations, the Maoist rebels agree to work with opposition politicians as a common front against King Gyanendra’s direct rule. 12-point agreement signed between the seven-party alliance and CPN (Maoists) in New Delhi.</td>
</tr>
<tr>
<td>2006</td>
<td>Coordinated protests by political parties and Maoists in April 2006 (Jana Andolan II). Political parties and the CPN(M) broker fragile peace agreement. In November, Top leaders of the Seven Party Alliance and Chairman Prachanda sign a landmark deal on arms management and political issues like constituent assembly, interim government and interim parliament; Prime Minister Koirala on behalf of the Seven-Party Alliance government and Chairman Prachanda sign peace accords ending the decade-long People's War.</td>
</tr>
<tr>
<td>2007</td>
<td>An interim government is formed with an an interim constitution, which designates Nepal as a federal republic. King Gyanendra is removed from power, ending the monarch and nearly two and half centuries of the Shah dynasty.</td>
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<tr>
<td>2008</td>
<td>Elections for a constituent assembly take place in April 2008 and CPN(M) becomes largest party. Prachanda, Supreme Commander of the CPN(M), becomes the first prime minister of Nepal as a federal republican nation.</td>
</tr>
<tr>
<td>2009</td>
<td>A coalition government, led by the CPN(M), falls in relation to ongoing dispute over the integration of former Maoist combatants in the national army. Prachanda steps down as prime minister. Political instability continues.</td>
</tr>
</tbody>
</table>
In January 1996, Babu Ram Bhattarai presented a 40-point demand on behalf of CPN (M) to the Nepali government headed by the Nepali Congress party leader Sher Bahadur Deuba. The points dealt largely with rectifying economic and social injustice, abolishing monarchy, and establishing a constituent assembly, and have been described by several non-partisan commentators in terms such as, “reasonable and not dissimilar in spirit to the election manifestos of mainstream parties,” (Thapa & Sijapati, 2004). Bhattarai insisted that if no progress was made towards fulfillment of the demands by 17 February 1996, they would have no choice but to resort to armed struggle against the existing state. When these demands were not addressed, the CPN (M) went underground and began its agrarian revolution. On February 13, 1996, (four days before expiration of their deadline) the CPN (M) declared a People’s War in Nepal, issuing a leaflet that called on the people of Nepal to “March along the path of the People’s War to smash the reactionary state and establish a new democratic state.” Violence commenced with the CPN (M) attacking police posts and a state-owned agricultural development bank.

Over 13,000 people were killed during the People’s War, with the majority of deaths at the hands of the Royal Nepal Army and the government’s police force (Mehta, 2005). The war ended in November of 2006, when the CPN (M) signed a peace treaty with the government, which led to the inclusion of the CPN (M) in the national government. During the April 2008 elections, the CPN (M) won a relative majority and now is the largest party in the constituent assembly.

During the war, children were recruited into the CPN (M)’s People’s Liberation Army (PLA) and the Royal Nepal Army as soldiers, sentries, spies, cooks, and porters (Human Rights Watch, 2007). Local groups estimate that at the conclusion of the war approximately 9,000 members—one-third of the PLA—comprised fourteen to eighteen year olds with 40 percent being girls (Human Rights Watch, 2007), an even greater percentage of PLA soldiers now over the age of eighteen years likely had joined before they were eighteen. Ten percent of the Royal Nepal Army during the conflict was below the age of eighteen (Singh, 2004).

Promoting psychosocial well-being is central to peace building on a social level by reducing the risk of continued political violence, reducing the spread of political violence to the domestic and criminal spheres, and reducing retaliatory cycles of violence. Furthermore, addressing psychosocial needs reduces psychological distress such as substance abuse, harm to self, and other forms of emotional suffering.
The CAAFAG Working Group in Nepal conducted a rapid assessment of children associated with armed groups and the community perceptions of the children’s reintegration (CAAFAG Working Group, 2006). This report highlighted psychosocial issues of returned children. Psychosocial problems as identified in the rapid assessment include trauma, stress, children being lost in themselves, difficult behavior, interruption of studies, anger, aggressiveness, crying, shouting, and being rude. Fear was mentioned repeatedly including both generalized fear and specific fear of retaliation and being beaten by seniors. The report also includes positive psychosocial functioning of returned children: increased interest in school, positive thinking, and being clever. The report listed psychosocial factors that placed children at risk for recruitment to armed groups, for example, “lack of success in studies, family internal relationship problems”, “social inequality”, and “poverty, discrimination, and poor family environment.” The report suggested that children were at risk of physical torture and sexual harassment. Community members reported that girls associated with armed groups have been sexually exploited, were forced to have abortions. The report identified community psychosocial resources such as building relationships and supports at the community level, information sharing, awareness raising, community leaders facilitating forgiveness, and emotional support in the form of social acceptance as practiced through clubs and groups.

The findings from the CAAFAG WG rapid assessment provided an important first look at the psychosocial distress of returned children. However, to date, the severity and prevalence of psychosocial problems among returned children have not been documented. Nor has there been a comprehensive investigation of the risk factors for psychosocial distress and the community resources available to reduce and prevent psychosocial distress. This report based on research conducted by Transcultural Psychosocial Organization (TPO) Nepal addresses specifically these issues then provides recommendations for activities at the community level to promote psychosocial well-being among returned children.

1.3 Major Concepts

Children Associated with Armed Forces and Armed Groups (CAAFAG)

The term CAAFAG has been considered preferable to child soldier because the former term is thought to be more inclusive. The 2007 Paris Principles refer to child soldiers as “children associated with armed forces or armed groups” (CAAFAG) meeting the following criteria:
Any person below 18 years of age who is or who has been recruited or used by an armed force or armed group in any capacity, including but not limited to … fighters, cooks, porters, messengers, spies or for sexual purposes. It does not only refer to a child who is taking or has taken a direct part in hostilities. (UNICEF, 2007, p.7)

We follow this Paris Principles definition in referring to CAAFAG throughout this book. Thus, children who joined the People’s Liberation Army were considered CAAFAG regardless of whether they were performers in Maoist cultural programs, soldiers, or any other role.

*Child*

The Convention on the Rights of the Child (CRC) refers to children as persons less than eighteen years of age. Article 1 of the CRC defines children:

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, maturity is attained earlier. (United Nations, 1989)

However, the local conceptualizations of ‘child’ vary significantly based on local cultural, legal, educational, and economic processes. For the purpose of consistency with international approaches, in this book we refer to children as anyone under the age of 18 years. This, however, is inconsistent with legal definitions of children in Nepal. In Chapter 1 of the Children’s Act of 2048 B.S. (1992 A.D.), "child" means a minor not having completed the age of sixteen years (His Majesty’s Government, 1992). Under the Children’s Act, parents are obliged to provide persons under sixteen years of age with education, healthcare, and “maintenance and upbringing,” (Chapter 2, Article 4). Chapter 2, Article 11, deals with children and criminal liability. The article states,

1) If a Child below the age of 10 years commits an act which is an offence under a law, he shall not be liable to any type of punishment.

2) If the age of the Child committing an offence which is punishable with fine under law, is 10 years or above and below 14 years, he shall be admonished and convinced and if the offence committed is punishable with imprisonment, he shall be punished with imprisonment for a term which may extend to six months depending on the offence.
3) If a Child committing an offence is 14 years or above and below 16 years, he shall be punished with half of the penalty to be imposed under law on a person who has attained the age of maturity.

4) If a Child commits an offence under advice or influence of any person, the person doing such act shall be liable for full punishment as per the law as if he/she has committed such offence. (His Majesty's Government, 1992)

Terminology for “child” also varies significantly in Nepali—as in most languages. The term chosen for “child” in this book typically refers to the Nepali term baalbaalikaa because when CAAFAG is translated into Nepali, ‘child’ is translated as ‘baalbaalikaa’. This term is the combined referral to boys (baalak) and girls (baalikaa) and based on the root for child (baal). Baalbaalikaa is the term used by NGOs in conducting programming for children affected by armed conflict. The term bacchaa is commonly used in Nepali, however, this more commonly is used locally to refer to babies. Another common term in political discourse is the term for youth (yubak/ yubaa). However, this is commonly used to also include individuals in their twenties and thirties. In this book, we provide more details of age cut-offs or language when referring ‘child’.

IASC Guidelines

Throughout this book we refer to the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007). This document provides an overview the prioritized areas for assessment, coordination and intervention in conflicts, natural disasters, and other complex emergencies. The research and intervention work with CAAFAG in Nepal has been done in coordination with these IASC Guidelines.

Mental Health and Psychosocial Support (MHPSS)

There is no single definition of mental health. The World Health Organization (WHO) defines mental health as:

> a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (World Health Organization, 2005)
The most cited definition of “psychosocial” is the one agreed upon by members of the Interagency Psychosocial Working Group and INGO’s during a meeting in Nairobi in 1997 (UNICEF, 1997). In that definition, it is explained that

Psychosocial refers to the dynamic relationship that exists between psychological and social effects, each continually inter-acting and influencing the other. (UNICEF, 1997)

Given these definitions, it may be challenging to distinguish between the terms of psychosocial and mental health. The Psychosocial Working Group definition adds that the concept of psychosocial is broader than ‘mental health’:

The term 'psychosocial' is used to emphasize the close connection between psychological aspects of our experience (our thoughts, emotions and behavior) and our wider social experience (our relationships, traditions and culture). The two aspects are so closely inter-twined in the context of complex emergencies that the concept of 'psychosocial wellbeing' is probably more useful for humanitarian agencies than narrower concepts such as 'mental health'. (Psychosocial Working Group, 2003a)

The IASC Guidelines provide additional information on possible distinctions between mental health and psychosocial:

For many aid workers these closely-related terms reflect different, yet complementary, approaches. Agencies outside the health sector tend to speak of supporting psychosocial well-being. People working in the health sector tend to speak of mental health, but historically have also used the terms psychosocial rehabilitation and psychosocial treatment to describe non-biological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organisations, disciplines and countries. (IASC, 2007, p.16)

Ultimately, in order to deal with the significant overlap and lack of clear boundaries between the terms, the IASC Guidelines employ the combined term: “mental health and psychosocial support.”

Mental health and psychosocial support (MHPSS) is a composite term used in these guidelines to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. (IASC, 2007, p.16)
In this book, we have chosen to predominantly employ the term *mental health and psychosocial (MHPS)* when referring to wellbeing of CAAFAG. When referring to the intervention, however, we employ the term *psychosocial* because of its more salient association with generalized interventions rather than ‘mental health’ interventions because the latter is more commonly associated with health-sector and possible pharmacologic interventions as mentioned above. Figure 1.1 presents the public health pyramid for mental health psychosocial interventions. In Chapter 2 of this book, we go into significantly greater detail on the concept of psychosocial and the intervention pyramid.

![Figure 1.1 Intervention Pyramid for Mental Health and Psychosocial Support. Adapted from (IASC, 2007, p.12) and (Jordans et al., 2010).](image)

Psychosocial support includes a range of activities. Psychosocial support can affect the greatest number of children through group activities such as classroom based interventions, peer support groups, sporting and athletic activities that include a psychosocial framework, sensitization and awareness programs with a psychosocial message, and family/community group activities that are guided by psychosocial principles. Psychosocial support also includes one-to-one activities such as counseling. However, counseling is best utilized for a small number of children who have met screening and referral criteria. Moreover, counseling can only be provided by trained counselors who have received significant training with supervisions by a trained counseling supervisor. It is also important to note that psychosocial activities should not be stand-alone programs. Rather, a psychosocial framework should be included in all reintegration activities for CAAFAG.
Social Ecology

The theoretical framework for understanding child MHPSS in our work with CAAFAG in Nepal is rooted in the concept of ‘social ecology’. Ecology refers to the study of interactions between organisms and their environment (Haeckel, 1866). Social ecology, originally developed to highlight the role of human social problems in producing environmental problems (Bookchin, 1990), emphasizes that a dominant component of the human environment are other humans, this is especially true for man-made conflict and for the experience of children, whose experiences are shaped by their social worlds. Bronfenbrenner (1979) originated ecological systems theory to describe child development within different nested levels of the social world. Psychologists, social workers, social scientists, and policy makers have used social ecology to develop models and design interventions for general child development and the prevention of child maltreatment (Bronfenbrenner, 1979; Cicchetti & Lynch, 1993). Increasingly, there is attention to social ecology of child soldiers and other children affected by armed conflict (Boothby et al., 2006; Cummings et al., 2009b). The Psychosocial Working Group (2003b) included social ecology as one of the central three domains of psychosocial wellbeing.

Nested interacting spheres of social relationships that determine individual behavior and wellbeing are the fundamental components of analysis in social ecology (see Figure 1.2). At the outer levels of the nesting (macro-system), social, political, economic, and religious institutions dictate the type, quality, and frequency of social interactions. These institutions, therefore, shape how families, school staff, students, and community members interact with each other and with the developing child (Exosystem). The most intimate and strongest influence is ultimately between the family and child (micro-system). There are different types of violence at each level (Cummings et al., 2009a).

![Figure 1.2 Ecological Levels and Violence Typology](image-url)
Ecological Resilience

A focus on psychosocial wellbeing in an ecological framework is the basis for understanding ecological resilience. Resilience refers to the ability to return to normal after receiving a stress. In the case of psychosocial well-being and armed conflict, "resilience" refers to the ability of children, their families, and their communities to maintain and/or restore psychosocial well-being in the face of violence, disruption of the social fabric, and other socio-economic-political changes that occur as a result of political violence. Ecological resilience refers to “those assets and processes existent on all social-ecological levels that have shown to have a relationship with good developmental outcomes after exposure to situations of armed conflict,” (Tol et al., 2009). Thus, social-ecology frameworks can be used to design interventions that build resiliency within the broader social world of developing children affected by armed conflict. The intervention described in section three of this book is grounded in this approach of supporting CAAFAG by fostering healthy social ecological support systems.

War in Context

The final core concept is “war in context.” With the horrors of war such as abduction, torture, bombings, and sexual violence, it is not surprising that these issues are a priority when considering psychosocial interventions for CAAFAG and other children affected by armed conflict. However, it is very important to remember that children have lives and experiences beyond these war-related traumas. While war trauma may be a top priority for outside intervention and other humanitarian workers, the most important factors for children could also be experiences outside of the war. These may be experiences prior to association with an armed group or experiences after one has returned home after the period of conscription (see Figure 1.3). For example, the experience of domestic or sexual violence in the home as well as poverty, lack of education, and inability to meet basic needs may have made a child vulnerable to recruitment by armed forces. And, these factors may be as important or in some cases more important to CAAFAG MHPSS than war traumas. Experiences after war and during reintegration are also significant factors related to MHPSS. For some children, the discrimination and rejection upon returning home may be more distressing than sometimes distant traumas of war.

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These pre-war and post-war experiences are also very important sources of support, wellbeing, and resilience. Therefore, the goal of the research and of the intervention was to take children’s life broadly into account rather than solely focusing on war-related experiences. This helps to understand the most important contributors to MHPSS and the ideal foci for intervention. While it is not possible to change the experience of war trauma, interventions can influence the social experience after returning home.

Figure 1.3 War in Context: Developmental and Historical Context of Children’s Lives.

1.4 Conclusion

CAAFAG represent a potential vulnerable group who need special psychosocial intervention. The key to properly addressing these putative needs are to employ a psychosocial framework, to begin with research, to ground intervention in research, and to evaluate to the impact of intervention to determine remaining unmet areas as well as foci of successes. We hope that the following chapters outline how this process was done in Nepal and provides a framework to consider similar approaches in other settings.
KEY CONCEPTS

1.1 Psychosocial interventions should be rooted in research of the local needs and resources of children associated with armed forces and armed groups (CAAFAG).

1.2 Mental health and psychosocial support (MHPSS) refers to the aspects of wellbeing ranging from individual psychological conditions to social relationships and the interaction of these factors.

1.3 Social ecology refers to nested levels of influence upon developing children ranging from cultural and economic processes to individual relationships with teachers, parents, and peers. Ecological resilience refers to the elements and interactions of these different social levels which contribute to positive MHPS wellbeing of children, such as those affected by armed conflict.

1.4 War in context refers to the understanding of children affected by armed conflict in the broader context of their lives, not limited only to war-related experiences.
References


Cummings, E. M., Goeke-Morey, M. C., Schermerhorn, A. C., Merrilees, C. E., & Cairns, E. (2009b). Children and political violence from a social ecological perspective: implications from research on


2.1 Dimensions of Psychosocial Wellbeing

As introduced in Chapter 1, the most cited definition of “psychosocial” is the one agreed upon by members of the Interagency Psychosocial Working Group and INGO’s\(^1\) during a meeting in Nairobi in 1997 (UNICEF, 1997). In that definition it is explained that psychological refers to the dynamic relationship that exists between psychological and social effects, each continually inter-acting and influencing the other.

Psychological effects include people’s feelings, behavior and thinking and social effects include the relationships between people, economic environment, cultural norms and values. It is, for instance, easier for children to move on from past bad experiences and feel they are leading a meaningful life (feeling/thinking: psychological), if they have money to go to school and prepare for a job, while living with their family members (economics/education/relationships: social).

Because the definition of psychosocial itself does not give so much concrete ideas about what is and what is not a psychosocial intervention, the following dimensions of psychosocial wellbeing are explained (See Figure

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\(^1\) Including the International Rescue Committee (IRC), Save the Children UK (SCUK), the United Nations Children’s Fund (UNICEF), the United Nations High Commissioner for Refugees (UNHCR), International Committee of the Red Cross (ICRC) and World Vision International (WVI).
2.1. These dimensions give us more hands-on clarification of what general parts psychosocial wellbeing consists. They are taken from the *Psychosocial Working Group* (Psychosocial Working Group). If an intervention is aimed at increasing the psychosocial wellbeing of a person in the following three domains, it can be called psychosocial.

![Dimensions of Psychosocial Wellbeing](image)

*Figure 2.1 Dimensions of Psychosocial Wellbeing (Adapted from Psychosocial Working Group, 2003).*

### 2.1.1 Human Capacity

The first dimension of psychosocial wellbeing is Human Capacity. Human capacity “includes the physical and mental health of a person, as well as his/ her knowledge or skills” (Psychosocial Working Group, 2003, p.1). Further, human capacity indicates a person’s individual capacity that one person has, in terms of their health, knowledge and skills. In comparison, the World Health Organization also underlines a broad definition of health: "Health is a state of complete physical, mental, (family), social and (spiritual) well-being, and not merely an absence of disease or infirmity". For psychosocial wellbeing, of course it is important that one has good health and that one has knowledge and skills to secure basic needs (housing, nutrition, clothing) and to deal with challenges in the environment.

Examples of psychosocial programming that are aimed at increasing this part of psychosocial wellbeing are

- Training doctors in mental health
- Support groups for children with problems related to fear
- Training hygiene skills to children
- Counseling services
- Vocational training programs
- Working together with water and sanitation programs
2.1.2 Social Ecology

The second dimension of psychosocial wellbeing focuses on relationships, rather than individual health. With social ecology “the social connections and support that people share” (Psychosocial Working Group, 2003) are indicated. As discussed in introduction to social ecology in Chapter 1, when thinking about psychosocial wellbeing, it is important to realize that the relationships that people have with others are crucial. In the case of younger children, parental support is crucial to strengthen their overall well-being while for adolescents, peer support is essential.

Examples of psychosocial programmes targeting this part of psychosocial wellbeing are

- Group discussions between CAAFAG and other community children
- Sports competitions between children
- Family mediation can help strengthen bonds between parents and their children.
- Supporting self-help groups
- Explaining the possible normal problems that children can have in the aftermath of war
- Educational opportunities (formal/ informal)
- Play activities, so children can make friends
- School-based psychosocial care programs

2.1.3 Culture and Values

Culture and values refers to “the specific context and culture of communities that influence how people experience, understand and respond to events” (Psychosocial Working Group, 2003). Culture has an influence on psychosocial wellbeing and the way that psychological and social problems can be expressed. Culture does not only exist of the outside of shared social life (e.g. the dress of a Gurung, dancing of the Tharu, painting of the Maithili, etc.), but also the inside (e.g. the way that people think about what is right and wrong; drinking alcohol or eating certain types of meat by some but not other groups, the way they feel about certain things: importance of family life in Nepal). For example, if a man talks openly about the sexuality of a certain woman in a rural Nepali village, it will strongly affect her “reputation” and her psychosocial wellbeing. If the same would happen in a bar in the United States, it will have less effect on wellbeing.
When thinking of psychosocial wellbeing, it is thus also important to look at the culture and the values of the group we are working with. It could for instance be that something that is very beneficial in one culture does not work in another culture. For instance, it might be better in Nepal to work with families or groups of people than with individuals. We should also understand, however, that cultures are not like museums. Cultures are dynamic and always changing and adapting to new challenges in the environment. With a psychosocial intervention we are not trying to keep everything the same as it was in the past. For instance in Nepal, where the Maoist insurgency was aimed at changing social structures, trying to keep things the same as they were before the Maoist insurgency will have counter-productive effects. Thus, for CAAFAG children’s psychosocial well-being, child protection agencies should promote the positive aspects that children have adopted, if any, from their involvement in armed forces/armed groups.

Examples of psychosocial programs that focus on this dimension are

- Providing opportunities for normal religious practice
- Working with traditional, religious healing resources
- Appropriate privacy for women
- Asking the target group about the appropriateness of interventions
- Doing assessment on people’s views on psychosocial issues

2.2 Guidelines for Psychosocial Programming

A number of principles for guiding psychosocial programming have been recorded at various international forums. Table 2.1 below shows a compilation of the psychosocial principles developed.

Guiding Psychosocial Principles

1. Do-no-harm approach
2. Culturally sensitive approach
3. Participatory approach
4. Needs-based approach
5. Resilience approach
6. Human rights approach
7. Systems approach
8. Applicability and relevance approach
9. Care-for-caregivers approach
10. Long-term approach
11. Collaborative approach

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2 This Section is based on guidelines development for and endorsed by, the CAAEAGWG (Nepal)
2.2.1  Do-No-Harm Approach

All psychosocial work should start from the stance that it should ‘Do No Harm’ (Anderson, 1999). In politically sensitive environments like conflict-affected Nepal, researching certain topics in the post-war setting may also be more harmful than others. Asking individuals about sexual violence, especially asking young girls about their experiences can put them at significant risk of harm. We had met a number of girls who had been forced into an armed group as punishment based on the accusation that they had disclosed that they or another girl in the village was the victim of rape. In some parts of the country, there is little support or care for rape survivors and in some cases the victim is blamed for the rape. Therefore, asking about rape would have put the girls, their families, and our research staff at considerable risk. Moreover, screening for sexual violence in an environment where there is little to no treatment services in place for survivors of sexual violence also raises ethical concerns.

Another risk of harm was that the introduction of services for child soldiers and other children affected by war could lead to the marginalization of other existing care systems. For example, the use of medical missions (e.g. short-term health camps often administered by expatriate clinicians with little knowledge of local context) in Nepal is associated with less reliance on existing healthcare systems in rural areas, including the idea that medications brought in by medical missions are more effective than those available in the local pharmacy. Similarly, novel psychosocial interventions can also lead to the underutilization of existing systems of social support, community recovery, and traditional healing. Therefore, in Nepal, prior to implementing an intervention, we felt it was crucial to understand existing support systems and ensure that a key role of psychosocial workers is the mobilization of community members and resources. This is also advocated by the IASC Guidelines (2007).

Some things to keep in mind not to do harm are being constantly reflective of one’s impact, consult the emerging psychosocial evidence-base on doing work in emergency and post-conflict settings, becoming aware of power relationships in families, communities and wider society, be careful to know but not use stigmatizing labels (like paagal, ‘madness’ in Nepali), and be aware and plan for security concerns.

2.2.2  Culturally Sensitive Approach

Psychosocial work in emergency and development settings have in the past
taken knowledge from Western knowledge and practice and transposed it to low income settings. This has been because the only knowledge about psychological therapies that have been used for people in distress came from a narrow part of the available knowledge about psychological therapies. Knowledge has been draw mainly from psychodynamic and humanistic schools of practice, which traditionally has the therapist meet the person in distress alone in a closed off room away from others who might see or overhear them. We know now that these practices can be counter to what feels comfortable or appropriate in some communities. This cultural insensitivity has at best, produced ineffective programme outcomes, but at worst been inappropriate and damaging to the people who were being ‘helped’. Other psychological therapies, such as those stemming from Family Systems Therapy, such as Narrative Therapies have the person’s cultural context central to any therapeutic intervention.

Secondly, knowledge about how psychosocial issues are managed in local settings are important to know, prior to developing any intervention, to avoid the danger of imposing a practice that either duplicates what already exists or putting in place practices that are inappropriate.

A “community approach” that uses the existing human and material assets within communities is a more sustainable because the psychosocial work takes into account the resources and potential resilience of communities. For instance in Nepal, if we neglect the protective role that grandparents traditionally play in the development of many of Nepal’s children, we might be missing an important resource for psychosocial work.

Similarly, we find that psychosocial difficulties are often framed in terms of the influence of spirits (bhut-pret). It is logical within this belief system that the first person to seek out for help would be a traditional healer (dhami-jhankri), who claims to provide direct solutions or ‘treatment’ for the spirit problem. It is preferable to understand the role of traditional beliefs and healing in psychosocial work in Nepal, rather than neglect it. In this way, helpful practices can be acknowledged and alternative treatment suggestions made for unhelpful or harmful traditional practices. Because cultures are changing and not static we see some people from higher income and urban families who now think dhami-jhankri are “old fashioned” and should be trained in Western biomedical treatment approaches. Therefore a ‘middle way’ between neglecting local resources and idealizing them is advocated here.
Aside from traditional healing, community leaders have knowledge and experience about dealing with stressors, and religious resources. Meeting with community leaders can be a starting point and so it is crucial that local staff are employed to facilitate communication by not only overcoming language barriers, but also coaching foreign workers on etiquette and common practices in a community. They are also more likely to be approached and confided in by community members when there are in problems.

2.2.3 Participatory Approach

A participatory approach should be used in planning and implementing psychosocial programs. This means that psychosocial programming is compatible with, and based on, the ideas of community members.

Constant interaction and dialogue the community is important for effective participation and can be built into the project to ensure that the project work is benefiting the people it intends to help. Participation of the community, especially when it concerns children is crucial to build into all phases of a psychosocial project from project design, implementation, monitoring, evaluation and follow-up. To achieve this, it can be helpful to think of the government or organizations as having a facilitative role. They are there to provide the means that people in the community need to fulfil their own initiatives. This is a more sustainable approach than assuming the community does not know how to manage it’s problems and so provided with “foreign” solutions that will be forgotten later.

2.2.4 Needs-Based Approach

An important aspect of psychosocial work is to implement only on the basis of observed needs. The community must define what the priorities are. This avoids the risk of offering people interventions which they don’t need, which could undermine their own resources and force them into taking a ‘sick role’ or passive role.

Before starting a psychosocial intervention, a needs assessment must take place. Resources on how to do this, are available in documents for psychosocial interventions (IASC, 2007; UNICEF, 2006). In Nepal, which is a fast changing and multi-ethnic society, a needs assessment must take into account the socio-cultural context. By which we mean the impact of power relations, gender roles, family set-up and religious rules and laws on individuals and communities. Too often an initial short needs assessment
is done to provide broad priority areas and later more in-depth, focused needs assessments are done.

We recommend needs assessment as an ongoing continuous activity. In undertaking needs assessments, various methods are possible. However, to gain a picture of severity of an individual’s difficulties, symptom checklists based on international psychiatric classification systems such as the *International Classification of Disease* (ICD) (WHO, 2004) or *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA, 2000), are frequently used but not recommended as the *only* method of data collection because there is question whether these classification systems are applicable outside the countries from where they were developed. Instead, a mixed-methods approach is recommended that includes international standardized measures, local developed checklists, and qualitative data collection (Betancourt et al., 2008; Betancourt et al., 2009; Creswell & Plano Clark, 2007; de Jong & Van Ommeren, 2002; Kohrt et al., 2009; Ungar et al., 2005). In the next chapter, we describe the process of developing assessment measures with children through a participatory process known as *Child Led Indicators*.

### 2.2.5 Resilience Approach

Most children do not develop longer-term psychosocial problems after experiencing a traumatic event. Straight after an adverse event it is *normal* to show a level of emotional problems, and for most people this is a temporary state of being while their mind tries to make sense of the event. To assist our bodies in this process it needs an environment that gives a sense of safety and security. If children’s basic needs are met, if they have a meaningful daily structure (e.g. home routines, schooling) and if they live in a secure family environment, most children will be able to recover from their challenges.

Resilience, however, needs to be viewed from a context perspective; it is not enough to simply assume resilience in a given population. An assessment should take into account which socio-cultural resilience mechanisms such as local support systems through groups and traditional healing or religious practices. These are at play in a given group because a child is part of a wider social ecology; there are complex social processes that influence their individual wellbeing.

Resilience can be seen from an individual and group perspective.
Individual coping skills that children possess, such as the ability to distract themselves by playing, making music or dancing are therapeutic. Likewise, groups methods to deal with the challenges in their environment such as women organizing themselves to complain with armed forces to get their husbands out of detention, can give these women a sense of power and agency over their circumstances that benefit their psychosocial well-being.

The goal of any reintegration program should be to promote psychosocial resilience by supporting children, their families, and their communities in manner that promotes their existing coping and restorative resources.

2.2.6 Human Rights Approach

Psychosocial work has an intricate relationship with human rights protection services. For instance, in Nepal the demobilization of children formerly associated with armed forces and armed groups will have a direct improvement on children’s wellbeing by taking them out of situations that are highly stressful.

In the current, post-conflict environment in Nepal, the concept of “transitional justice” is important. Transitional justice is the full range of processes and mechanisms associated with a society’s attempt, to come to terms with the legacy of large-scale past abuses, in order to ensure accountability, serve justice, and achieve reconciliation. Clearly, an essential component of coming to terms with past abuses is for individuals and communities to acknowledge the psychosocial losses they have experienced and find ways to heal so that they can forgive their abusers.

Organisations working with human rights on issues of transitional justice should consider how to incorporate psychosocial healing within their programming. Although that is beyond the research and intervention discussed in this book, it is a crucial endeavour which needs to be considered further.

2.2.7 Systems Approach

Systemic psychosocial approaches take the view that and individual’s thinking and behaviours are formed out of the context (familial, social, political, economic, religious) that they have experienced or developed within. Therefore, difficulties are understood and resolved by working with the individual in context with their environment.
In planning programmes, systemic or holistic approaches are more effective than targeted interventions which can have incomplete benefits for their intended beneficiaries.

Some children will require more specialized interventions to address their suffering and help restore their flow of development. Immediately after traumatic events, activities and opportunities which allow children to talk about or otherwise express painful experiences and feelings, such as physical and artistic expression, are most beneficial if facilitated by people the children know and trust, such as parents, teachers or neighbours. However, “trauma counselling”, should never be the starting point for psychosocial programming, because this may create unnecessary distress in the child when structured, normalizing and empowering activities, within a safe environment, will help the majority of the children recover over time.

For example, interventions should not just focus on the returned child. Rather, psychosocial support during reintegration should address the child, family, and community. At the community level, psychosocial support can include encouraging inclusive activities such as participation in child clubs, sporting activities, women's and mother's groups, religious activities, and school programs. Other community reintegration activities such as formal and non-formal education and income generating activities should also include a psychosocial framework. Below, we provide more specific examples about these group activities and how to conduct them.

Regarding the family, reunification of returned children with their families is one of the most powerful psychosocial supports. If children feel welcomed and supported by their family, this provides the foundation for many other psychosocial supports. At the individual level, there are many forms of psychosocial support. A small group of children may need personalized psychosocial counseling, for issues such as trauma, sexual violence, and substance abuse. Psychosocial counseling should only be conducted by certified individuals who have received four to six months supervised counseling training.

Psychosocial work is most productive when it is aimed at different social levels the same time. In other words, it is more effective when it can target the child individually, as well as the family the child lives in, the community the child is part of and the wider government system. This approach takes an ecological perspective. If we do not take this perspective our work is
less likely to be effective. For instance, if we only work with the individual emotional problems of a child, but the child goes back to a family that has no resources to support them or where the father abuses alcohol and beats his wife, our goal of increasing the wellbeing of that child is unlikely to be met. From this example the need to work with the whole family is clear. Secondly, individual interventions is less desirable for another reason in that they run the risk of stigmatizing individuals receiving help.

From a public health perspective, it is important to target the community at all three levels. Working with the community we target all children (at the ‘universal intervention’ level e.g. with awareness-raising on psychosocial issues); we target at at-risk children (at the ‘selected intervention’ level e.g. with specific support groups for children); and, at the same time, we target children that show more severe problems (at the ‘indicated intervention’ level e.g. with specialized counseling or medical services). The benefit of providing psychosocial interventions at different levels simultaneously is that they support one another and so can mutually benefit the client and wider community to create sustainable benefits.

2.2.8 Applicability and Relevance Approach

In Nepal, there is a lack of government presence in psychosocial work. Instead this work is conducted by NGOs who unfortunately are dependent on donor agencies to fund their work and so indirectly can dictate the priorities in the psychosocial sector. Goals set out in psychosocial projects are more difficult to measure in a quantifiable way, compared with projects that distribute food and non-food relief items or building latrines for instance. The results of the latter are easy to see and present to visiting donor representatives. It is the responsibility of organisations conducting psychosocial work to educate donor and government agencies about the importance of this work and find ways to measure and demonstrate psychosocial benefits. Attention must be given to this at the start of a project to include (monitoring and evaluation) methods to record changes to people’s lives using objective (e.g. locally standardised questionnaires measuring symptoms) and subjective (individual and group interviews) tools. A log-frame approach can help in deciding on the objectives, output, indicators and activities of psychosocial work. In keeping with good planning practices, objectives, outputs and indicators of success need to be decided on together with members from the community and other stakeholders.
If the focus is solely on individual psychosocial wellbeing, then indeed it is more difficult, but far from impossible, to measure progress through time. If psychosocial interventions are viewed within the three dimensions of improved ‘human capacity’, ‘social ecology’ and ‘culture and values’ outlined above, it is easier to plan a monitoring and evaluation (M&E) strategy. If not already done so, this may involve adapting tools from other country settings to the Nepali context. It is not recommended to use instruments imported from other settings without considering the cultural biases and appropriateness to the current setting. Nepali colleagues can advise on cultural appropriateness and if fluent in the local language, can assist in adapting questionnaires using language that accurately conveys the meaning behind the questions. M&E can be done through a combination of both qualitative and quantitative assessment methods.

Social workers should do regular follow-up with children to monitor their changes. This information will be used to determine what percentage of children have increased psychosocial well-being as a result of the support provided.

2.2.9 Care-For-Caregivers Approach

The work that psychosocial workers do is, mostly viewed as very rewarding, but is nevertheless often difficult. To live in environments affected by complex emergencies, to be confronted with human misery and deliberate hurt, to be confronted with death and destruction, all strain the psychosocial wellbeing of the caregiver (psychosocial worker or other front-line worker). It is therefore essential that the organization in which psychosocial work is done, is sufficiently prepared to deal with this strain.

One aspect of care for caregivers is acting before it is too late, by providing a supportive working environment. Good social contact with colleagues who bring humour to the work or are open to sharing difficult experiences). Good supervision and guidance, including peer supervision and support, are all part of a supportive working environment. Moreover, managers can prevent harm on the job by recruiting people with an inherent interest and ability in psychosocial work, by providing preparation and orientation to staff about their tasks, and by building in sufficient rest and relaxation.

Secondary distress is emotional difficulty that program workers such as social workers, social mobilizers, psychosocial workers, and counselors may feel from working with distressed and vulnerable populations. It is important to recognize secondary distress symptoms so that you can
seek help from colleagues and others. Common symptoms of secondary distress include difficulty concentrating, crying, difficulty sleeping, desire to be alone, headaches, stomachaches, easily irritated, frustration, and nightmares. When these symptoms occur, you should seek time with your colleagues and other psychosocial workers. Secondary distress can be prevented and minimized by regular meetings with colleagues to discuss feelings and emotional responses to work experiences and work demands.

In the event that these preventive practices are not sufficient in some cases, for instance in the case of a sudden overwhelming set of experiences, the organization must facilitate access to psychosocial services for its service providers (e.g. paying of a limited number of sessions with a counsellor that the worker does not know). Group-based Critical Incidence Debriefing as an intervention in general has not proven beneficial to prevent problems after adverse events, and in some cases can do harm.

2.2.10 Transitioning Emergency Response to Long-Term Approach

The desired follow-up to emergency psychosocial work should be that appropriate psychosocial and mental health interventions are built into existing (e.g. government) structures, and so likely to be sustained. All too often in the past, humanitarian agencies receive project funding for a short period of time (usually six months) to respond to an emergency. After which time the international organisation maybe required to leave and respond to another humanitarian crisis elsewhere. As we know, it is common for most people to show distress immediately after a crisis but most people, recover on their own, and it is only after several months that it becomes clear who are the people that require specific psychosocial support. Usually at that time, international agencies are preparing to leave. This type of short-term programme approach does not, in the longer-term, increase the psychosocial wellbeing of their target population. Conversely, it can leave the population dependent on foreign aid, and more difficult for other organizations to build up a longer-term relationship with the area and its communities.

Organizations intervening in complex emergencies that have built the capacity of local actors to be able to carry out work has proven to be beneficial. A hand-over strategy should be built in to all psychosocial projects from the start, as part of the planning exercise. Sustainability should be at the core of programming. It is important that programs consider the long-term to help children and communities strengthen their...
coping skills, increase their knowledge of psychosocial well-being, and enhance local ways to support psychosocially vulnerable populations. This not only helps children and communities to have the capacity to address the majority of their psychosocial issues locally but enables them to be more resilient to cope with any future adversity.

2.2.11 Collaborative Approach

Psychosocial work, when it is done well is multi-disciplinary. Through contact with the target population, psychosocial workers are often aware of the gaps in basic needs and other services. Therefore they can be helpful to organizations working in complex emergencies, so should work together and coordinate their efforts.

Within psychosocial work in Nepal, there has been some effort at cooperation between organizations in the psychosocial sector. This has proven challenging, perhaps partly due to competition among organizations over relatively little financial and other resources. Although some competition can be healthy in stimulating quality work, it is important that organizations do not view their successes and lessons learned as secrets to be kept to themselves but shared between relevant organizations. This avoids duplication and builds on knowledge rather than making organisations re-invent the wheel and make the same mistakes, which the target population have to repeatedly endure. With greater cooperation, the resources of all the organisations, in effect, get pooled to create synergy between organizations and becomes easier to refer between organizations to benefit the target group. Since it is not possible for one organization to offer all services that people need it is useful to remember that everyone works towards the same goal of sustained psychosocial wellbeing for the people of Nepal.

2.3 Do’s and Don’ts in Psychosocial Programming

Prior work in psychosocial programming has also identified a series of dos and donts.
### Table 2.1 Do’s and Don’ts

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</thead>
<tbody>
<tr>
<td><strong>Training issues</strong></td>
<td>1. Train paraprofessionals in clinical techniques (such as EMDR-eye movement desensitization and reprogramming)</td>
</tr>
<tr>
<td>1. Ensure that staff are suitably qualified to conduct activities</td>
<td>2. Conduct 1-off trainings</td>
</tr>
<tr>
<td>2. Training professionals in clinical techniques</td>
<td>3. Conduct training in basic counseling skills through short term training programs</td>
</tr>
<tr>
<td>3. Provide ongoing support and supervision to staff who participate in trainings</td>
<td>4. Have a narrow trauma focus to treatment and interventions</td>
</tr>
<tr>
<td>4. Focus training for community members in how to provide basic psychosocial support (e.g. psycho-education)</td>
<td>5. Don’t name interventions counseling or trauma treatment if they are not</td>
</tr>
<tr>
<td>5. Focus training on teaching people how to identify severe psychosocial problems</td>
<td></td>
</tr>
<tr>
<td><strong>Activities</strong></td>
<td>1. Claim to heal trauma with short activities</td>
</tr>
<tr>
<td>1. Support people to play an active role in rebuilding their community and return to normalcy</td>
<td>2. Treat people as victims in need of support from outside</td>
</tr>
<tr>
<td>2. Support indigenous, culturally and religiously appropriate healing</td>
<td>3. Import external or foreign techniques without integrating or grounding them in local healing traditions</td>
</tr>
<tr>
<td>3. Take participants through a healing process</td>
<td>4. Use technical terms or terms that can stigmatize except in a clinical setting</td>
</tr>
<tr>
<td>4. For the community use easily understandable terms that normalize and de-stigmatize reactions</td>
<td>5. Focus only on the past</td>
</tr>
<tr>
<td>5. Focus on resilience and coping</td>
<td>6. Focus on vulnerability, trauma and illness or focus only on trauma related problems</td>
</tr>
<tr>
<td>6. Address stress and trauma related problems together</td>
<td>7. Ask children to retell their difficult experiences without appropriate skills or support</td>
</tr>
<tr>
<td>7. Provide the safest way for people to express their difficult events, which should be part of a larger healing process</td>
<td>8. People not well-known to the child ask sensitive questions</td>
</tr>
<tr>
<td>8. Ensure that only people with ongoing relationship with children ask them sensitive questions</td>
<td>9. Create dependency</td>
</tr>
<tr>
<td>10. Integrate psychosocial and mental health services within integrated services for beneficiaries</td>
<td>11. Create stand-alone specialized services that are disconnected from the existing systems</td>
</tr>
<tr>
<td>11. Promote integrated and staged approach with referral system to higher levels of specialization as required</td>
<td></td>
</tr>
</tbody>
</table>
2.4 Conclusion

In this chapter we expanded on psychosocial concepts and introduced guiding principles for MHPSS interventions. The central lessons in this chapter is that the concept of psychosocial wellbeing needs to be considered very broadly including human capacity, social ecology, and culture and values. The importance of including these elements lays in the need to incorporate each of these elements when considering interventions. Psychosocial programming needs to think about not only the child, but the broader social network in which the child lives. In some cases, the best intervention for a child is one that is done with the parent, teacher, and community, rather than an intervention only done with the child. Culture and values cannot be ignored because within culture resides many existing support systems. However, cultural practices may also be risk factors for threatening MHPSS. Therefore, strong research into the three domains of human capacity, social ecology, and culture and values should precede and be ongoing during any intervention. In the following chapter, we discuss research and ethics of conducting studies to build psychosocial interventions.

**KEY CONCEPTS**

2.1 The dimensions of psychosocial wellbeing include *human capacity, social ecology, and culture and values*. These three domains need to be considered in any psychosocial intervention.

2.2 Prior experience across settings and needs have led to psychosocial guiding principles which need to be considered in any intervention work:

2.2.1 *Do-no-harm approach* – Any intervention in an emergency or post-conflict situations should not be harmful to its recipients. Interventions in a war setting are implemented within a very *sensitive* political environment.

2.2.2 *Culturally sensitive approach* – Use resources available in communities, for instance knowledge/ experience, healing resources such as religious/ traditional healers, community leaders. Ground psychosocial interventions in the culture, unless it is not in the best interests of the child, is both ethical and more likely to produce a sustained recovery.
2.2.3 **Participatory approach** – Participation by representative community members and target groups integrated into all phases of the intervention. Children, and adults’, participation in decisions that affect their lives have a positive effect on their mental health, is empowering and helps to regain control over their own lives.

2.2.4 **Needs-based approach** – Community needs should be assessed by speaking with community members. Do not assume their needs. Assessment of the socio-cultural context is necessary. Meeting psychosocial needs goes hand-in-hand with meeting basic survival needs. Individuals with good psychosocial functioning are best able to meet their basic survival needs and the needs of their families. Psychosocial needs should be addressed in conjunction with other reintegration needs, rather than having them viewed separately.

2.2.5 **Resilience approach** – Most children will be able to recover by themselves or with minimal support from their challenges. Interventions should focus on the child’s existing resources and should focus on strengthen aspects that foster resilience (such as normal daily lives, social support).

2.2.6 **Human rights approach** – The psychosocial sector by its nature overlaps with human rights protection work.

2.2.7 **Systems approach** – As much as possible conduct interventions should operate on multiple levels: Community, Group, Family, and Individual. Isolated interventions run the risk of stigmatizing or isolating populations within a community.

2.2.8 **Applicability and relevance approach** – Objectives of the program need to be clearly defined, in cooperation with the target group. Evaluation of services and impact must be measured.

2.2.9 **Care-for-caregivers approach** – Supportive working environment/ colleagues. Good supervision and guidance. Peer supervision and support. Psychosocial services available for workers.
2.2.10 *Transitioning emergency response to long-term approach* – Repeated short-term help is not the same as long-term help: the ultimate goal is that your help is not necessary anymore.

2.2.11 *Collaborative approach* – There is often some competition between care providing agencies, but cooperation leads to more effective results because it: Avoids duplication, Maximizes synergy between organizations, Establishs referral for different services. Knowledge available in organizations should be able for use by others.

2.3 *Psychosocial Do’s and Don’t’s* need to be considered for both training issues and activities. These simple recommendations highlight the common mistakes made in programming and the approaches which have been successful in prior work.
References


Chapter 3 Goals – The goals of this chapter are

(i) introduce the CAAFAG Four Principles (C4P) approach to ethical research
(ii) present the difference methods used to conduct research with CAAFAG
(iii) describe the process of transcultural translation and validation of measures for local contextual use.

This chapter discusses the overall research approach. The research approach and methods described here were used to produce the research results described in Section II.

3.1 CAAFAG Four Principle (C4P) Approach to Ethical Research

CAAFAG represent a challenging population for mental health and psychosocial support (MHPSS) as we have little evidence regarding their needs or efficacy of interventions. Despite an increasing breadth of MHPSS interventions for children affected by war, very few are supported by evidence (Jordans et al., 2009). Expanding on the principles described in Chapter 2 regarding psychosocial interventions, here we discuss four principles of research (see Figure 3.1): the CAAFAG Four Principle (C4P) Approach (Kohrt et al., 2010a). We present these principles as location and context specific examples of the growing effort to develop guidelines and recommendations for research and intervention in acute post-conflict settings (Allden et al., 2009; IASC, 2007).

3.1.1 Principle One: Do No Harm

While originating in the clinical ethic of non-maleficence, what is meant by “do no harm” when working with CAAFAG has not been well defined. In conflict settings, harm can manifest as threats to safety of former CAAFAG, their families, and their communities. Research and intervention may expose CAAFAG who have tried to hide their association with an armed group, thus placing them and their families in danger of revenge by other soldiers or aggrieved civilians. Many children in Nepal concealed their identity as former combatants. When boy soldiers returned home, they often told family and neighbors they had been working in India rather than disclose they were fighting with an armed group. When girl soldiers returned home, their parents would often send them to live in remote regions with other relatives or they would marry the girls to men in distant villages where their status as former soldier would not be known. To address this potential harm, we did not limit the research and service-provision exclusively to focusing on CAAFAG. Rather, we designed the project to explore the mental health of both CAAFAG and civilian children. Participation in the study did not automatically identify a child as a former combatant. This was also beneficial from a theoretical and needs-assessment level. At the time of the study, it was not known empirically if CAAFAG needed additional intervention above and beyond other children because of the lack of studies comparing CAAFAG with never-conscripted children.
Mental health research also risks stigmatization of former CAAFAG. Mental health continues to carry a strong stigma in Nepal, as in most parts of the world (Kohrt & Harper, 2008). In a generalized Nepali ethno-psychology, the components of the self include the physical body (saarir or jiu), the spirit (saato), social status/face (ijjat), the brain-mind (dimaag), and the heart-mind (man). In Nepal, problems with different parts of the self are treated by different types of healers (See Figure 3.2). However, there is considerable variation across cultures, regions, and education levels with regard to interpretation of the ethno-psychological framework. The brain-mind is the organ of reason, decision-making, and compliance with social norms. The heart-mind is the organ of memory and emotion. Behaviors labeled as brain-mind dysfunctions tend to be stigmatized. Mental illness is considered a brain-mind dysfunction. In contrast, symptoms of heart-mind distress include sadness, worries, bad memories, and nightmares. Extreme distress in the heart-mind leads to brain-mind dysfunction. (See Table 3.1)
Table 3.1 Explanatory Models of Brain-Mind and Heart-Mind

<table>
<thead>
<tr>
<th>Explanatory Model</th>
<th>Brain-Mind Dysfunction</th>
<th>Heart-Mind Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patterns of distress (disorders &amp; symptoms)</td>
<td>Epilepsy, severe intellectual disabilities, psychosis, violence, aggression, ‘mental shock’</td>
<td>Sadness, worries, bad memories, nightmares, loneliness</td>
</tr>
<tr>
<td>Perceived causes</td>
<td>Physical trauma to the head, alcohol use, bad karma, excessive heart-mind activity.</td>
<td>Social stress, poverty, lack of education, accidents and personal loss</td>
</tr>
<tr>
<td>Help seeking &amp; social response</td>
<td>Often considered incurable (treatment not sought), isolation from family, occasionally call upon traditional healers or psychiatrists, strongly stigmatized</td>
<td>Sharing feelings with others, social engagement, traditional healers, relaxation, meditation, not stigmatized</td>
</tr>
</tbody>
</table>

Mental health inquiries may appear as accusations that one is “crazy” or “mad” as was the case with terms used to describe posttraumatic stress disorder (PTSD) by some clinicians in Nepal (Kohrt & Hruschka, 2010); and, the experience of traumatic events can also be stigmatizing because some interpretations of karma blame individuals for their suffering (See Figure 3.3). Therefore, we focused on normative language related to Nepali concepts of the heart-mind. This language gave children a therapeutic opportunity to share feelings and emotionally support other children in a non-stigmatizing atmosphere (Karki et al., 2009).

Figure 3.3 Nepali Ethnopsychological Framework and Understandings of Traumatic Experiences

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**Psychosocial Support Model for Children Associated with Armed Forces and Armed Groups in Nepal**
3.1.2 **Principle Two: Balance Research Costs & Benefits**

Overriding concerns for studies in post-conflict settings are necessity, feasibility, and who will be the direct and indirect beneficiaries (de Jong, 2002). One must consider *hierarchies of need* in conflict settings. Is mental health research the most pertinent topic to be investigating? Research on food security, livelihood, safety and security, or other medical concerns may be more necessary. For the child participants, is time in a research study as beneficial for long-term mental health as engaging in other activities, such as rebuilding damaged structures, going to school, or working? In Nepal, children said MHPSS was a top priority alongside education and poverty relief. Having opportunities to express feelings, promote belonging, and increase social cohesiveness were considered first steps for successful re-integration of CAAFAG. As will be described in Section II, CAAFAG participating in our research highlighted goals of “feelings of belonging,” “being respected and listened to,” “having opportunities to express feelings,” and “dealing with fear, regret, and hopelessness,” (Karki et al., 2009).

The balance of costs and benefits raises the need to consider *integrated frameworks*. Isolated MHPSS interventions may detract from addressing other basic needs, physical health, education, and economics. MHPSS intervention in isolation risks inefficacy. Therefore, we incorporated MHPSS alongside “reintegration packages” comprising formal education, non-formal education, vocational training, and income generating activities. CAAFAG with mental health care were able to maximize educational and occupational opportunities. In addition, we provided MHPSS training to teachers. Teachers discriminated against CAAFAG because of fear and insecurity related to a transformed balance of power (Kohrt et al., 2010b). During the war, child combatants had threatened, abducted, and tortured teachers. Now, their comrades in the classroom were expected to obey teachers’ edicts. Interventions were needed to help teachers to disclose their fears and consider ways to promote safe classrooms and non-violent expressions of agency for students.

3.1.3 **Principle Three: Transform Research to Intervention**

The transformation from research to intervention development and quality is center stage when working with CAAFAG. In post-conflict settings, research that does not contribute to interventions should raise ethical concerns. *Participatory research* avoids this by providing strong connections
between research and intervention salient to the local community. We adopted a participatory method to develop “Child Led Indicators” (see description below) in a process conducted over three days with small groups of eight to ten CAAFAG (Karki et al., 2009). CAAFAG identified psychosocial problems affecting them and processes to address these needs. The children developed indicators to evaluate the effectiveness of interventions.

Interventions in the absence of research can be even more problematic. Evidence-based interventions are crucial. While interventions have typically prioritized CAAFAG over other children affected by conflict, there is a paucity of data demonstrating greater need. In addition, war trauma is often presumed to be the predominant cause of child soldier mental health problems. We found that for some CAAFAG their experiences after war were more damaging to MHPSS than war-related traumas (See Section II of this book). These findings helped us target the type and location of reintegration interventions to best allocate resources to those most vulnerable.

3.1.4 Principle Four: Transition from Relief to Development

The fourth principle recognizes the need to consider long-term development of mental healthcare services rather than solely attend to acute relief efforts. World regions affected by war often lack a standing and effective mental healthcare system, especially for children. There is a need to consider how the energy, manpower, and finances invested during the post-conflict period can be extended to services that will last beyond the acute bolus of support. Moreover, in post-conflict settings, MHPSS problems after war may be as related to chronic structural violence factors as to war related exposures. Therefore, interventions should strongly consider chronic social problems as well as war trauma.

In Nepal, we addressed these concerns by designing a multi-layered care approach that aimed to have a multiplicative effect (Jordans et al., 2010) (See Section III). We trained a small group of community psychosocial workers (CPSWs) in a number of districts and these individuals were then able to transmit skills, engage with, support, and mobilize community stakeholders. The skill building of CPSWs was alongside training psychosocial counselors who received six months of instruction and provided a second level of care, bridging community-focused and individual-focused care. The training focused on improving the resources
within children’s social networks rather than just dispensing individualized care to children. This approach also benefited other CAAFAG and civilian children who were not receiving individualized care but profited from the augmented community services.

In areas of limited clinical resources, there are opportunities to address significant mental health needs of CAAFAG. Working in the acute post-conflict settings, the CAAFAG Four Principle (C4P) Approach comprises addressing the costs and benefits to research amidst limited time and resources, transforming research into intervention to assure that programs are evidence-based, and designing interventions that transition from emergency relief efforts to long-term sustainable development of mental health services. Taken together, these principles represent a do no harm framework that maximizes wellbeing in clinically resource-poor environments.

3.2 Phase I: Pilot Study of CAAFAG Psychosocial Wellbeing in Four Districts

Phase I was conducted in 4 districts prior to implementation of any reintegration activities by UNICEF, other organization, or partner organizations. The goal of this research was to identify the extent of psychosocial distress among returned children, the risk factors for psychosocial distress, and the resources available to address psychosocial distress, with a particular focus on traditional healing. Recommendations, based on these findings, were developed to reduce risk factors, promote existing resources, and design programs to fill gaps in psychosocial intervention. The four specified research questions are as follows:

- What is the psychosocial well-being of returned children compared to community children who never associated with armed groups? This question helps to identify the needs to specific to returned children as well as the pervasiveness and severity of psychosocial problems among returned children.

- What are existing risk factors that impede psychosocial well-being of returned children? This question addresses cultural and community issues related to gender, religion, caste, and ethnicity that may be barriers to maximizing psychosocial well-being of returned children.

- What are existing (traditional) protective factors for the psychosocial well-being of returned children? This question examines community
practices that promote psychosocial well-being, such as some forms of traditional healing.

- **How will families and communities be involved in the psychosocial care and support of children returning to their home communities?** The question will examine beliefs and practices among families and communities that will facilitate reconciliation and dialogue between returned children and their communities. The findings from this question form the foundation of recommendations to foster local psychosocial resources.

A combination of qualitative, quantitative, and participatory methods were used to conduct this study. The research was divided in two phases. In phase one, we employed key informant interviews, narrative focus group discussions, case studies, and child-led indicator sessions. In phase two, we conducted quantitative psychosocial surveys comparing returned children with children in the community who were not associated with armed groups. Below we describe the different approaches used.

The study took place over a four-month period (January – April 2007) in 16 districts (Ilam, Panchthar, Taplejung, Terathum, Sankhuwasabha, Morang, Dolakha, Ramechhap, Kavre, Sindhupalchowk, Kathmandu, Palpa, Jumla, Dailekh, Surkhet, and Kailali) with the majority of research focusing on the four regions of Ilam, Surkhet, Dailekh, and Kailali. Five research methods were employed:

### 3.2.1 Qualitative Methods

**Key Informant Interviews (KII)** - Key informant interviews were used to identify community perceptions of and experience with returned children. We designed a 38-question survey regarding beliefs of child development, children’s ability to understand politics and conflict, reasons for recruitment to armed groups, experiences during armed groups, return from armed groups, experience in community upon return, use of traditional healing, and supports available to returning children. This survey was designed for use among any individuals, but was especially targeted to parents of returned children, community leaders, teachers, traditional healers, journalists, health workers, etc. Interviews were conducted with 152 individuals (See Table 3.2).
Table 3.2  Key Informant Interview Demographics

<table>
<thead>
<tr>
<th>Role</th>
<th>Ilam</th>
<th>Surkhet</th>
<th>Dailekh</th>
<th>Kailali</th>
<th>Other*</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>3</td>
<td>12</td>
<td>10</td>
<td>16</td>
<td>5</td>
<td>46</td>
</tr>
<tr>
<td>Men</td>
<td>23</td>
<td>24</td>
<td>18</td>
<td>30</td>
<td>12</td>
<td>107</td>
</tr>
<tr>
<td>Teachers</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>CAAFAG</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>20</td>
<td>107</td>
</tr>
<tr>
<td>Health Workers</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>9</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>Political/Community Leaders</td>
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<td>3</td>
<td>9</td>
<td>1</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Maoist Party Members</td>
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<td>2</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Traditional Healers</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>9</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>NGO Staff</td>
<td>1</td>
<td>9</td>
<td>4</td>
<td>11</td>
<td>2</td>
<td>27</td>
</tr>
<tr>
<td>CAAFAG Parents</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>11</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Businessmen</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Journalists</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Students/Youth/Club Members</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
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<td>3</td>
<td>3</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
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<td>2</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>36</td>
<td>28</td>
<td>46</td>
<td>17</td>
<td>152</td>
</tr>
</tbody>
</table>

* Other includes Jumla, Terathum, Taplejung, and Sankhuwasabha.

Narrative Focus Group Discussions (NFGD) - NFGDs were designed as a modification of standard focus group discussions. In NFGDs, individuals are provided with a story (narrative) about a returned child, and then the respondents discuss major issues with regard to the psychosocial reintegration of the child in the community. The NFGD was designed for use among returned children, their families, other community children, women’s groups, teachers, etc. Twenty-three NFGDs were conducted with separate groups (See Table 3.3). Below is the narrative provided to focus groups to discuss the issue of returned children.
Narrative Provided for NFGD: “Mailaa is a 13 year old boy [Optional, you can also present the story as a 13 year old girl.] His home is in Sindhuli district. He has two little sisters, one little brother, and one older brother. He studied up to class 7 in the middle school. During class 7, he left school and became associated with armed forces. He was involved with armed forces for two years.”

### Table 3.3 Narrative Focus Group Discussions Demographics

<table>
<thead>
<tr>
<th></th>
<th>Ilam</th>
<th>Surkhet</th>
<th>Dailekh</th>
<th>Kailali</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-CAAFAG Children</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Community Leaders/ Groups</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>CAAFAG</td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Women’s Groups</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>CAAFAG Parents</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>NGO</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Teachers</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Student Union (Maoist)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Journalists</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>23</td>
</tr>
</tbody>
</table>

Case Studies – We developed a case study checklist to obtain case studies of well-integrated and poorly-integrated returned children in the community. The goal was the get one positive and one negative case study from each of the four major districts where we would be working. The case study intended to record the returned child’s narrative as well as corroborating narratives from family members, teachers, NGO workers, etc.

#### 3.2.2 Quantitative Methods

Surveys – Quantitative surveys were designed to assess the psychosocial well-being of returned children and compare this with children who did not associate with armed groups. The goal was to identify the special psychosocial areas of need among children associated with armed groups versus general effects of armed conflict on children. This was designed to help identify specific needs of returned children. The quantitative survey
included a number of psychological surveys that have been adapted specifically for use in the Nepali context. Furthermore, other psychosocial questions were taken directly from indicators that returned children identified in the CLI process (described in Chapter 4). Other questions were included based on the results of the qualitative research phase. One-hundred-forty-two returned children and 142 children never associated with armed groups participated in the quantitative section. (See Table 3.4.)

**Components of Quantitative Survey**

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Identification</td>
</tr>
<tr>
<td>B</td>
<td>Demographic Background</td>
</tr>
<tr>
<td>C</td>
<td>Daily functioning questionnaire (DF)</td>
</tr>
<tr>
<td>D</td>
<td>Experiences while associated with armed groups*</td>
</tr>
<tr>
<td>E</td>
<td>Strengths and challenges from association with armed groups*</td>
</tr>
<tr>
<td>G</td>
<td>Reintegration Process*</td>
</tr>
<tr>
<td>H</td>
<td>Anxiety questionnaire (SCARED)</td>
</tr>
<tr>
<td>I</td>
<td>Depression questionnaire, Depression Self Rating Scale (DSRS)</td>
</tr>
<tr>
<td>J</td>
<td>Use of traditional and community healing</td>
</tr>
<tr>
<td>K</td>
<td>Physical aggression questionnaire (PA)</td>
</tr>
<tr>
<td>L</td>
<td>Health and well-being including physical and spiritual illness</td>
</tr>
<tr>
<td>M</td>
<td>Child-led measures of psychosocial well-being</td>
</tr>
<tr>
<td>N</td>
<td>Traumatic events and exposure to violence</td>
</tr>
<tr>
<td>O</td>
<td>Child PTSD questionnaire, Child Posttraumatic Symptom Scale (CPSS)</td>
</tr>
<tr>
<td>P</td>
<td>Attitudes toward politics</td>
</tr>
<tr>
<td>Q</td>
<td>Child Hope Scale (CHS)</td>
</tr>
<tr>
<td>R</td>
<td>Future life expectations</td>
</tr>
</tbody>
</table>

* Items were administered only to CAAFAG participants.

Note: Section F was removed from the analyses.

142 CAAFAG and 142 non-CAAFAG community children completed the survey. The sample was 54% female, 35% Dalit, 35% Janajati, and 30% Brahman/Chhetri. Regarding age, 48% were 17 years old, 31% 15-16 years old, and 21% 11-14 years old. Participants were predominantly single (84%), with 14% married, and 2% divorced.

### 3.3 Phase II: Study of CAAFAG in 8 UNICEF Districts prior to Reintegration Programming

The initial study with CAAFAG was started from Jan 2007 in sixteen districts of Nepal. The districts were selected Ilam, Panchthar, Terathum and Morang from eastern region, Dailekh and Surkhet were hilly districts from mid western region, Kailali the Terai district of far western region. Similarly, Sindhupalchowk, Kavrepalanchowk, Dolakaha and Ramechap from Central region and Palpa from Western region were selected for data
collection. The cross-sectional research was applied with both qualitative and quantitative research methods. Initially, qualitative research was conducted which provided in-depth cases and effects associated with psychosocial well-being of children. Then, structured questionnaire was developed with some of the existing and validated psychosocial screening tools and some of them were developed on the basis of qualitative information.

Community perceptions were identified through 152 key informant interviews and 23 focus group discussions with community residents. Psychosocial problems among CAAFAG were identified through nine case studies and four participatory Child Led Indicator sessions where CAAFAG identified their own psychosocial problems and resources. To compare CAAFAG and community children never associated with armed groups (non-CAAFAG), a quantitative survey of 142 CAAFAG and 142 non-CAAFAG was conducted in 10 districts.

Almost 2 months was spent in field to collect data and report was submitted to UNICEF at the end of May 2007. The study provided detail information on the psychosocial situation of children in different settings.

After analyzing the data of previous four districts, it was identified that the follow-up of the children was essential to track their psychosocial well-being. At the same movement UNICEF started reintegration project to CAAFAG to facilitate in reintegration process. Case-cohort longitudinal research was designed to find the changes in psychosocial well-being of children after receiving the reintegration support from UNICEF partner organizations in eight districts (Chitwan, Makawanpur, Rupandehi, Kapilbastu, Sindhuli, Dhankuta, Dhading and Dolakha) of Nepal. Some of the psychosocial tools were adapted and some of them were developed on the basis of previous research. The study was started in July, 2007 and finished at Dec, 2007. Altogether 258 CAAFAG and, Non-CAAFAG and 80 vulnerable children were interviewed during the period of six months.

The research was conducted in accordance with IASC guidelines. For example, instruments were developed for children in risk groups; the instruments were locally validated; instruments developed in the local context to assess daily functioning were included; all research was conducted with approval of an ethical review board; all researchers were trained in ethical conduct and psychosocial support (e.g. prevention of re-traumatization). Furthermore, Action Sheet 2.1 and 2.2 of the IASC
Guidelines calls for participatory assessment, monitoring evaluation and development of participatory monitoring and evaluation mechanism (see Chapter 4), and questions were included that were developed through extensive qualitative research conducted during TPO-Nepal’s previous collaboration with UNICEF. The research included five methods which reflect many of the approaches described above for Phase I:

Quantitative surveys included pre-designed measures, locally developed measures, and CAAFAG specific questions developed through qualitative research. The child and a caregiver provided informed consent for these interviews. Interviews required 60-90 minutes to complete. The goal was the collection of a minimum of 30 CAAFAG and 30 community ‘control’ children interviews per district.

Quantitative surveys were also developed for use with “vulnerable children”. These surveys included pre-designed measures, locally developed measures, and specific questions developed through qualitative research. The child and a caregiver provided informed consent for these interviews. Interviews required 60-90 minutes to complete. The goal was the collection of 10 vulnerable children interviews per district.

Case studies were conducted with CAAFAG who were either having a successful time during reintegration and also among CAAFAG who were have specific difficulties. For case studies, researchers interviewed a CAAFAG as well as family members, friends, and other community contacts familiar with the child. Two case studies were conducted per district totally 16 case studies. In addition, one case study per district (totally 8 case studies) was collected from “vulnerable children” and their family members, friends, and other informants.

Focus group discussions (FGDs) were conducted with community leaders to discuss the presence of CAAFAG in their community. The main difficulties encountered by returning CAAFAG. And, the ability to mobilize resources locally to assist CAAFAG.

Participatory methodology through Child Led Indicators (CLI) was also initiated (see Chapter 4).
3.4 Phase III: Follow-Up Study of CAAFAG After 1-year of Reintegration Support

Continuous follow up to the same CAAFAG, Non-CAAFAG and vulnerable children was started from July 2008 to find out the progress of children in their psychosocial well-being. Above 85% children were tracked even after one year time period. Similar structured of questionnaire was employed in field. Children were tracked not only in their residence but also from other districts. Remarkable support received from UNICEF partner organizations during tracing out the children.

![Diagram of Process of Identification of CAAFAG and Data Collection]

Figure 3.4 Process of Identification of CAAFAG and Data Collection

As mentioned above, both qualitative and quantitative methods were applied in the series of study with CAAFAG. The qualitative described experiences, behavior and the current situation of children. Only guidelines were developed in the qualitative stuffs. Researchers had proved in depth regarding the issues during the involvement and after the involvement as required. Purposive and snowballing sampling methods were applied for selecting the research participants. The methods used were similar to those described for Phase I.

Key Informant Interviews (KII) - Key informant interviews were used to identify community perceptions of and experience with returned children. Interviews were conducted with returned and community children, their parents and relatives, community leaders, teachers, traditional healers, journalists, health workers, NGO workers, service providers etc.
Focus Group Discussion/Narrative Focus Group Discussions (FGD/ NFGD) – Different nature of group discussion was conducted during collecting data. FGD was generally completed with community people to identify the resources available in their community that support CAAFAG to integrate successfully. In NFGDs, individuals were provided with a story (narrative) about a returned child, and then the respondents discussed major issues with regard to the psychosocial reintegration of the child in the community. Twenty-three NFGDs were conducted with separate groups including returned children, their families, other community children, women’s groups, teachers, etc. Mostly this nature of discussion was taken place to discuss in the sensitive issues.

Case Studies – Case studies of well-integrated and poorly-integrated returned children in the community were collected from nine returned children and their social networks. The aimed of the case studies was to identify real experiences of support and difficulties perceived by children during the reintegration process and its effect in their psychosocial well-being.

Quantitative Surveys – Structured questionnaire was used for all children interviewed. Some of the instruments were measuring the psychological distress which were mostly adapted from the western settings and validated in Nepali context and some of them were developed on the basis of qualitative information.

Quantitative surveys were designed to assess the psychosocial well-being of returned children and compare this with children who did not associate with armed groups. The quantitative survey included a number of psychological surveys that have been adapted specifically for use in the Nepali context. Furthermore, other psychosocial questions were taken directly from indicators that returned children identified in the CLI process (see Chapter 4).

3.5 Transcultural Translation and Validation

Effectiveness research of psychosocial interventions for children affected by armed conflict in Nepal has used these instruments as outcome indicators. In international mental health research, brief self-report questionnaires are commonly used as they require minimal time, limited or no clinician involvement and are readily available. However, these instruments are usually developed in western populations and are validated in the same populations. We cannot therefore assume that in
other cultural and social contexts such instruments will measure what they are intended to measure. The different meaning, clustering and experience attached to symptoms cross-culturally may cause bias. Therefore, a self-report questionnaire should be validated in a new socio-cultural setting. Validated instruments serve several purposes: (1) better interpretation of the conducted effectiveness research outcomes; (2) for future research into mental health of children in Nepal; (3) validated screening instruments can be used for treatment planning, as well as for assessment purposes for clinicians. Validation was done against the clinical assessment by an experienced psychosocial counsellor.

The objective was to assess the psychometric properties of the outcome instruments for the effectiveness studies on psychosocial interventions. The aim of this research was to test the psychometric properties of the instruments used in the effectiveness research. Validation means the level of accuracy of the instrument to detect caseness compared to the standard. This means comparing the scoring of children on instruments against a counselor’s clinical assessment, to assess how well instruments detect ‘caseness’.

One school was randomly selected for data collection. Random selection was done based on a list of all accessible schools in the targeted (project) district. The validation study took place within Dang district, at the Mahendra secondary school in Tulsipur. The validation study included 162 school children from Dang district of whom 52 (32.1%) were boys and 110 (67.9%) were girls. The age of the respondents ranged from 11 to 14 years (Mean=13.2, SD=0.93). They were primarily from grade 6 (14.8%) and the remaining (85.2%) were from grade 7. Roughly three-fifths (57.4%) of the study participants were Brahmin/Chhetri caste followed by Tharu (24.1%) and Dalit caste (7.7%). Of the sample, almost all the children (98.8%) were Hindu, had 5 to 8 family members (67.3%), and were living in their original village (90.1%).

In this study an experienced psychosocial counselor was chosen as the golden standard. Through a clinical assessment, using the semi-structured Global Assessment of Psychosocial Disability (GAPD) tool (Dyrborg et al., 2000), the counselor divided the group into those indicated for psychosocial treatment and non-indicated. The Global Assessment of Psychosocial Disability (GAPD) interview’s primary goal is to identify to what degree an individual’s daily functioning is impaired by psychosocial problems. The GAPD scores children on psychosocial disability in a range between zero and eight.
Subsequently, trained interviewers administered the Child Psychosocial Distress Screener (CPDS), Child Post-traumatic Stress Scale (CPSS), Child Anxiety Related Emotional Disorder (SCARED) and Depression Self-Rating Scale (DSRS).

For the effectiveness research mentioned above, a context-specific instrument to assess impairment of daily functioning of children was developed, using an adaptation to the methodology of Bolton & Tang (2002). The main reasons to develop a new instrument was to emphasize functioning as an outcome measure (rather then symptom oriented instruments only) and to include a context specific outcome measure (as opposed to Western developed instruments only). The Daily Functioning tool consists of 10 items, representing daily activities that children have reported and ranked in order of importance/relevance (Tol et al., under review).

Table 3.4 Instruments Undergoing Transcultural Translation and Validation

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPSS</td>
<td>Child PTSD Symptom Scale (Foa et al., 2001); 17 items</td>
</tr>
<tr>
<td>SCARED-5</td>
<td>Screen for Child Anxiety Related Emotional Disorders (Birmaher et al., 1997); 5 items</td>
</tr>
<tr>
<td>DSRs</td>
<td>Depression Self-Rating Scale (Birleson, 1981); 18 items</td>
</tr>
<tr>
<td>DF</td>
<td>Daily Functioning Adaptation of methodology by Bolton &amp; Tang (2002); 10 items</td>
</tr>
</tbody>
</table>

All instruments were translated into Nepali, with a procedure develop for cross-cultural translation of research instruments (Van Ommeren et al., 1999). The procedure consists of five steps, after each of which the working translation is revised: 1) Translation from English into Nepali, and lexical back translation; 2) Review by a bilingual mental health professional; 3) Evaluation of items in a focus group of children from the study area; 4) 'Blind' back translation from Nepali into English by a bilingual professional who was unfamiliar with the original version and comparison of the back-translation with the original; 5) Pilot testing in a school.
Figures 3.5 and 3.6: The Dhoko scale (pictured above) was an example of a locally developed rating scale for severity of symptoms. However, this scale was rejected in favor of the water glasses rating scale (pictured below), which was more salient for children. The research assessor solicited for each study participant his or her parents a written consent from prior to enrolment in the study. Only respondents with parental consent were included in the study. All study participants were informed of their right to refuse participation and to leave the interview at any time. Moreover, confidentiality of the information provided by study participants was ensured.

Statistical analyses were done with SPSS 12.01, and included paired t-test to compare the averages of instrument total scores between indicated and non-indicated groups and Receiver Operator Characteristics (ROC) to assess the overall accuracy of the instruments to detect caseness as established by the counsellors, characterized by an area under the curve measure (AUC). Diagnostic sensitivity is the probability of a positive test.
result given the condition is present. Specificity is the probability of a negative test result given the condition is absent. Sensitivity and specificity are the most widely used statistics used to describe a diagnostic test. Sensitivity is probability of a positive test among patients with disease. Similarly, specificity is the probability of a negative test among patients without disease.

The mean scores between indication to treat and non-indication to treat group in all instruments were significantly different. Children indicated for psychosocial treatment (GAPD>4; n=28 [17%] of the sample) had higher scores on all standardized instruments. For example, the mean score of CPSS among the "indication to treat" group (22.6) is greater than the "non-indication to treat" group (16.5). Similarly, the mean score among the "indication to treat group" in depression self rating scale (DSRS), and the daily functioning (DF), are higher in "indication to treat" group than the "no-indication to treat" group. To test whether this difference is statistically significant we have carried out t-test analyses. For all instruments these differences in means between the "indicated" and "non-indicated" groups are statistically different.

Table 3.5 T-Test Results

<table>
<thead>
<tr>
<th>Instruments used</th>
<th>No-Indication to treat (n=134), Mean (SD)</th>
<th>Indication to treat (n=28), Mean (SD)</th>
<th>T-test, T (d); p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression self rating scale (DSRS), 18 items</td>
<td>11.0 (3.2)</td>
<td>15.6 (4.1)</td>
<td>-6.520 (160); .000**</td>
</tr>
<tr>
<td>Child post stress symptoms (CPSS), 17 items</td>
<td>16.5 (5.8)</td>
<td>22.6 (6.4)</td>
<td>-4.999 (160); .000**</td>
</tr>
<tr>
<td>Daily functioning (DF), 10 items</td>
<td>4.1 (3.0)</td>
<td>6.2 (3.5)</td>
<td>-3.216 (160); .002**</td>
</tr>
<tr>
<td>Anxiety (SCARED), 5 items</td>
<td>3.1 (1.7)</td>
<td>4.1 (2.1)</td>
<td>-2.959 (160); .004**</td>
</tr>
</tbody>
</table>

Additionally, the correlations between all the instruments and the clinical assessment are positive and significant. The significant difference in mean scores between the two groups and the significant correlations means that we can continue to establish the exact psychometric properties of the instruments.
Psychometric Properties of Instruments

Based on the ROC analysis, the areas under curve (AUC) values indicated good accuracy for DSRS (.82); fair accuracy for the CPSS (.77); and poor accuracy for DF (.67) and SCARED (.64). Optimal cut-off scores are determined by looking at the point when sensitivity and specificity are highest. In determining the cut-off scores we have chosen optimal points that give a premium to specificity for DSRS, CPSS and SCARED. Optimal cut-off scores a summarized in Table 3.7.

Table 3.6 Psychometric Properties of Instruments

<table>
<thead>
<tr>
<th>Instruments used</th>
<th>AUC</th>
<th>Cut-off Score</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression self rating scale (DSRS)</td>
<td>.82</td>
<td>14</td>
<td>.71</td>
<td>.81</td>
</tr>
<tr>
<td>Child post stress symptoms (CPSS)</td>
<td>.77</td>
<td>20</td>
<td>.68</td>
<td>.73</td>
</tr>
<tr>
<td>Daily functioning (DF)</td>
<td>.67</td>
<td>4</td>
<td>.71</td>
<td>.48</td>
</tr>
<tr>
<td>Anxiety (SCARED)</td>
<td>.64</td>
<td>4</td>
<td>.57</td>
<td>.61</td>
</tr>
</tbody>
</table>

This study was conducted to assess the psychometric properties of instruments used for the effectiveness research of psychosocial interventions for children affected by armed conflict in Nepal. The DSRS has a good level of accuracy while the level of the CPSS had moderate ability in detecting indications for psychosocial intervention. The SCARED and DF have a poor level of accuracy in determining such caseness. Though they are fairly accurate, it needs to be kept in mind that the DSRS and CPSS are not designed to be screening instruments for the general population, rather they measure a specific construct/disorder. This study provides information on the accuracy of these instruments only in terms of indications for treatment, not their accuracy for assessing the constructs they have been developed for. The DF appears to be poor in detecting indication for psychosocial treatment, however the instrument was not designed as a screening tool. Implications for the interpretations of the effectiveness studies are important. We can now better interpret the (baseline) levels of psychosocial problems and interpret the changes that have taken place in terms of a Nepal-specific threshold.
3.6 Conclusion

This chapter described the need to consider ethical principles central to conducting research with a vulnerable population such as CAAFAG. In the beginning of the chapter, we introduced four principles that combine research human subjects’ protection concepts with the psychosocial intervention guiding principles outlined in Chapter Two. The four themes are do no harm, balance research costs and benefits for participating CAAFAG, connect research to intervention to produce evidence-based interventions, and assure that planning includes a transition from emergency relief to long term MHPSS infrastructure and human capacity development.

The remained of the chapter outlined the specific research approaches used. We highlighted the need for mixed-methods approaches, i.e. a strong integration of qualitative and quantitative research methods. The design also emphasized researching not only CAAFAG but also other non-combatant children, families, community groups, traditional healers, leaders and other in children’s social ecological network. Only by understanding all of these levels is it possible to develop appropriate interventions that can benefit the entire community. The design approach also emphasized the need to not rely upon only Western-developed questionnaires of mental health. Local adaptation through the transcultural translation process is crucial for any instruments used. Moreover, developing instruments locally is also crucial to assess MHPSS in culturally appropriate and meaningful way.

KEY CONCEPTS

3.1 Any research should take a do no harm approach to avoid this risk of exacerbating mental health and psychosocial problems through the research process. Safety is a primary concern as children may be put in jeopardy by participating. Secondly, participation in research risks stigmatization which should be addressed by choosing the least stigmatizing language according to local ethnopsychology.

3.2 Research should balance risk and benefits. For example, participation in research should have greater benefits for children compared with the time that could be spent in other activities. Research should identify the main needs. Research
on psychosocial issues should not occur isolation, but should be incorporated into other activities such as education, physical health, and transitional justice.

3.3 Research in complex emergencies should be done always keeping in mind the *translation to intervention*. Research that does not contribute to improved intervention may not be optimal for individuals in complex emergencies. Interventions designed for complex emergencies should rely strongly upon the local context. Therefore, evidence-based interventions should be the gold standard for complex emergency psychosocial activities.

3.4 Research should be designed in a way to assess both long-term chronic social problems and acute changes in the emergency setting. Research should then be used to develop intervention programs that *link emergency relief to development of long-term mental health services*.

3.5 Research in complex emergencies should *combine qualitative and quantitative approaches in a mixed methods approach* to best meet identify resources, risk factor, and MHPSS in the local context.

3.6 Quantitative assessment tools should include Western measures that have undergone *transcultural translation and validation*. And/or, measure should include *locally developed psychosocial indicators*. Simply doing translations and back-translations of Western psychological and psychiatric resources may produce results that cannot be interpreted at best or may be misleading at worst.
References


Psychosocial Support Model for Children Associated with Armed Forces and Armed Groups in Nepal

Adolescent Mental Health, 14(1), 2-14.


Chapter 4 Goals – The goals of this chapter are

i. discuss the rationale for using participatory approaches

ii. introduce the psychosocial application of participatory processes

iii. describe the Child Led Indicator (CLI) approach used with CAAFAG

This chapter discusses a participatory approach that was used to collect much of the data presented in Section II. The participatory approach also strongly influenced the design and implementation of the intervention described in Section III.

4. Child Led Indicators

4.1 Background on Participatory Approaches

The concept of ‘child participation’ has emerged from the field of community development and global discourse on children’s rights. Participatory approaches evolved to improve the development process by engaging beneficiaries in programme planning, implementation and resource control. The increasing realization that economic progress alone does not improve the lives of the poor and disadvantaged, has led to philosophical and practical trends that seek to empower vulnerable populations. This is done by engaging them as the source of solutions rather than the source of problems (Freire, 1975, 1998). These ideas have influenced thinkers and actors in many fields, and underlie the development of participatory tools in which practitioners employ various techniques to encourage disadvantaged, usually rural, communities to reflect on their lives and propose solutions. At a practical level, humanitarian workers have found that such an approach encourages communities to ‘own’ solutions, thereby ensuring greater programme sustainability. Chambers (1992) referred this process as participatory rural appraisal (PRA), a methodology that grounds rural empowerment in local analyses of existing realities, and local ownership of actions geared toward changing those realities.

1 This chapter is adapted from Karki, Kohrt, Jordans (2009) Child Led Indicators: Pilot testing a child participation tool for psychosocial support programmes for former child soldiers in Nepal. Intervention 7(2): 92-109.
The United Nations Convention on the Rights of the Child (CRC) (United Nations, 1989) aided this approach to empowerment by setting standards for child rights that emphasized child participation. The convention provided a clear mandate for attending to needs and concerns, as voiced by children themselves, rather than imposed a priori by adults. The CRC recognizes children as rights holders with the capacity to participate in defining their own wellbeing, rather than treating children as passive objects of adult interventions (Woodhead et al., 1997).

Landsdown (2001) writes;

“Article 12 is one of the general principles of the CRC. It states the right of children and young people to express their views freely in matters that affect their being, provided the opportunity to do this in various forums that have a responsibility for their affairs. Children’s participatory involvement in the process to improve their collective situation and those within their community exemplifies their role as citizens. This article presents one of the CRC's most fundamental and far-reaching principles.”

In order to maximize the benefit of participatory approaches, a number of researchers and interventionists have proposed possible solutions. For example, there is some consensus in the development sector that development agencies should make resources available to children in order to promote participation and empowerment (Ennew, 1994). Children’s input has demonstrated some positive outcomes in programme development. This has been seen at the local level in South Asian countries, where children have been successful in influencing local level decision making without endangering them by overtly threatening pre-existing power relations (Williams, 2004). While there have been advances, such as the World Bank considering how to include children as programme partners to further enhance their participation in programmes (Miljeteig, 2000), other fields have generally ignored child participation. For example, programme planning in emergencies (Jabry, 2005). Ultimately, many of the problems raised by children at the local level require national level solutions. To address this, political agreement among power holders at the national level is required to realize child rights (Hart, 2008). It is not only local cultural issues, but also organizational culture and internal power structures of development and humanitarian organizations, which may significantly mute the voice of children (Hart et al., 2004).

UNICEF (2001) suggests that children who grow up in a participatory
atmosphere do better, reach higher levels of moral development, become more socially involved, and have fewer psychological and social problems. The growing field of psychosocial interventions is a key arena to address both issues of child participation as well as possible limitations of this approach. The Psychosocial Working Group (PWG) (2003) suggests that participation itself is psychologically beneficial because it helps to restore dignity and a sense of control, especially following overwhelming experiences (Hobfoll et al., 2007). Child participation in the aftermath of disaster will help them to regain a sense of agency and security, and ultimately foster resilience (Markenson & Reynolds, 2006). Similarly, a study conducted by Hart (2004) suggested that child participation in humanitarian action can open doors for enhanced protection. This was illustrated in one of the examples; ‘...a child is much more likely to be preoccupied with the difficulties of crossing a mine field to fetch water today, than remembering an experience of fighting which happened several years ago’ (Hart, 2004, p23). This example illustrates how the reality of children’s wellbeing may be counter-intuitive to programme developers, who may in turn focus on major traumatic events. Whereas for children, daily struggles may be more debilitating. A participatory approach may therefore have large implications for programme planning and funds allocation.

Humanitarian workers have incorporated the need for participation in their guidelines and consensus statements. The most recent edition of the Sphere Handbook (2004), which outlines minimum standards for the response of agencies to disaster, emphasizes the need to involve children as participants in the various stages of the programme cycle. Similarly, the Inter-Agency Steering Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) emphasize the necessity for participatory assessment, monitoring and evaluation with children.

The aim of this chapter is to present a pilot-tested method for child participation, within a protection programme for former CAAFAG focusing on psychosocial support. The approach links different steps of participation with programming stages, using a psychosocial framework. We outline a systematic method highlighting successful outcomes and major limitations. While we present a specific model here, practitioners should not feel limited to any single stereotyped approach, but rather consider myriad ways in which they can foster children’s participation. The model presented here is just one such example.
4.2 Methods

The Child Led Indicator process was developed by the Transcultural Psychosocial Organization (TPO) Nepal, drawing upon initial input from Save the Children Sweden, with the goal of having a tool to better involve children in designing and monitoring psychosocial support programmes. TPO fieldtested, and subsequently modified, CLI based on input from child participants.

This approach highlighted a number of areas where children can be involved. First, children can provide relevant insights, experience and views unique to their lived experience. Second, children can determine the characteristics of their wellbeing, specific to their particular socio-cultural context, and revealing their knowledge of socio-ecological resources in their community. Third, children can outline the necessary steps and activities required to elicit support from community resources. This sets the foundation for the development and implementation of subsequent programming. Fourth, children can develop indicators that they are able to identify, record, and follow over time. Fifth, children can assess the programme impact by evaluating changes in the lives of girls and boys, using the developed indicators. In addition, practitioners can employ indicators developed by children to guide other programming in similar topical areas, or cultural contexts.

Before going through each of the steps, it is important to consider group composition. Similar to forming a focus group, it is important to create a balance between homogeneity and diversity. In our work, the larger groups (about 5-12 children) were CAAFAG in a specific age range (13-16 years old). Then, facilitators subdivided the groups into smaller working units, such as dividing the participants into subgroups based on gender. The structure and subdivisions ultimately will depend on the topic and type of children in the programme.

Below we described the seven steps of CLI sequentially, highlighting the unique information emerging from each step, Table 1 provides an overview of the steps and their goals.
### Table 4.1 Steps and Goals of Psychosocial Child Led Indicator Process

<table>
<thead>
<tr>
<th>Steps</th>
<th>Activities</th>
<th>Outputs</th>
<th>Skills developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heartmind map</td>
<td>Drawing the heartmind, positive and negative emotions, and experiences related to these emotions</td>
<td>Visual map for children to show positive and negative emotions with life experience</td>
<td>Describing feelings, emotions, and experience</td>
</tr>
<tr>
<td>2. Priority ranking of psychosocial problems</td>
<td>Identify main psychosocial problems which produce stress in a children’s lives</td>
<td>List of 3-5 main psychosocial problems, and selection of a common problem for all children to discuss in subsequent steps</td>
<td>Identify concerns and prioritize them. Work in a group to come up with a shared psychosocial problem</td>
</tr>
<tr>
<td>3. Cause and effect tree</td>
<td>List a range of causes of main psychosocial problem, identify both proximal and distal effects of the psychosocial problem</td>
<td>A cause and effect tree diagram illustrating causes to mitigate and effects to minimize</td>
<td>Connect psychosocial problems with larger social issues in the community and think about consequences in both short and long term framework</td>
</tr>
<tr>
<td>4. Desired state of psychosocial wellbeing</td>
<td>Utilizing the problem analysis helps children to envision the situation where there is no such traits of psychosocial problems</td>
<td>A list of important positive psychosocial objectives to achieve through certain interventions</td>
<td>Help children recognize strengths and positive attributes even among children with difficult psychosocial problems, and help children envision wellbeing to achieve when addressing psychosocial problem</td>
</tr>
<tr>
<td>5. Resource mapping</td>
<td>Make a list of existing community and personal resources which can be mobilized to address psychosocial problem</td>
<td>A resource map of personal and social factors to include in intervention programming and activity development</td>
<td>Help children to identify existing resources in their community which can be mobilized to improve their wellbeing</td>
</tr>
<tr>
<td>6. Proposed activities</td>
<td>Make a list of activities which could be done with existing community resources to address psychosocial problem</td>
<td>An activity matrix for addressing the psychosocial problem including the roles of children, families, and other community members in carrying out the activity</td>
<td>Help children to think about solving problems with existing resources, and help children to plan concrete activities they can do with peers</td>
</tr>
<tr>
<td>7. Indicators for programme monitoring and evaluation</td>
<td>Refer to the objective situation and ask children what kind of changes you would see if you achieved your stated objectives and implemented your planned activity</td>
<td>A list of child led indicators which can be used by children for self monitoring and by programme implementers for participatory monitoring and evaluation</td>
<td>Help children envision what a successful programme looks like and how to recognize improvement</td>
</tr>
</tbody>
</table>
4.2.1 Description of the Seven Steps of the Child Led Indicator Process

(1) The heartmind map (manko chitra) is a tool to help children discuss their psychological and social wellbeing in terms of the Nepali concept of ‘heartmind’ (man). The heartmind (man) is the organ of emotion and memory, and the site of anxiety (chinta) and sadness/depression (dukha) (Kohrt & Harper, 2008). Facilitators ask children to draw their heartmind in any form they choose; examples have included faces, flowers, fish, and flags. Then, the children write any positive or negative emotion within the picture of the heartmind. The facilitator helps the children by encouraging them to write any emotion they would like. The facilitator explains that it does not need to be his or her own emotion, it can be anyone’s. This helps children feel comfortable and less self-conscious. Thus, the heartmind map forms the basis for children to express both their positive and negative feelings. After drawing the heartmind and writing thoughts and feelings within it, the next step is to have children map out the type of experiences that can contribute to these feelings, thoughts, and memories. The final picture typically resembles an image with feelings written inside and then surrounded by different types of experiences and activities.

(2) Priority ranking and selection of focal psychosocial problem The goal of this step is to have children work together in their subgroups to identify the most important issues confronting their lives. The facilitator may ask the participants to look at their heartmind maps and think about the emotions, thoughts, or feelings that cause them the greatest distress. This may be fear of domestic or political violence, worries about how to meet basic needs, bereavement, regret about having left school, etc. We have found that children often combined feelings with the events that created them. It was rare to have children describe a single emotion, such as fear, independent of the cause. Moreover, we found that having emotions tied to the context actually was beneficial in later steps, thinking about solutions. Facilitators ask the groups to select three to five of these important psychosocial problems in their lives. Then the groups pick one psychosocial problem to discuss. They can pick it based on severity, frequency, or any other criteria they choose.

(3) Cause and effect analysis The goal of this step is to help children describe the causes of the main psychosocial problem. Then the children describe how the problem affects their lives. During this step, the facilitator asks the children to come up with a list of causes that contribute to their psychosocial problem. If their concern is domestic violence, a cause
may be alcoholism. If the psychosocial problem is regret about leaving school, causes may include the family being unable to pay for a school uniform, or needing to stay at home and care for younger siblings. If the psychosocial problem is loneliness, the cause may be the death of a relative or being forced to move because of a natural or manmade disaster. Often, with some encouragement, children are able to identify a range of causes creating the chosen psychosocial problem. The facilitator then asks the children to consider the effects of the psychosocial problem - both current, and in the future. For example, if the family or armed group forced the child to leave school, the child should describe how that is affecting him or her now, and how it will affect him or her in the future. This helps to give a clear overview of the causes and effects of the main problem. Thereafter, this provides comprehensive analysis of the problem from the children’s perspectives and educates the programme staff more about the broader context and concerns regarding the problem. One effective way to conduct this step graphically is through a cause and effect tree. In the tree, roots represent the cause, the trunk is the main problem, and the branches and leaves symbolize the consequences, with more proximal effects on close branches and distal effects on distant branches or leaves.

(4) Developing a desired state of wellbeing. It is crucial that the CLI process focuses on strengths, resilience, and building hope, and not solely on problems. While problem analysis presents the negative aspects of an existing situation, analysis of objectives is an opportunity to describe a positive future situation where children have solved their main problem. During analysis of objectives, children identify potential solutions for a given problem. This involves the reformulation of the ‘problems’ identified into positive ‘objectives’. The objectives derived should reflect the future, desired situation, but should also be realistic and achievable. The rationale of the reformulation is to derive the objectives directly from the actual existing problems identified earlier. In fact, children have to develop a wellbeing situation, which is opposite of the negatively formulated problem. The children benefit by foreseeing a future where they are better equipped to prevent, or cope, with psychosocial problems. The outcome of this step will help in developing child framed project objectives, with the target of achieving this desired state of wellbeing, and guide development of activities and resources in the next steps.

(5) Resource mapping helps children to identify socio-ecological resources present in the community. They deem these resources necessary to achieve their desired state of wellbeing. In many post conflict and post disaster
settings, the infrastructure is significantly destroyed, or in various states of reconstruction. In such circumstances, children often creatively rebuild their social support systems. The goal of this step is to help children brainstorm which resources in their community they could access to help address their psychosocial problem and achieve their desired wellbeing. At the same time, children need to help determine and assess the strength and weakness of existing resources. The facilitator may gently point out possible challenges of resources proposed by children, so that the children can brainstorm how to overcome these factors. In doing so, the facilitator needs to identify the expected support of the children from the identified resources, i.e. to help children realize that they are responsible for being proactive agents meeting their own needs. This step will help to incorporate the existing resources into programme planning.

(6) Activity listing helps children plan, and take initiative, in designing the activities that could form an important base for developing the programme to reach their ascribed wellbeing situation. Children feel more ownership and willingness to participate in its implementation when they see that dedicated adults are assisting in bringing their designed activities to life, in order to achieve their wellbeing. This step is another opportunity for the facilitator to encourage children to think about their own responsibilities and agency in helping to achieve their target psychosocial wellbeing. In addition, activities should rely upon existing community resources to the greatest extent possible, to minimize the requirement of external (and possibly less sustainable) resources. The child designed activities should include the role of children in such activities, along with the clearly defined roles that children expect from their families, community members, and NGOs, and to develop an estimated timeframe and concrete action plan to implement those activities.

(7) Development of indicators is the final step of this CLI process. Indicators are the measurement of changes that children are trying to develop, based on their earlier identified objectives (Step 4). Children will ask to connect different positive psychosocial traits with different activities and resources in the development of indicators. Thereafter, evaluators can employ these indicators to monitor the activities conducted, to achieve their set objectives. This step helps children to come up with distinct measures and endpoints for their activities. These developed indicators are contextually relevant and will further strengthen the programme by providing a basis for a monitoring and evaluation mechanism. Moreover, the IASC Guidelines on MHPSS call for the development of contextual indicators, which will help to
guide programme planning, monitoring, and evaluation processes within a particular cultural context (IASC, 2007). The child developed indicators set a benchmark against which programmes could be evaluated, both at the outcome and impact level. This step is particularly important so that children see if their activities will actually address all of the psychosocial goals they set up in Step 4. If they find that one of their psychosocial goals does not fit as an indicator for any activity, then they may need to go back to Step 6 and design another activity.

4.2.2 CLI Process with CAAFAG

The results below provide an example of the CLI process as conducted with former girl CAAFAG. The CLI was conducted by a psychosocial facilitator who had received 1 month of qualitative and quantitative training, as well as a specific 3 day training in CLI, including conducting a CLI learning process, in Kathmandu. Participants were recruited from the sample of former CAAFAG in the larger quantitative study. For the CLI described in this chapter, the group included eight girl soldiers (ages 14-16, mixed caste and religion). All girls were no longer associated with an armed group and were now living back in their home community. The CLI was conducted in a rural area (district name not disclosed for security reasons).

Table 4.2 Example Data from One CLI Process

| Step 1: Heart-mind map | Positive feelings: Happy to return back to their community; Ability to speak and learn more; Increased understanding of helping ‘Dalit’ communities; Increased leadership ability  
Negative feelings: Facing hardships in armed groups; Feeling bad after the commander’s punishments; Feeling sad because of the behaviour of community members after returning home; Being teased by friends and teachers; Feels angry when meeting armed group |
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<tbody>
<tr>
<td>Step 2: Identification and priority ranking of psychosocial problems</td>
<td>Feeling afraid of re-recruitment; Being hit, beaten and not allowed to speak; Made to do sit ups as a punishment; Feels awkward to eat in the laymen’s/citizen’s home; Society being negative; Backbiting by girls; Being teased by teachers and peers; Friends do not want to sit together at school</td>
</tr>
</tbody>
</table>
| Step 3: Causes and effects of primary psychosocial problem | Main Problems: Fear of re-recruitment  
Cause: Recruited for election and revolution processes; Because we were admitted in army before; To take us into battle; For women’s development  
Effects: We don’t get to study; Our future is spoiled; Difficulty in sustaining life; Unable to fulfil the things desired in life; Possibility of being kidnapped again, ruined life; Family is affected by separation; Be put in a situation in which even death should be faced |
<table>
<thead>
<tr>
<th>Step 4: Ideal wellbeing</th>
<th>Able to study with full concentration; Having no threat of re-recruitment; Increase in self-confidence; Become hardworking and faithful; Development of speaking ability</th>
</tr>
</thead>
</table>
| Step 5: Resource mapping | Family/relatives: Family and relatives should manage time for studies  
Home and society: It would be better if, people from villages and society perceive us in a good way; People from the village should not use the words like ‘Maoist’  
Organization: It would be good if organizations helped children like us to study  
Teachers: Teachers should behave towards every child equally  
Politicians: All political parties should stop using children  
Nation: It would be better if plans related to the rights of children to improve future |
| Step 6: Activities | Creating public awareness programmes in villages, society and nation;  
Pasting leaflets to give out different types of information; Circulating information through media; Making, giving and pasting wall-magazines; Informing about child rights; Campaigning at the National level |
| Step 7: Child led indicators | Indicators: Living happily with family at home; No fear of re-recruitment; Good behaviour from teachers; Good behaviour from society and neighbours; Getting love, affection and help from everybody; Getting to study and be independent; Getting to participate in extra curricular activities at school; Adjusting well with neighbours  
Means of verification: Can be seen from the ways of speaking, sitting, dressing and eating; Marks obtained in respective subjects in exams; Inquiring through teachers, principal and friends; When neighbours become friendly; Through school records and attendance registers |

### 4.3 Benefits of CLI Participatory Approach

This chapter is an introduction to a framework for more systematic participation of children in psychosocial programming. In this example, a seven-step child led indicator (CLI) process was developed and piloted to incorporate child participation at different stages of programming during needs assessment, planning, implementation, monitoring and evaluation. The first two steps of CLI are ideal to elicit information on psychosocial status, especially for children in areas of conflict and war zones, or children affected by disasters. These initial steps highlight the areas of psychosocial distress most concerning children, from their perspective, and thus helps to inform programming to meet the needs specified by the children. The next four steps supplement this initial information by providing insight into the programme development approach, emphases, and actions for programme implementers. CLI produces clear goals and objectives for project work as defined by children. In addition, the steps shed light on existing socio-ecological resources and uncover pathways to take advantage of these resources. The last step results in specific indicators, which both children and adult evaluators can use to assess the impact of
a programme. When successful, the CLI process achieves the objective of bringing about positive changes in children’s lives in a manner amenable and acceptable to the children themselves.

In this pilot implementation of CLI, we worked with CAAFAGs reintegrated into home communities in Nepal. Below, we discuss the successes and challenges of this pilot work as it reflects upon the broader endeavour of child participatory approaches.

4.3.1 Needs Assessment

CLI was useful in eliciting information regarding the psychosocial needs of children who were the beneficiaries of proposed programming. Children of different backgrounds (e.g. differences based on caste, ethnicity, gender, class, educational background, disability, religion, region, etc.) had an opportunity to express their different needs within a common framework. For example, the concept of ‘heartmind’ allowed children of different genders, ethnicities, or caste to connect with a common understanding of feelings and wellbeing that was comparable across linguistic and ethnic groups (Kohrt & Harper, 2008). This way of data collection, utilizing heartmind as a framework, helped children to define psychosocial problems within their socio-cultural setting without the need to frame their emotions and experiences within Western concepts of mental health and psychology.

For example, evidence of a good heartmind (or ‘big’ heartmind) (McHugh, 2001) provided by girl and boy soldiers included helping people in difficult times, not discriminating against others, playing and enjoying time with friends, spreading peace in society, studying and becoming a good person, and sharing feeling with peers. Examples of a ‘small’ heartmind (an undesirable state) included friends teasing them for being Maoists, backbiting, not being able to study, friends not listening to them, feeling sad, people getting angry, staying alone, and being separated from family and friends. Experiences that cause pain in the heartmind included community discrimination, lack of acceptance upon their return in the community, not able to complete their education, and guilt. Children had the opportunity to describe these issues through verbal reports and visually, through drawings and other art.

By using CLI, we gained insight into the needs of children and the framing of those needs within a local ethno-psychological context. We would advocate the use of similar procedures in other settings of
intended psychosocial intervention. However, there is a limitation to the CLI process when used as needs assessment. By structuring the process into the heartmind map and subsequent steps, facilitators specifically channel children into identifying and describing their problems within a psychosocial framework. Children, using this approach, are not able to start with a totally blank slate to discuss their concerns. That said, with humanitarian and other agencies operating under specific mandates, they have definite constraints on children’s freedom in the type of needs that practitioners can address. This area needs further investigation.

4.3.2 Programme Development

CLI provides children with a basis to participate in the planning process. It helps in identifying (1) programme objectives to reduce target problems; (2) resources to achieve these objectives; (3) activities required to put those resources into action; and (4) the overall arch of programme activities aimed toward meeting a locally defined target for wellbeing among children. Child participation can help to identify resources in the midst of damaged social fabric observed in post conflict settings (Desjarlais et al., 1995) For example, boy soldiers in one of the districts identified guilt as one of their major problems because they had been involved in a lot of deforestation activity when building canals for the Maoists. Now, they blame themselves for the current consequences, such as landslides in their village. As a result, they want to reduce their feeling of guilt by planting trees in the affected communities. These boys saw the first step of a programme as the need to identify the resources in the community of those who could help in such tree planting activities. This example illustrates how children designed activities that could help improve their psychosocial wellbeing. This step also has two major limitations. The first is the scope of solutions available to children. While children’s strength may be their awareness of local solutions, they may be unaware of broader regional, national, or international solutions to problems. This is where it may be helpful to combine the interventions developed by children with interventions proposed by experts in the field. The challenge is to address balancing expert knowledge with children’s knowledge, so that children’s voices do not become lost in the chorus of more traditional sources of power. The second challenge is how to follow through with child developed activities. Contextual factors, as well as the commitment of intervening agencies, strongly dictate what can and cannot be done with and for children, as we will describe below.
4.3.3 Programme Implementation

In order to implement activities designed through CLI, it is important that children develop a detailed action plan to guide their involvement, and that of their peers, to facilitate effective adult supervision. For example, during the CLI activity design process, children discuss and divide the roles and responsibilities between adults and children for the implementation stage. Therefore, interventionists need to build regular communication between children and adults into programmes so that children can update adults continuously about their monitoring activities based on the selected indicators. The indicators developed during the process also help to guide adult activities during the implementation stages.

Programme implementation can be the major bottleneck in attempting child participatory psychosocial programmes. As mentioned above, while children are able to identify problems and design interventions, it is ultimately in the hands of adults running intervention programmes if, and how, this become translated into actual activities. Adults typically will decide which programmes to implement and how to modify child recommendations based on expert knowledge. As Hart (2008) and others have pointed out, a child based needs assessment and programme development may ultimately be used to justify preconceived programmes from development agencies. Development agencies may selectively choose to support some recommendations made by children, which are in keeping with prior activities of the organization, while discarding child recommendations that are novel or contrary to prior activities.

4.3.4 Monitoring, Evaluation and Impact Assessment Using Child Led Indicators

Participation of children in the development of indicators is crucial in setting up a participatory monitoring and evaluation system. Children develop indicators based on their concepts of desired wellbeing and their planned activities to achieve that wellbeing. For example, during the piloting of the CLI process with former child soldiers, many of the specific indicators were tied to a successful reintegration process. This illustrates how psychosocial wellbeing indicators are contextual and depend upon the programme’s target group, e.g. psychosocial indicators for CAAFAG may be very different from psychosocial indicators among child workers in brick factories. Table 4.2 lists some of the indicators in this pilot project.

One example of an employed child developed indicator was ‘positive
views of children from neighbours in the community.’ Based on this goal, interventionists directed considerable attention toward improving community members’ perceptions of former CAAFAG, especially girl soldiers. A significant part of this was fostering communication to counter suspicion of the motives of returning children, which often motivated community members to discriminate. They were concerned that the former CAAFAG were still associated with the Maoists and that they were acting as spies. By addressing this fear and children communicating their motives to adults, community perceptions improved. This was done in some communities through street dramas written and performed by children, in cooperation with local child clubs and facilitated by NGOs providing child soldier reintegration packages. Another factor influencing children’s treatment by community members was the perception that they would not be able to function in society. This became a ‘chicken and egg’ situation. Community members prevented children from participating in educational or vocational activities, thus the children could not demonstrate their ability to fit into civilian life. Reintegration support from NGOs took the form of enrolling children in school and in vocational training, this then helped jumpstart community involvement.

‘After getting support from the local NGO, the community perception toward us has changed. There is more respect and concern for us, especially when people find that we are doing well in school or in learning job skills’. 16-year old former girl soldier in Nepal

However, we also encountered a number of challenges for implementing a truly participatory approach to monitoring and evaluation activities. Originally, we had proposed having former CAAFAG take part as assistants in the field evaluation process. However, after exploring the ground reality of former CAAFAG in the community, it was determined that this would put the children’s safety in jeopardy, particularly in communities that expresses significant feelings of revenge toward former CAAFAG. Moreover, by being more visible, former CAAFAG would have been at greater risk of re-recruitment by armed groups. Thus, a fully child led evaluation would have been neither feasible, nor ethical. The outcome was to have research staff use child led indicators, in consultation with children in evaluating the impact of programmes. We would expect similar constraints in other settings, especially areas that have recently experienced political violence, in fully participatory approaches for child led evaluation.
4.4 Conclusion

A child led indicator process has the potential to include children throughout the programme cycle period, in a systematic and child friendly way. Children provide their input regarding issues and concerns, and propose solutions for appropriate interventions. The ultimate goal is to foster psychosocial growth through empowerment in the child participatory processes. A challenge facing advocates of child participation is when to consult children, and how to consult children, in designing programmes, particularly for programmes that could enhance their psychosocial wellbeing. Another drawback is the potential for threats to participation. This pilot project demonstrates the successes and challenges of including former CAAFAG in a reintegration programme in Nepal. The major challenges for the organization in this setting, and in general, are to take up child developed recommendations and work with the children to implement them. Future CLI approaches that carry through to the implementation phase should evaluate the impact of participation specifically as a contributing factor to improvement in children’s psychosocial wellbeing. The ability of organizations to take up the issues of children in an effective way provides a real platform for children’s effective and meaningful participation. However, participation in and of itself is not a panacea for psychosocial wellbeing, as it carries with it a series of risks and concerns that need to be addressed.

KEY CONCEPTS

4.1 Participatory approaches decrease the risk of stigmatization, increase local ownership and engagement, and are ideal to promote effective communication with the community.

4.2 Participatory psychosocial approaches require a grounding understanding of local ethnopsychology as a starting point to engage with beneficiaries about needs and challenges.

4.3 The CLI process, as conducted in Nepal, comprises 7 steps: (i) heart-mind map, (ii) psychosocial ranking, (iii) cause and effect analysis, (iv) ideal wellbeing, (v) resource mapping, (vi) activities, and (vii) child led indicators.

4.4 Participatory approaches, such as CLI, are best employed for (i) needs assessments, (ii) programme development, (iii) programme implementation, and (iv) monitoring and evaluation.
References


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Psychosocial Support Model for Children Associated with Armed Forces and Armed Groups in Nepal
SECTION - II

Conscription Risk Factors and the Impact of Conflict
Psychosocial Support Model for Children Associated with Armed Forces and Armed Groups in Nepal
5.1 Background on CAAFAG Conscription in Nepal

Contexts that promote recruiting children into armed groups are the result of larger national and international processes that produce local vulnerability. Poverty, gender and ethnic discrimination, and legacies of state-sponsored violence create circumstances in which children voluntarily join armed groups.

One of the major challenges in discussing children in war is considering how war specifically impacts children’s wellbeing against the backdrop of other threats to child welfare. In many war-affected regions, there are a range of other economic, social, and health problems. These include poverty, lack of education, exploitation to work in high risk employment, high prevalence of physical health problems, lack of clean water, and high risk of harm from traffic accidents. These problems are more common in settings vulnerable to war and are likely to worsen during the experience of armed conflict.
The question of whether a child’s wellbeing is impaired due to a war-specific event or other societal problems is difficult to separate. Careful identification of both war-specific and broader categories of stress and vulnerability is crucial to designing the most effective interventions. This involves practical considerations such as selecting appropriate screening tools and methods, and deciding who should be screened for interventions, as well as more broad policy issues about reducing the vulnerability of children. If all problems experienced by children are attributed exclusively to war, there is a danger that policymakers and interventions will divert resources to war affected children. This may not be appropriate or the best use of limited resources in low-income settings.

To understand child well-being, it is important to understand the threats and opportunities for child wellbeing in the pre-war context of Nepal. It would be easy to attribute the majority of psychosocial and mental health problems among children in Nepal today to the experiences of war. However, there was a range of threats to child wellbeing that existed prior to the People’s War. These threats existed before, during and after the war, and affect the general population and are not exclusive to children. For example, these risk factors include gender discrimination, caste-based discrimination, child labour, lack of healthcare, education, child abuse, child marriage, and poverty. Later in this chapter, we will discuss each of these individual factors and how they contribute to both poor psychosocial status and increase the risk of conscription into armed groups. Keeping these risk factors in mind, our goal is to address the following two questions:

1. What were the conditions of marginalized children before joining the armed groups?
2. How did these factors contribute to children joining armed groups?

To answer these questions we employed qualitative and quantitative tools to understand the mental health and psychosocial consequences of children’s participation in armed groups. The qualitative component included participatory approaches (with a technique known as Child Led Indicators (CLI) in which children developed their own psychosocial indicators of distress and well-being, see Chapter 4), narrative focus group discussions (N=25 groups) with children and community members, key informant interviews (N=152) with children and community members, and case studies (N=8) of CAAFAG. Study participants were identified through local nongovernmental organizations involved in child protection. Pseudonyms are used for all child case studies presented).
Data were gathered by a Nepali research team employed by TPO Nepal¹, who had a background in field research and had received a month-long training on qualitative and quantitative data collection as well as on the ethics of research with vulnerable children. The quantitative psychosocial epidemiological study was an assessment of 142 CAAFAG and 142 matched children who were never conscripted by armed groups.

Interesting findings arose from this research to answer our questions address (i) why did children join the Maoists, (ii) is there a typical profile for children who join the armed groups, and (iii) what were the conditions for children before they were being recruited?

5.2 Findings: How Children Become Associated with Armed Groups²

We begin the discussion of findings with case studies. The two cases presented below show differences in motivations for children to become Maoists. Raj, a Dalit boy from the western hills of Nepal, was conscripted at age fourteen. Shova, a Chhetri (high caste) girl from the southern plains of far western Nepal, joined when she was thirteen-years-old and spent three years with the People’s Liberation Army (PLA). Their stories are in the following boxes.

Case Study: Raj (17-year-old boy from Dalit caste)

In 2003… my father was plowing his field. Maoist boys and girls and their commander came and started beating my father so badly that he almost died. My father was innocent, but they said he had spoken against the Maoists… I was so helpless. I could not do anything for my father because I was scared that the Maoists would kill me. My father lost consciousness. The Maoists came into our house and threatened to kill my father if I did not go with them. I told them that I wanted to continue my schooling, but they did not listen to me. I was forced to go with them… I was only fourteen at that time. They took me… and I started training in their army.

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¹ All interviews were translated into English and analyzed using Atlas.ti with a codebook developed by three independent coders (intercoder agreement: percent agreement 0.90, Cohen's κ 0.82).
Case Study: Shova (16-year-old girl from Chhetri caste)

I was thirteen years old. I was a very shy girl who wouldn’t speak with people other than my mother… In our village, people used to come to ask my hand in marriage even when I was very young. Even a mention of marriage gave me a headache. I hated it! I wanted to avoid marriage in any way possible… I have a slightly older friend in the village. Against her will, her father married her off at a young age. She was miserable. She often said she would go to India or join the Maoists. She would die there, if need be. At least, she would be free from marriage. Like her, liberation was what I needed. At the time, many Maoist activities used to take place in our village… I liked their cultural program. Very entertaining! What a wonderful life—I would often think—I would have if I became a Maoist. I would get to travel a lot and wouldn’t have to be forced into marriage. Besides, I would also have a lot of friends!

5.2.1 Push and Pull Factors to Join Armed Groups

‘Push factors’ – The social reasons that drive children to join armed groups are known as “push factors” (Somasundaram 2002). These are aspects of the child, family, and community that recruiting groups will use to entice children to join up with them. The most important ‘push factor’ perceived by the communities interviewed was poverty. For teachers, parents, health care workers, political leaders, and others, poor economic conditions, unemployment, and inability to meet basic needs in the community were reasons for joining. Community members typically view returned children as coming from and returning to impoverished families. Brahmans, Chhetris, and Janajati in the different districts also highlighted poor family environment as the main reason for children joining. They viewed children who were associated with armed forces as coming from families that have domestic violence and alcoholic fathers. This perception was less common among Dalit community members. Janajati community members, more than other caste members, believed ‘fear’ was the reason that children joined. Other “push factors” included discrimination of certain groups within the community such as non-Brahman/Chhetri groups and women who were marginalized and thus joined the Maoists to escape this discrimination.

Direct interviews of children who had returned from their time with armed forces gave their reasons for joining. Their answers reflected a
range of push factors that matched the views of community members. 24% of children said they joined out of poverty, and 15% said they joined because change was needed in society, such as eliminating discrimination. Children also said they joined because of lack of opportunities in their communities and family problems. Girls said they joined to escape abusive marriages or joined before they could be forced into arranged marriages.

‘Pull Factors’ - Pull factors are created by the armed group itself. They are both methods of intimidation or enticement and promises made to children. Community members perceived the Maoist’s organised ‘cultural programs’ as one of the main tools to entice and appeal to children to join the CPN-M. Cultural program were propaganda activities typically held with singing and dancing to revolutionary songs, speeches by Maoist leaders, and other community activities to encourage the revolutionary spirit. Community members also highlighted the role of peer pressure in getting to children to join. Peers would goad children by saying, “If we can do it, then so should you.” Community members often described this recruitment as a “lahai-lahai” (children following one after another). Research in Sri Lanka with CAAFAG has referred to this process as a “Pied Piper” effect of children following one another.

Brahman, Chhetri, and Janajati community members also believed revenge was a common reason to join the armed groups. They explained how government security forces had killed family members or even tortured the children directly. In retaliation against the armed forces, children joined the Maoists. Community members also thought personal gain was a “pull” factor. For example, children who joined the Maoists could move forward in society, obtain a government job, and become wealthy through their association with an armed group. Another pull factor was thought to be sexual desire. A Brahman health-post worker from an eastern hill region described his experiences of seeing how young boys joined the Maoists as a sexual opportunity. Although this worker was the only respondent to spontaneously stated sexual desire as a pull factor, several other community members implied that sexual activity occurred within Maoist forces.

Of the returned children, 38% said they joined up because they were pressured by the Maoists. They explained the Maoist policy of ek ghar ek (one person from each household) dictated that one person from their home had to go. The children often saw their parents as unable to go because they were too old, too physically weak, or had too much responsibility.
for the family. Thus, children reported going in place of their parents. Personal advancement and personal interest was also a pull factor for 24% of returned children. The children explained that they joined to become big leaders, politicians, army commanders or similar roles. Other pull factors included interest in the Party philosophy (10%), and to get revenge on security forces for their actions (5%).

5.2.2 Push and Pull Factors in Ecological Context

Push and pull factors can be examined across a range of ecological levels. Ecological levels represent the different social tiers affecting children (see descriptions in Chapters 1 and 2). Many researchers have employed the ecological-transactional model to understand the wellbeing of children exposed to violence (cf. Belsky 1980; Cicchetti and Lynch 1993). Psychosocial interventionists working with children affected by armed conflict also have used this type of model (Betancourt 2005; Tol, et al. 2009). This ecological model consists of four levels: the macro-social, intermediate social, micro-social, and individual levels (see Figure 1.2):

- The **macro-social level** represents institutions, structure of social relationships, and processes that drive socially-patterned experience. This level includes economic systems (e.g. feudalism vs. capitalism vs. socialism), manufacturing, and corporate institutions that dictate employment availability and gaps that create niches of poverty.

- The **intermediate social level** represents the institutions that translate global and national processes into regional variations in experience. The intermediate social level comprises the “formal and informal social structures that make up the immediate environment in which children and families function,” such as neighborhoods, social support groups, and employers.

- The **micro-social level** is the domain of immediate experience, which in transaction with the individual, shapes experience through the amount of agency and/or resources an individual mobilizes. This includes the family environment as well as others in the home, school, and workplace.

- The **individual level** reflects children’s different histories, personalities, and psychobiological states.
The macro-social level ‘push factors’ involved in children associating with armed groups in Nepal include discrimination and marginalization resulting from a feudal legacy that concentrate wealth and political power among local elites based in Kathmandu; gender based discrimination, and the marginalization of low castes and ethnic minorities (see Figure 4.1). This has deprived many groups of education and full participation in the political process (Thapa with Sijapati 2003).

![Figure 5.1 Push and Pull Factors for Children’s Association with Armed Groups](image)

At the intermediate social level, push factors include the failure to enforce child protection policies such as the ban on child marriages and the destabilization of communities by government security forces through widespread state-sanctioned human rights violations (Lykke and Timilsena 2002). Micro-social level factors included local manifestations of these practices and reflected in local historical political and ethnic tensions (cf. Shneiderman 2003) and other experiences of marginalization.

Maoist recruitment strategies, i.e. “pull factors”, draw upon individual experiences that occur within a specific micro-social context. Women’s Maoist groups recruit girls with the macro-social ideology of gender
equality as an escape from home situations that oppress women. Shova saw the Maoists as an escape from the ill-fate of being forced into an arranged marriage as a teenager. In Shova’s case, her friendship was probably an important micro-level factor. For children that were exposed to sexual violence at the hands of police or army, joining the Maoist army afforded an opportunity to take revenge upon the perpetrators and to work toward a new country where there would be a Maoist-led security and justice system. For children who wanted to be part of the political process, joining the Maoists was a pathway that would result eventually in a government post in the ‘New Nepal’ society. One of the more powerful elements of Maoist recruitment, however, was simply the promise of a good time in which children could travel the country singing and dancing or learning karate. The Maoists channeled these recreational tasks into cultural propaganda programs.

The position of a child in relation to these push and pull factors has important consequences for psychosocial wellbeing. For Asha and Shova, the push factors focused on escaping repressive environments for girls. And, the pull factors were opportunities for women to assume roles of power and autonomy within the Maoists. In contrast, Raj did not describe push factors driving him away from his home and village. Instead, it was the acute and violent pull factor of the Maoists threatening to kill his father. Thus, mental health problems for Raj were personally attributed to the association with the Maoists. Whereas for Asha, her mental health problems are not described in relation to time spent with the Maoists.

Furthermore, agency at that the family (micro-social) level dictates susceptibility to Maoist pull factors. In our larger sample, we found that children who report being forcefully conscripted generally are those in the most vulnerable positions due to the marginalization of their families in the broader community context. Forcibly recruited children were distinguished from voluntary recruits by higher levels of family poverty. Among the poorest families, giving up a child was seen as the only option to meet Maoist demands. A resident of western Nepal explained,

“Those who have money have to give them cash, those who have food have to give them rice, those who have clothes have to give them clothes, and those who have nothing have to give them one member of their family” (quoted in Ogura 2004:123-24).

These findings illustrate that participation, whether it is reported as voluntary or forced, recruitment of children within armed groups follows
a predictable pattern based on the restriction of power and agency from the societal (macro-social) level all the way to the individual level in Nepali society. Understanding of these power processes is a first step to considering how to reduce the vulnerability of children to conscription in armed groups.

Across districts, individuals had differing views on whether joining was forced or voluntarily. In Dailekh and middle hill eastern districts (Terhathum, Taplejung, and Sankhuwasabha), 80% of community respondents viewed joining as voluntary. In Kailali, 72% of respondents presumed that children joined voluntarily. However, the percentage of community members in other areas viewing joining as voluntary was lower, Ilam (57%), Surkhet (40%). When asking the returned children themselves about the level of person control in joining, 28% of returned children reported joining on a completely voluntary basis; another 28% reported that the joining was partly voluntary and partly coerced; lastly, 43% reported that joining was completely coerced.

5.2.1 Psychosocial Impact of Type of Conscription

The manner in which children joined armed forces impact on their current psychosocial functioning and contribute to the amount of trauma they experienced while associated with armed groups. Children who felt pressured to join (38%) and children who joined because of poverty (24%) were much more likely to have psychosocial problems after their return to the community. Children who reported being completely coerced (43%) were more likely to have psychosocial problems and to experience traumatic events while associated compared with children who felt partly coerced (28%) or volunteered (28%). In addition, children who reported joining involuntarily had less social supports upon return to their community than children who joined voluntarily.

5.3 Pre-War Factors Influencing Children

Ultimately, the experiences of war are an outgrowth of the experiences of children in peace time. Kunda Dixit, journalist and publisher, explains:

“[During the war] children were the messengers, the sentries, cooks, porters, and this was not just with the guerrilla army, the state also used children, as cooks, or messengers, or porters. But this is really nothing new, it's just that, even without the conflict children had been working as porters or various child labour in Nepal; quite a lot of it.
It's not that because of the war there are lots of children being forced to work as porters, and a prevailing situation where children are exploited anyway, the war just added another level of exploitation.” (Koenig & Kohrt, 2009)

The reasons for children joining armed groups had different impacts on psychosocial well-being. Children forced to associate had considerably worse outcomes than children voluntarily joining armed groups. Specifically, joining because of threats or because of poverty places children at greatest long-term risk of psychosocial distress. Below we describe pre-conflict threats to children’s psychosocial well-being

5.3.1 Gender

Gender discrimination is a profound factor that increases vulnerability to a range of psychosocial and mental health problems. The Gender Development Index and Gender Empowerment Index are 0.452 and 0.391 respectively, both on the low end globally. This reflects the difference between women and men with respect to their in burden of labour. Less than half of adult women (48.9 percent) receive compensation for their labour whereas 67.6 percent of men are involved in activities that compensate them for their work. (CBS/HMG, 2004). Gender discrimination can be observed at all socio-economic levels and across all ethnic and religious groups. However, gender discrimination is most profound among conservative Hindu groups and may be less severe in other ethnic groups. Women describe greater mental health problems compared with men in numerous studies conducted in Nepal (Kohrt et al., 2005b; Tausig et al., 2004; Thapa & Hauff, 2005).

One girl described how in her mothers generation, women were not allowed to talk to anyone in public. They could only speak with their husbands. Another girl explained,

“There is discrimination between males and females. There’s no equal treatment... In our Hindu tradition, women are prevented from moving ahead of men in any type of work... We’re deprived of higher education... [W]e have worked hard in our village to work toward a better future and to become like men.... Parents do not think of a bright future for their daughters at all. They themselves haven’t studied a bit and how can they understand. If I tell them to educate women then they ask me “Is the elephant big because it studied.” Then what can I tell them.”
Author and activist, Manjushree Thapa explains,

“[F]rom a quite small age, ... things like nutrition are different for girls, as opposed to boys. The amount of work they are expected to do in the household is different for girls. They are expected to cut grass, they are expected to bring fodder for the animals, take care of the animals, much more so than the boys are; and the boys are expected to contribute a little bit... [A]s they get older, the expectations start to diverge more dramatically, the girls are... are pressured greatly to be more domestic, to be more active in the household arena and boys are encouraged more to go to school.” (Koenig & Kohrt, 2009)

Girls are more likely to have micronutrient deficiencies compared with boys. While boys have diverse diets including dairy products, eggs, meats, and a variety of vegetables, especially green leafy vegetables. In times of scarcity, girls are more likely to only receive grains and potatoes.

5.3.2 Caste and Ethnic Discrimination

Nepal’s population consists of more than 60 ethnic and caste groups. The caste system in Nepal is rooted in the India varna system which divides society into social rankings based on ancestral lineages (Höfer, 2004). The top of the caste system includes two main ‘high caste’ groups. The highest being Brahman (historically priests) followed by Chhetri (historically warriors and rulers). At the bottom of the caste system are ‘untouchable’ or Dalit castes. There are other ethnic groups; Janajati, are predominantly Buddhist and shamanist, and they engage with the caste system to varying degrees. Although the country has recently become a secular, federal democratic republic there is a long history of hegemonic dominance by the Hindu high castes (Brahman and Chhetri) over the Janajati ethnic groups and Dalit (Whelpton, 2005). Punishment in Nepal traditionally has been disproportional; based on caste status (e.g. execution for low caste accused of adultery contrasted with banishment for someone of high caste for the same offence), and inter-caste marriage was prohibited (Kisan, 2005). The caste system also relegates certain groups of individuals to demeaning professions such as cleaning toilets and streets, compared with carrying out funeral rites for Brahmin caste. In both law and practice, upper castes severely restricted the customs of Untouchables that relate to feeding, clothing, wearing of jewelery, places they could settle, owning household goods, and access to education.

Caste discrimination impacts adults and children. Low caste children were
traditionally unable to attend school. As children and adults, Dalits continue to be marginalized throughout Nepal with violent reactions by upper caste Hindus when Dalits try to visit temples, use public water taps, or participate in religious ceremonies (Kisan, 2005). Low caste children were, in some regions, taken into the homes of upper caste families as a source of labour. A recent study in Nepal found that somatic complaints related to depression were more common among low caste groups (Kohrt et al., 2005b). A 15-year-old Dalit girl in central Nepal hills explained,

“There is discrimination... In the village, most people consider us as untouchables. My parents also tell me not to come in contact with the villagers. The old people still discriminate us as untouchables. The Brahmin and Chettri girls of our village are financially better and hence can eat and live as they wish. I can’t live according to my wishes. My wishes can never come true. It’s because of my strong desire that I am even reading and it hurts me when some people question my aim to study. I am not provided anything. My financial status is very poor so I can’t even think for my future.”

“The girls of my caste do not study much. My caste is Nepali [Dalit, low caste]. They marry very early. They are not even sent to school. They are not treated well and get married at the age of 12 and 14. That is the kind of practice in our village.”

One 14-year-old girl from an ethnic minority group explained,

“While I was studying in the school, the Chhetris, Brahmins and Bhotes [group with Tibetan ancestry] would dominate us. They tried to harass us and we would be quarrel in the bench. We sometimes fought.”

An upper caste 15-year-old boy in another village explained,

“There is high discrimination. There are many Dalits in this society. They’re are orphans like us. If they buy new notebooks, the rich kids hide and tear them. The rich kids say that they can’t drink the water and eat the food that they have touched. These rich kids sometimes slap and hit them.”

5.3.3 Children and Labour

Children under 16 years constitute 40.9 percent of the total population and are a main source of labour throughout Nepal. In the home and
agricultural setting, children historically have been, and continue to be, involved in housework: cooking, cleaning, and caring for other siblings. These activities typically fall to girls. For agricultural work, children are involved in feeding and shepherding animals. Boys may take animals up to higher altitude pasture in the summer months and care for the animals alone. Both girls and boys are involved in harvesting and carrying crops. Girls often carry heavy loads of firewood gathered in the forest, back to the house in the early morning hours. A Nepali journalist explained,

“I don’t think childhood exists in rural areas, especially in extreme poverty conditions, the childhood basically doesn’t exist because starting between the age of six and nine, a girl child must help her household seven hours a day. And for the girl child between 10 and 15, she must spend nine hours a day helping in her house, so you can imagine what the situation is like in Nepal. And you could feel that in these circumstances, working nine hours a day, is not a childhood. I don’t say it’s a childhood.” (Koenig & Kohrt, 2009)

A politician from the Nepali Congress representing a district in central Nepal suggests,

“Whether the children are used for manual labour in any harmful conditions, be it in any wars or any domestic work, even if they are paid, children shouldn’t be used and should be protected by the government. But because of the instability, lack of elected government and the inability to hold the constitutional assembly elections, the government has not been able to do its basic duties.” (Koenig & Kohrt, 2009)

Both boys and girls from poor, low caste, or ethnic minority families are often servants in the homes of high caste families. Treatment in these settings is variable. With changing modes of production and modernization, children are now involved in more vulnerable forms of labour. Children have been used in brick manufacturing plants where they are vulnerable to both mechanical and respiratory injuries. Similarly, children are often seen working with families breaking gravel; used as workers in restaurants; and work on buses. Children are also vulnerable to trafficking for carry out work in India and other countries. Children trafficked to Kathmandu or India are also vulnerable to be used in the sex trade. In the interests of child protection the Civil Code has been amended to include laws against Sexual and Labour Exploitation. However, there is little evidence that this policy has been enforced.
5.3.4 Healthcare

Children are susceptible to a series of health conditions to which they are particularly vulnerable because of their immature immune systems and can often die of diarrheal and respiratory diseases. The child mortality rate is 61 per 1,000; infant mortality rate is 48 per 1,000; and the neo-natal mortality rate is 34 per 1,000 (MoHP, 2006). Most rural poor populations and many urban populations lack access to clean water. Respiratory diseases are common among children because of poor air quality in Kathmandu valley, and over-reliance upon wood burning stoves and poor ventilation in homes in rural areas. Although there are hospitals and health posts outside of urban areas, there is a vast discrepancy across different regions in the country with regard to how frequently these centres are staffed.

Preferential treatment of male offspring, means that the delay between the onset of a serious health problem and seeking medical care is much longer for girls compared to boys. Thus, girls are commonly taken to the hospital only when their condition become severe. In contrast, boys are taken for treatment when their condition is less severe and are thus more likely to survive life-threatening illnesses.

5.3.5 Education

Another pre-war issue is the lack of good quality education for most children in Nepal. Education has been available to the general public only since the 1950s, after the Rana era. However, even since that time, education has not reached some rural areas. As access to education increased, more boys than girls went to school. In the primary schools, the average rate of admission is 87.4 percent of the population. Of the total number of children of school going age, 48% are girls is 48, 38% are from indigenous groups and 18% are Dalit and 1% are disabled children (CBS/HMG, 2004).

Families often send their sons for education while their daughters are expected to stay at home and work. More recently, this gender discrepancy is reflected by boys being sent to private English language boarding schools, which provide them with greater academic and employment opportunities, while girls are sent to public schools that generally have a poorer standard of education.

A school teacher in a rural community explained, “Parents feel that their daughters should not go to school.” This was explained in terms of the dowry system, which paradoxically, expects families with educated
daughters to pay higher sums of money to the groom’s family.

The quality of education is tied strongly to one’s economic status. There is a perception that the education in public schools does not compares with that available to those who can pay for their children’s education. A girl in the middle hills of Nepal explains,

“There are many differences. [Wealthy children in urban areas] get a good education. Here, we have to sit a hundred people in a classroom. [In private schools] there are hardly twenty students in a classroom... [from] There, they get good jobs. They don’t have to stay unemployed. Here, even if we get a degree, there’s no job.”

Kisan (Kisan, 2005) has suggested that rather than education being a site of social advancement, school is a centre for learning gender- and caste-based discrimination. For example, low caste children were often asked to sit on the floor rather than benches.

5.3.6 Child Abuse and Child Marriage

A major problem for children is abuse and neglect. Due to high rates of alcoholism, children are raised in environments of domestic violence and suffer from various forms of child abuse, defined as violations of children’s rights (United Nations, 1989). In addition to deliberate abuse, children suffer from neglect; because of endemic poverty and lack of basic health knowledge, children are often unable to have their basic needs met. Moreover, there are few laws to protect children from child abuse, and even fewer avenues for enforcement (Kohrt et al., 2005a).

Child marriage was a common historical practice, with children often marrying around the time of puberty, 13-15 years old. Nepal has one of world’s highest levels of child marriage, according to Nepal’s Demographic Health Survey. Over 63 per cent of girls marry before 18, and 7 per cent marry before reaching 10. When girls marry they are uprooted from their homes to live, sometimes in distant villages with the boy’s family. Child marriage was therefore especially difficult for girls whilst boys stayed in their parents’ homes after marriage. Girls were married at an early age to assure their virginal status. Women described being married as early as nine years old and suffering marital rape before puberty. Elderly men could have wives with ages ranging from ten to fifty years old.

Traditionally, upper caste widows could not remarry, and this practice
is still in place in some parts of Nepal. The combination of early age of marriage for girls and large disparities in age between husbands and wives leads to upper caste girls being widowed as early as ten years old and then being treated as childless burdens on surviving family members (Kohrt & Worthman, 2009). The practice of child marriage and young age at conception has contributed to severe maternal mortality which currently stands on 281 per 100,000 live births (MoHP, 2006); from 2000-2005 the maternal mortality rate in Nepal was the highest rate in South Asia (UNDP, 2005). Furthermore, the stresses upon women have led to suicide currently being the most frequent single cause of death among women of reproductive age (Suvedi et al., 2009).

5.3.7 Poverty

Poverty is an overarching impediment to well-being for children. One 16-year-old girl in southern Nepal explains,

“We are economically weak. There are many rich people who also hold great jobs. People like us who want to do something don’t get jobs. We can either go and wash others’ utensils or work in others’ hotels and get scolded.”

A 17-year-old girl in the middle hills describes her situation,

“I have no income at all. My brother also doesn’t do any work. He does farming and we have no source of money. I thought I’d join the army and help my family as well... My brother tells me that he would arrange for my marriage. Then I tell him that boys want a dowry with marriage and my family won’t be able to provide that. Even then, they didn’t let me join the army. My father won’t even spend ten rupees for my education. Rather he’d drink if he had even five rupees. There is no way my brother can finance my studies and neither can my sister in law. That’s why I wanted to join the army.”

5.4 Conclusion

The goal of this chapter was to describe the wellbeing of children in Nepal in a manner that places war in the broader context of life experience and history. An exclusive focus on war as the determinant of child wellbeing runs the risk of ignoring other important factors influencing wellbeing. However, it is not merely this exposure to war, but rather legacies of other social problems and the filtering of these experiences through
historical social relations that dictated children’s wellbeing. Historically marginlized groups such as girls and members of low castes are vulnerable to greater levels of mental health problems, which probably would have been observed in children prior to the war. For example, girls likely had higher levels of mental health problems even before the war, in part due to gender-discrimination. Long standing social inequities such as the rampant poverty in rural areas, lack of healthcare, and absent or poor education also likely influenced child mental health prior to the war.

The experience of war, which will be discussed in the next chapter, are filtered through pre-existing social and economic problems. And, these historical social, economic, and cultural problems do not necessarily go away during war and may continue to affect children during war, if not even be exacerbated. Thus, studies of children and war need to address these factors not only to understand child wellbeing, but especially to design and implement intervention in conflict and post-conflict conditions.

These findings lead to a number of implications for intervention. First, screening should be done to determine who needs psychosocial support. Within the screening, it would be helpful to ask children about their reasons for joining an armed group as this will affect their long-term psychosocial well-being. Second, psychosocial programs should pay special attention to the needs of poor and marginalized children such as girls and members of low castes, as these children are at the greatest risk of poor outcomes given their historical vulnerabilities. Community awareness programs should highlight the need to promote not only social support for children who were forced to join armed groups, but also social support for children in traditionally stigmatized groups. In Section III we describe how these findings regarding pre-association and conscription factors influences the intervention design and implementation. In the next chapter, we move forward to describe children’s experiences during association with armed groups.
KEY CONCEPTS

5.1 *Push factors* are social reasons that drive children to join armed groups. These are aspects of the community and culture that children wish to flee. They drive children into other activities such as migrant labor, running away to urban centres, joining gangs, or joining an armed group during times of conflict.

5.2 *Pull factors* are created by the armed group. They are both methods of intimidation or enticement and promises made to children. Armed groups often consciously create the appearance of improved conditions within their ranks compared to quality of life in the civilian community.

5.3 In Nepal, a number of *historical social problems* that pre-dated the People’s War were strong push factors that led to children leaving their homes and joining armed groups. These included gender discrimination, caste-based discrimination, lack of education, lack of healthcare, child abuse, child labour, forced marriage, and chronic poverty.

5.4 Community adults had different *perceptions on children’s agency* in joining armed groups. In some districts, 70-80% of community respondents viewed children as joining voluntary. However, in other districts, only 40-50% of adults thought children joined voluntarily.

5.5 Almost half (43%) of the 142 CAAFAG interviewed said that *joining was completely forced upon them*. Of the remaining CAAFAG, 28% reported joining on a completely voluntary basis, and another 28% reported that the joining was partly voluntary and partly coerced.

5.6 Children who felt pressured to join and children who joined because of poverty were much *more likely to have psychosocial problems* after their return to the community.

5.7 Theses findings emphasize the need for *interventions to address chronic social problems* such as gender and caste-discrimination, as well as whether a child joined voluntarily or was forced to become a combatant.
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CHAPTER 6

Children’s Experiences during War and their Psychosocial Well-being

Chapter 6 Goals – The goals of this chapter are

i. to describe the importance of comparisons between CAAFAG and non-combatant civilian children when assessing psychosocial status and needs,

ii. to describe the war-time traumatic and other events experienced by non-combatant civilian children living through political violence,

iii. to describe the specific experiences related to association with armed groups, and

iv. to compare the amount of trauma experienced by CAAFAG with the trauma experienced by civilian children living through the People’s War in Nepal

v. to compare the mental health and psychosocial support problems of CAAFAG with civilian children.

This chapter addresses the crucial question of “Do CAAFAG have more traumatic experiences and greater MHPSS problems compared with non-combatant civilian children living through the same conflict?” This question has not been addressed in prior CAAFAG psychosocial reintegration programming, but it is crucial to determine whether CAAFAG need special intervention, and if so, what type of intervention. These findings form the basis for interventions described in Section III.

6.1 Background on CAAFAG War Exposure and Psychosocial Well-being

In 1996, the Machel/UN Study "Impact of Armed Conflict on Children" brought the plight of CAAFAG to international attention (Machel, 1996). It also exposed the gap in knowledge about mental health consequences of child soldier experiences (Mendelsohn & Straker, 1998). In the decade

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since the Machel/UN Study, there has been a growing understanding of the mental health of this population. The mental health of CAAFAG differs from that of children who have lived through armed conflict but have never been recruited to armed groups. Former CAAFAG are both victims and perpetrators of violence (Boothby & Knudsen, 2000; Machel, 1996; MacMullin & Loughry, 2004; Mendelsohn & Straker, 1998; Pearn, 2003; Shaw, 2003). They also differ from adult combatants in mental health status because of their developmental stage (Dickson-Gomez, 2002; Punamaki, 2006).

Some clinicians have observed severe mental illness among former CAAFAG (Somasundaram, 2002), while psychosocial practitioners suggest that psychological trauma among CAAFAG is less frequent than expected (Wessells, 2004) (Dowdney, 2007) (Wessells, 2007). Girl soldiers are described as especially vulnerable to poor mental health outcomes (Lamberg, 2004; McKay, 1998, 2003; Specht & Attree, 2006; the Lancet, 2004; West, 2000). Recent studies in the Great Lakes region have illustrated that high rates of traumatic events among former CAAFAG showed no correlation between traumatic exposure and PTSD (Bayer et al., 2007; Derluyn et al., 2004). A follow-up study of boy soldiers sixteen years after they left their armed group illustrates that they are productive members of society but continue to suffer from psychological trauma (Boothby, 2006).

Literature on CAAFAG lack empirical studies that compare former CAAFAG and children who have lived through armed conflict but were not recruited by armed groups (Dowdney, 2007; Kuruppuarachchi & Wijeratne, 2004; Magambo & Lett, 2004). Without such comparisons, it is not possible to determine if the mental health impact is specific to the armed group experience or if it is a pervasive effect of armed conflict on children, both recruits and non-recruits. One study does compare former CAAFAG and never recruited children, finding the negative psychological impact of CAAFAG’ experiences are "moderate and concentrated in a minority" (Blattman, 2006). The study does not, however, include girls or examine the relationship between exposure to traumatic events and mental health.

Without a comparison between CAAFAG and never associated children, we cannot identify the unique mental health needs, during the process of reintegration, of CAAFAG versus the mental health needs of children in general, in armed conflict (Magambo & Lett, 2004). As increasing humanitarian resources are devoted specifically to CAAFAG, it is important to determine their relative vulnerability compared to other
children. Epidemiological studies of CAAFAG during the reintegration process can identify which mental health needs and areas of psychosocial functioning are particularly problematic for them. Many humanitarian programs appear to operate under the assumption that CAAFAG have unique mental health vulnerabilities, based only on qualitative and anecdotal discussions. As the goal of Disarmament, Demobilization, and Reintegration (DDR) programs with CAAFAG is, in general, to enable children’s return to their home community, assessment of mental health status should be done in the community setting. No studies are available that address these issues.

6.2 War Experiences of Civilian Children

The children in our study have had a numerous war-related experiences; ranging from witnessing violence through to disruption in education and the inability to meet their basic needs. Displacement and separation from their family was particularly distressing. We found that these war-related experiences impacted on their mental health to lesser or greater degree depending on their pre-war and post-war circumstances. As we would expect, many of these experiences had a negative effect on children’s mental health. However, in some cases children seemed to reflect on their experiences positively. Children’s accounts of what they experienced are given next.

Caught in the Middle

Children² described how they were caught in the middle between the People’s Liberation Army and government security forces:

“The conflict helped to remove the business of alcohol from our village. The Maoists punished bad people in the village who treated villagers badly. On the other hand, people had to leave their homes and businesses because of the conflict. Villagers were confused because they did not know what they should do. They were forced to cook food and give shelter to the Maoists. Then the Royal Army punished and questioned them for providing food and shelter. And, if the villagers provided food and shelter to the Army, then sometimes villagers would get beaten by the Maoists. Sometimes, the Maoists

² Information regarding the children presented here is anonymized; pseudonyms for child and place names are given. Identifying information from other individuals is used if they have given their permission.
forced villagers to join them and follow what they said. Sometimes, the Maoists tortured people if people did not listen to them. So villagers suffered from both the government and the People’s Liberation Army. All the people wish and want to have peace soon.”


Witnessing Violence

A girl in southern Nepal explains that the "State of Emergency" which began in 2002 was the cause of her fear.

"1-2 years ago there was conflict in our village and many people were beaten by the army, police, and Maoists. Once my father was arrested and he was beaten very badly by the army and police. So, I get scared thinking something might happen to him again."

This girl had witnessed her father being beaten and arrested by the police and army, she also reported that, in her village, the army had killed ten or eleven Maoists, and had witnessed a fire and a bombing in her village. Unsurprisingly, she reports that whenever police, army, or Maoists come to her village, she becomes very frightened. "I get scared most of the time. Because of them, many people have died. Many people have suffered. And, many people have been beaten."

The case below is from a fifteen-year-old boy who witnessed violence against his family and as a result was displaced to Kathmandu.

“The main reason I came to Kathmandu is because of the Maoists. My father and two of my brothers were in the RNA [Royal Nepal Army]. In 2003 my brother was in Nepalgunj and he came home during a vacation to our village. [Our] area is highly affected by Maoists. The Maoists knew that my brother had come home, so they came to our home. It was evening… They locked my mother in a room, and then told my brother that he had to come with them because he was in the RNA. That was about the time that I returned home. I don’t live in the village. I stay in the district headquarters where I had been living for the past seven years while going to school. But I would go home every Friday night around 7pm, and this just happened to be a Friday evening. I entered the house, but they wouldn’t let me see my brother
or mother. I heard my brother saying to the Maoists, “I can’t go with you today. I am sick. Please come back tomorrow and I will go with you then.”

They replied, “Don’t you know us? We are Maoists!” Then they dragged him out into the jungle. I wanted to follow my brother but they told me not to. Still, I ran out of the house and ran towards my brother who was about 100 meters away in the jungle. They had tied him to a tree with a rope. I got within 5-7 meters of my brother and heard the Maoists say to him, “You only have a few minutes to live. You must tell us how many Maoists you have killed right now or will we kill every member of your family.

“When I heard this, I knew that my brother had no chance for survival. I shouted at the Maoists, “We haven’t done anything bad to you! Why are you doing this? Why are you making us suffer?” Then they started beating me. All their anger toward my brother was poured out on me. “What have I done wrong?” I pleaded. I grabbed a khukhuri [Gorkha hunting knife] from one of them. I wanted to kill them. My mother had also overpowered the Maoist in the house and stole his khukhuri. She ran outside and cut my brother loose while I was struggling with the others. My brother escaped and ran away, but the Maoists got the khukhuri back from me and started beating and cutting me. They also chased down my mother. They cut and beat her, too. We were both left for dead in the jungle. A few hours later some villagers came looking for us in the jungle and found our bodies. They carried us to the village health post, but we couldn’t be treated there.

They eventually brought me and my mother to Army Hospital in Kathmandu. I regained consciousness about 12 hours after reaching the hospital, but I didn’t recover enough to leave for three months. My brother also came to Army Hospital in Kathmandu. He had banged his knee against a tree when he was running away. Even today he cannot walk normally. My mother still hasn’t recovered fully. She lost the use of one hand. After we where taken to Kathmandu, the Maoists published in their newspaper, in our village, that we are targeted persons and will be killed if we return. They detonated bombs inside our house, so we have nowhere to live even if we go back. They have also taken all our land. They have left it barren and threatened to kill anyone who tilled it.”
Physical Trauma

Children were also exposed to forms of direct violence; bombings were not infrequent and both sides planted improvised explosive devices throughout the country. Children often picked up these items and suffered the consequences. Children have been both killed and maimed from the explosive devices. The local officer of a human rights organization explains:

“Due to the [explosive] devices, children’s mental condition was very poor. Even now, people are scared as there may be old fitted bombs that haven’t exploded yet. One case occurred here. A bomb was thrown by the Maoists near by a school. But, the bomb didn’t detonate until many days later when the children were playing. Three children were killed. A similar event happened in another nearby community.”

Disrupted Education

Keeping in mind the poor quality of education, sporadic availability of teachers in rural areas, and discrimination in which children attended school, the People’s War appeared to further worsen education for children in Nepal. In some areas, schools were closed down for more than a year during the conflict. The Maoists used schools as a major recruitment site. Bombs also detonated around schools. Therefore, some children chose not to attend school because they felt in danger, and parents chose not to send their children because they were worried about their safety. In other cases, children did not go to school because their teachers had fled; because teachers were often targeted by Maoists.

Displacement

Children were displaced during the conflict, in part to reduce their vulnerability to violence or recruitment into armed groups. A girl who was displaced from the middle hills to southern Nepal explains:

“When I studied in the hills, I was always afraid of being taken away by the Maoists to join their movement. The Maoists took away my first cousin to join their movement. Because I saw that with my own eyes, I was always afraid that they might and come take me as well. That is why I left my school, my parents, and my village and ran away from home to live in this village. That was very sad for me.”

Similarly, it is distressing when children are sent away from their families.
as this girl who was relocated from western Nepal to Kathmandu explains:

“My father is a political leader. In 1999 my father had been elected. During the election period Maoists attacked us... they stole everything we owned. Their main objective was to kill our father... [But] he was hiding in a safe place.... They [Maoists] tried to get me to join them. They said that there is no future here. They followed me constantly for ten days. They stayed at our house and ate our food. Whenever I wanted to sleep, they wouldn’t let me. They wouldn’t let me study. Anytime I started to do schoolwork, they made me read their Maoist books. Finally, after all of this, I gave up and said I would join. The day before I was to join their cultural program, my mother helped me to run away with teachers in my village My mother said that the Maoists won’t leave me so I better escape from here. Early one morning at 5am, I left and never returned. For safety, we slept during the day and only traveled at night so the Maoists wouldn’t see us. Then I came to [name of a city in the middle hills]. I didn’t have any relatives there. I have never traveled in a bus so it was very difficult for me... Finally, I made it to my aunt’s house in Kathmandu.”

Aside from these reports of being displaced due to the children or family’s own convictions about gaining safety away from their village. There were accounts of children or their family members being abducted, and having to leave their homes against their will.

When family members were abducted, children witnessed the abductions. A young girl and member of an ethnic minority group, described how armed forces had targeted her family. This ethnic group, the Tharu, had traditionally been targeted by police and security forces. In this instance, this police and army came to the girl’s house, they beat up her father in front of her, and then abducted him. He was eventually returned, badly bruised. From that time, the girl then did not want to leave her father’s side; she insisted that he not leave the house and every time that he did, she was worried he would not return. Living with this uncertainty and fear for her father’s safety, her own mental health is effected.

Child Marriage

Child marriage may have increased in some communities during the conflict. Some parents married off their children at an earlier age in the hope that this would prevent Maoists from recruiting them. Anthropologist Sara Shneiderman describes:
“Women, young women especially, were targets for recruitment, […] in later phases of the movement when many of the men had already fled or those who are going to join had joined, so the Maoist turned to the women, and particularly young women were targeted, […] between the ages of 14 and 18, and particularly unmarried girls. If they are already married, they’re basically seen as a lost cause… This actually lead to a trend of child marriages, or at least very young marriages.” (Koenig & Kohrt, 2009)

6.3 War Experiences of CAAFAG

Children were recruited into the People’s Liberation Army (PLA) within the Communist Party of Nepal-Maoist (CPN(M)). They were also recruited into the Royal Nepal Army (which became the Nepal Army in 2006). Local groups estimate that between 9,000 and 12,000 members of the PLA were under 18 years of age when the peace accords were signed, of these CAAFAG 40 percent were girls (Human Rights Watch, 2007). Ten percent of the Royal Nepal Army during the conflict was below the age of eighteen (Singh, 2004). Similar to the accounts from civilian children made earlier, CAAFAG experienced war-specific events, such as bombings and violent deaths, however, they typically experienced them more frequently. CAAFAG also experience conscription, indoctrination, and placed in positions in which they participated in violent acts. Returned children in this study reported a range of negative consequences arising from their association with armed forces and armed groups; including violence, lack of education, hard labor, punishment, and lack of health care.

Roles of Children During Association and the Impact on Psychosocial Well-being

Children described different roles while associated with armed groups (See Table 6.1). The majority of children had multiple roles. However, we find that the role alone did not determine whether a child reported their experience during association with the Maoists in a positive or negative light. Instead each child was impacted differently and this seemed to relate to the interaction of a number of factors including their personal life history, which they brought to their identity as a soldier; the experiences of trauma exposure and personal opportunities they had during their association. Contrary to what might be expected, individuals who participated in military combat did not have greater risk for mental health problems when controlling for exposure to traumatic events (Kohrt et al., 2008).
Table 6.1  Role during association

<table>
<thead>
<tr>
<th>Role of Child</th>
<th>Percent of Children in Role*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentry</td>
<td>54%</td>
</tr>
<tr>
<td>Messenger</td>
<td>25%</td>
</tr>
<tr>
<td>Spy</td>
<td>12%</td>
</tr>
<tr>
<td>Porter</td>
<td>35%</td>
</tr>
<tr>
<td>Cook</td>
<td>47%</td>
</tr>
<tr>
<td>Cultural programs</td>
<td>40%</td>
</tr>
<tr>
<td>Soldier (PLA/SF)</td>
<td>21%</td>
</tr>
</tbody>
</table>

* Note: Total percentage is greater than 100 percent because most children assumed multiple roles.

The type of role held by conscripted children did have different impact on psychosocial well-being to some extent. Children who were involved primarily in cultural programs or used as soldiers had more psychosocial distress than children in other roles. Those used as spies, sentries, and messengers had better well-being. This might be because children used as soldiers were likely to be exposed to more violence and traumatic events. The amount of time that children spent with armed groups varied from one month to 4.75 years; but one third of the children spent between three to four months with armed groups. Interestingly, there was no association between the length of time children spent with armed groups and their psychosocial distress.

Case Study: Raj (17-year-old boy from Dalit caste, continued from Chapter 5)

“I was scared at the beginning, but I learned to work with weapons. During the conflict, I was shot and injured. It happened when the commander of our group told us to go plant rice in a distant community. However, on the way there, he suddenly told us that we were actually about to attack the Royal Nepal Army. Instead of planting we had to carry bombs and prepare for attack.... After our commander’s orders, we started attacking. Then, the RNA returned fire. A government helicopter started bombing. Many of my friends and I were injured. We did not have any proper medical treatment. I think I was injured by mistake from a bullet when my friend fired his gun in the wrong direction. Many people from both sides died in that battle. I thought there was no hope for me to survive. I thought that day was the last day of my life. We carried our friends’ dead bodies and took them to a nearby village for cremation.
“When I was with the Maoist armed forces, there were clashes from both sides and I feared all the time that I might get killed by the government army […]. We had four young girls with us, they were new to our group. When we were going to another village, the government army surprised us. They captured us and took two young girls from our group. They raped them, cut them with knives, poured chili powder in their wounds, and then killed them. We ran away, otherwise they would have killed us, too […]. Many of my friends were dying, but I was so helpless that I could not do anything for them […]. I still get scared and sweat when I think of that day. I especially remember one friend who asked for water on that day […]. I cannot do any work if I think of that day. I get very disturbed and want to be just by myself in a quiet place. I need to keep myself busy to forget about that day […]. When I think of those events, I still get very scared. I do not even want to think about those for a second.

“The worst experience happened in a different battle. Many of my friends were dying and asking for water. But, I was so helpless that I could not do anything for them because the battle was very dangerous. I still get scared and start sweating when I think of that day. I especially remember one friend who asked for water… I cannot do any work if I think of that day. I get very disturbed and want to be by myself in a quiet place. I need to stay busy. That helps me to forget about that day.”

Positive Experiences of Recruitment

The case study below illustrates a different experience. Some CAAFAG reported that they benefited from their time associated with armed groups.

Case Study: Shova (16-year-old girl from Chhetri caste, cont. from Chapter 5)

At first, I felt lonely because I didn’t have friends. I couldn’t mingle with people. Soon after, however, 15-16 other girls from my village also came to the Party. So eventually things were alright. At the beginning, I couldn’t speak much, but slowly I improved […]. They didn’t allow us to sit idle. Whenever there were at least two to four people, we used to practice our oratory skills. One person would play the chairperson, the other the guest, the third the audience, and the fourth, the speaker […]. They got me involved in the women’s organization. There, my job was to mobilize women […]. Although I didn’t miss home too much, I often regretted dropping out from school. While traveling for work, sometimes we would clash with
the state military. In one battle, twenty five of our friends had died, and over a thousand were injured [...] But as time passed, I adapted to the environment and gained a lot of political knowledge. Then I became actively involved in uniting women.

Another CAAFAG girl also described her experience with the Maoists as generally positive. She especially enjoyed the opportunity to engage her artistic talents:

“There taught me painting and writing. I distributed papers, printed pamphlets, and painted slogans throughout the villages. They liked me. They treated me well. They taught me how to deliver speeches. They would encourage me to speak like them. They didn’t tell us anything about the Party’s principles. They would tell me to speak with everyone the way they did.” (16-year-old Dalit CAAFAG girl)

This research corroborated the CAAFAG WG Report (2006) findings concerning child roles and experiences while associated with armed groups, which found both positive and negative experiences during association.

Health Risks During Association with Armed Groups

Children ranked lack of access to medical care among their top concerns (children in Surkhet and Kailali ranked lack of healthcare as their number one concern). Health risks during association fall into two main categories: (i) injuries resulting from the association and (ii) girls’ health needs. In the former children explained that they had been wounded in battle or training. One girl reported still being unable to move her right arm because of a training injury. Another boy still had bullets lodged in his leg. Obviously, children exposed to bomb explosions and torture are likely to need medical attention. For children, addressing their physical health problems can ameliorate their psychosocial distress arising from their physical pain and fear of survival.

Female CAAFAG described how they were forced to walk and go into battle during menstruation and pregnancy. In many Nepali cultures girls are expected to withdraw themselves from the community and remain alone during menstruation. Girls in mid-Western Nepal hill regions are still placed in animal sheds for four to seven days with no activity permitted during menstruation. Girls were concerned that because they had walked and been active during menstruation, that this meant they
were now infertile. Another concern among girls was about sexually transmitted diseases, resulting from consensual and non-consensual sex during association. These physical health concerns weighed heavily on these former CAAFAG affecting their psychosocial well-being.

*Decision Making and Control During Association with Armed Groups*

Returned children reported having different levels of control over their actions while associated with armed groups. 30% reported complete control over their actions, 27% reported partial control over their activities, and 43% reported that others (typically senior commanders) controlled all of their activities. This latter group of children with the lowest level of personal control displayed the highest levels of psychosocial distress. These findings are consistent with our knowledge of stress on the body and people’s perceived ‘Locus of Control’. That is people who view their circumstances as within their control are less likely to feel stressed and show lower stress-levels in their body. Whereas, people who view circumstances to be out of their control show the highest levels of psychological and physiological stress reactions (Solomon et al., 1988).

*6.4 Comparison of Experiences and Psychosocial Outcomes Between Civilian Children and CAAFAG*

CAAFAG were exposed to traumatic events during their association with armed groups, and generally had more traumas than civilian children. Table 6.2 shows the frequency of traumatic exposures among civilian children and former CAAFAG in Nepal. Nevertheless, from both groups, children who experienced traumatic events, especially bomb explosions, were more likely to have symptoms of posttraumatic stress, as well as impaired daily functioning compared to children with exposure to fewer traumatic events. The experience of torture was most strongly associated with poor mental health (Kohrt et al., 2008). Victims of torture had the most severe mental health problems, followed by perpetrators, followed by observers of torture; all of these groups had greater mental health problems compared with children not exposed to torture in anyway.
We compared the post-conflict mental health and psychosocial status of CAAFAG with children who had never been conscripted, with the expectation that CAAFAG would show markedly more problems than the community group. However, we found that both groups displayed a substantial burden of mental health and psychosocial problems (See Table 6.3 and Figure 6.1). The mental health burden among CAAFAG ranged from 39 to 62 percent of participants depending upon the type of distress, and 18 to 45 percent among children not conscripted by armed groups. CAAFAG had significantly worse mental health outcomes (symptoms of depression, PTSD, general psychological difficulties, and functional impairment) than the comparison groups, except anxiety symptoms in which the difference was not significant.

Table 6.3 Percentage of Civilian Children and Former CAAFAG with Psychosocial and Mental Health Problems

<table>
<thead>
<tr>
<th></th>
<th>Civilian Children (n=141)</th>
<th>Former CAAFAG (n=141)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>24.1%</td>
<td>53.2%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>37.6%</td>
<td>46.1%</td>
</tr>
<tr>
<td>PTSD (all)</td>
<td>20.0%</td>
<td>55.3%</td>
</tr>
<tr>
<td>PTSD (boys)</td>
<td>17.4%</td>
<td>44.8%</td>
</tr>
<tr>
<td>PTSD (girls)</td>
<td>21.9%</td>
<td>64.0%</td>
</tr>
<tr>
<td>General psychological difficulties</td>
<td>18.4%</td>
<td>39.0%</td>
</tr>
<tr>
<td>Functional impairment</td>
<td>44.7%</td>
<td>62.4%</td>
</tr>
</tbody>
</table>

3 Civilian children in the community group were matched for age, sex, education, caste, religion, and socio-economic background with CAAFAG for comparison.
Higher mental health problems of CAAFAG compared with never conscripted children can be explained, perhaps by the greater exposure to traumatic events among CAAFAG, resulting in greater general psychological difficulties and functional impairment. However, even among those CAAFAG who were not exposed to trauma, they still had poorer outcomes for depression and PTSD, compared with community children. Interestingly, no single type of traumatic event alone, explained the relationship between soldier status and mental health; rather it seemed to be the cumulative traumatic exposure burden. Another finding was that among the CAAFAG, the occurrence of PTSD among girls was twice that seen among the boys, even after controlling for trauma exposure and other potential confounding factors. This suggests that factors, other than the traumatic exposures we assessed for, contribute to depression and PTSD, the latter especially among girl soldiers.

Figure 6.2 Frequency of Psychosocial Problems Among CAAFAG and Non-CAAFAG

The results also suggest that being a soldier exposed children to more traumatic events which increased the rates of depression, PTSD, generalized psychological difficulties, and functional impairment. These findings are, in part, congruent with other studies’ conclusions, which suggest that the difference between CAAFAG and civilians is concentrated among the soldiers with greater trauma exposure (Betancourt et al., 2008; Blattman, 2006). However, our study differs in finding elevated depression and PTSD even after controlling for trauma, especially among girls, indicating that factors other than trauma may contribute to poor mental health outcomes among soldiers.

The lack of a significant difference in anxiety symptoms among the two groups of children, and higher than expected rates of mental health and
functional difficulties within the community group suggest that children are psychologically effected by living in a war environment regardless of their status as soldiers or civilians. Also, from the personal reports given earlier, we see that civilian children have been exposed to traumatic events such as witnessing extreme violence, loosing family members and living in fear for their life and the lives of their loved ones. All of which would have psychological consequences. These findings support this view with empirical evidence.

6.5 Conclusion

Although, traumatic events (especially bomb blasts) had an impact on posttraumatic stress symptoms and impaired daily functioning, trauma was not identified as impacting on well-being by children on the child-led psychosocial indicators. Instead children said they were distressed by the disruption to their education caused by association with armed groups.

In terms of predicting risks to psychosocial health children who were used in cultural programs and as soldiers are at greater risk of psychosocial distress than children involved in other roles. Lack of health care, particularly women’s health care, during association contributed strongly to psychosocial distress. As did the feeling of lacking control over one’s activities during the time of association, which predicted psychosocial distress upon return to the community. There was no relationship found between the duration children spent with armed groups and their psychosocial distress.

In general, conscripted children showed greater distress on all measures of mental health and psychosocial distress compared with children who had not been conscripted. Nevertheless, surprisingly high levels of mental health and psychosocial difficulties were seen among children who had not been conscripted into armed forces. Demonstrating the impact of a war environment on civilians’ mental health.

This study supports those authors who suggest that severe mental illness is found among former CAAFAG (Somasundaram, 2002), and that girl soldiers are especially vulnerable to poor mental health outcomes (Lamberg, 2004; McKay, 1998, 2003; Specht & Attree, 2006; the Lancet, 2004; West, 2000). Contrary to the findings in recent studies in the Great Lakes region we found that high rates of traumatic events among former CAAFAG did show a correlation with PTSD (Bayer et al., 2007; Derluyn et al., 2004), but other factors, such as community rejection, health and
education concerns were identified by children as more significant concern to their mental well-being. A follow-up study would be useful to demonstrate how well CAAFAG integrated or contributed to society after the reintegration programmes ceased to operate.

The leads to a number of important considerations for intervention development and implementation: (i) Psychological trauma programs are important for children who have exposure to traumatic events, particularly bomb explosions and combat, because these children have impaired daily functioning. However, psychological trauma programs should be limited to children with these exposures rather than used as a widespread program for all returned children. Thus, screening for events and traumatic stress is essential to identify children in need of trauma programs. Furthermore, psychological trauma programs should focus on posttraumatic stress and impaired daily living, while other psychosocial programs should be made available to a larger percentage of children.

(ii) Psychosocial programs should take into account the role played by children while associated with armed groups. Children who were used in cultural programs and as soldiers should be provided special assistance. Programs should screen for the types of roles experienced by returned children. (iii) Psychosocial programs, additionally, should seek out and support children who report no control over their activities while associated with armed groups.

(iv) Integrated health programs that involve medical care (especially gynecological and obstetric care) and psychosocial care are crucial because of the strong link between these factors. Community health workers and health professionals who conduct evaluations when children arrive at Interim Care Centers should be trained in recognition and referral for basic psychosocial problems.

In the next chapter we move forward to discuss experiences of CAAFAG when they return home and the implications for intervention and other psychosocial support.
KEY CONCEPTS

6.1 Both CAAFAG and civilian children experienced significant levels of trauma ranging from displacement to witnessing killings to torture. However, the amount of trauma experienced was significantly greater among CAAFAG for most types of war-related trauma. For example, CAAFAG were 5 times more likely to experience bombing compared to civilian children.

6.2 Main types of trauma and other war experiences among civilian children include being caught in the middle between Maoists and government security forces, witnessing violence against family members and others in the community, physical trauma from armed groups, disrupted education, displacement, and putative increases in child marriage.

6.3 CAAFAG assumed many different roles during their association with armed groups including being sentries, cooks, performers in cultural programs, porters, messengers, soldiers, and spies (presented in order of decreasing frequency).

6.4 CAAFAG reported positive experiences during association with armed groups in addition to negative experiences. Positive experiences including being able to travel, using talents such as art and performing, and living in an environment of gender and caste equality.

6.5 Both CAAFAG and civilian children reported high rates of MHPSS problems. They did not differ in rates of anxiety (about 40% of children in both groups). CAAFAG compared to civilian children did show significantly greater depression (53% CAAFAG vs. 24% civilian children) and PTSD (55% CAAFAG vs. 20% civilian children). CAAFAG girls were especially vulnerable to PTSD with 64% of CAAFAG girls endorsing posttraumatic stress symptoms.

6.6 Intervention implications include (i) the need for limited trauma specific programs such as for survivors of bombing and torture, (ii) targeting of interventions based on roles played during association with armed groups, (iii) integration of psychosocial care with girls’ health programs (gynaecological and obstetric care), and (iv) the need to care for both CAAFAG and civilian children because children in both groups had significant MHPSS problems.
References


CHAPTER - 7

Community Supports and Difficulties during Reintegration

Chapter 7 Goals – The goals of this chapter are

i. to describe the experience of CAAFAG when they return home,

ii. to highlight the main sources of support available to CAAFAG during reintegration,

iii. to examine sources of discrimination and difficulties for CAAFAG with an emphasis on how cultural beliefs may contribute to stigmatization,

iv. to pay special attention the reintegration supports and difficulties for girls, and

v. to explore how supports and difficulties are associated with psychosocial wellbeing.

This chapter addresses the crucial question of “What are the main sources of support and discrimination of CAAFAG and how does this influence psychosocial wellbeing?” This question is crucial to determine how community supports could be augmented and community difficulties could be reduced through interventions to promote CAAFAG psychosocial wellbeing. These findings form the basis for interventions described in Section III.

7.1 Background on Reintegration Supports and Difficulties

In studies of CAAFAG in African conflicts, community supports and difficulties played important roles in reintegration of children into the community. In some communities, CAAFAG and especially girl CAAFAG were strongly stigmatized against. We do not know how community supports and difficulties impact reintegration and psychosocial wellbeing in the Nepali context. In this chapter, we ask the following questions: How do community supports and difficulties differ between CAAFAG and non-CAAFAG? What is the association of reintegration supports and difficulties with psychosocial wellbeing, and how does this change from the beginning of reintegration programming to one year after the start of reintegration programming?
Across many contexts and conflicts, children have reported problems during the reintegration. Children have mistreated by not only community members but also by their parents and other family members. Girls are especially vulnerable to mistreatment by their families after returning home (Bush, 2008; Derluyn et al., 2004; Honwana, 2006a, 2006b; Mazurana & McKay, 2001; McKay, 1998; Stark, 2006). In Mozambique, girls reintegrated in the community faced unemployment, lack of access to education, and medical support (Honwana, 2006b). Moreover, girls bore a large percentage of physical problems because they tended to be the ones carrying the heavy loads for the militia.

In Sierra-Leone, ex-combatants had high expectations for the support they would receive during reintegration. They anticipated a high level of skill training and assured employment. However, these demands could not be met because of the lack of funding and the duration of the reintegration services, which only lasted six months (Ginifer, 2003). Moreover, there were misunderstandings between ex-combatants and community people with regard to motivation and perpetration of violent activities during the war. Thus, fear of revenge strongly threatened the well-being of ex-combatants.

While girls and boys often bear comparable exposure to war-time traumas, the burden of reintegration discrimination and difficulties tends to be much greater among girls after they return home. Often, girls are expected to return to traditional roles, following customs and rituals that are gender-biased. In Uganda, the divorce rate among former combatants was much higher than other groups because of the rejection of female ex-combatants as respectable wives (de Watteville, 2002).

Across settings, the supports which children desire are education—first and foremost—and vocational training such as carpentry and auto mechanics. However, in some context it has been very challenging to reintegrate 13-14 old ex-combatants into schools of children learning the same material who tend to be considerably younger. That said, creating school environments separate from non-combatant children also has the drawback of discrimination and stigmatization in perceived favoritism (Becker, 2004).

Taken together, these findings from other regions raise important concerns about reintegration of CAAFAG in Nepal: What are the attitudes of community people towards the children involved in armed conflict? What
are the supports that children are getting from their family and community during the reintegration? What are the difficulties that children are getting from their family and community during the reintegration? What are the specific issues of girls who returned in the community? What is the relationship of community reintegration supports and difficulties w/ psychosocial outcomes on wellbeing?

7.2 Methods

To address these questions, we incorporated a number of methods (see Chapter 3). Qualitative semi-structured interviews were conducted with teachers, government officers, security forces, leaders of political parties, nongovernmental organization staff, religious leader, and representatives of women groups. Focus groups discussions were conducted with community leaders and CAAFAG. Quantitative surveys were conducted with CAAFAG, and these interviews included questions highlighting their experiences returning home and reception in their communities. All of the quantitative survey questions were developed in accordance with the qualitative findings. One of the instruments developed was a Community Supports and Difficulties Questionnaire. These results reported here are based on primarily on this measure. In addition, the participatory approach Child Led Indicators was used to assess experiences of support and discrimination.

7.3 Case Study

The case study below provides an example of ex-combatants experiences when they returned home:

Durga (a pseudonym) joined an armed group when she was fifteen and spent two years traveling throughout the country carry loads, training in weapons use, and performing in cultural programs. She has seven siblings and said that she joined the armed group because there was not enough money to feed and clothe all of the children. Only the boys could go to school, whereas the girls in the family were forced to care for other children and doing housework and farmwork.

Durga did not like her experience with the armed group because of the grueling physical work and never having a place to stay. She wanted to go back with her family. However, when she returned home, her family did not want her to stay there. Her parents said that no man would ever marry a girl ex-combatant. However, Durga
did not want to marry, her goal was to be with her family and try to go to school. While in the armed group she met many girls who had learned to read and write. They had taught her the basics and now she wanted to join a school.

Only through the support of community-based organizations and human rights organizations was Durga able to enter school. However, the family felt pressured into sending the girl to school and so they tried to marry her to a man in a distant village instead—a family that did not know she was an ex-combatant. She was married to the man and taken out of school.

The in-laws soon learned that she had been a former-combatant. The family and neighbors mistreated Durga. Neighbors insulted her whenever she left the house. The in-laws wanted Durga to go back to her maternal home. However, the new husband defended his wife. He said that if Durga was forced to leave he would leave as well. Durga was allowed to stay, but she reports still being abused by her in-laws whenever her husband is out of the house. Durga says that what she wants more than anything is to return to school and then get a job so she and her husband can move out of the in-laws house.

7.4 Findings: Reintegration Supports and Difficulties

7.4.1 Reintegration Supports

Despite negative reports from the community, CAAFAG did report that they also received help and support in some instances. They identified six key forms of support (see Figure 7.1): support from friends, family, political parties, and neighbors as well as medical care and NGO support in the form of awareness-raising programs.

Figure 7.1 Reintegration Supports Identified by CAAFAG.
When 258 CAAFAG were surveyed about the most important types of support, 39% said educational support was the most important, 29% said emotional support was the most important, and 24% said basic needs (food, shelter, and clothing) were the most important. CAAFAG reported that most of this support came from family members: 73% of CAAFAG said the most important support came from families whereas 11% of CAAFAG said the community provided the most support.

A regression analysis was used to identify the most significant predictors of reintegration supports. Table 7.1 below lists the most important demographic predictors for supports. For example, support from friends was most common among younger CAAFAG, those residing in Makwanpur, and those residing in Dhading. Support from teachers was more common among girls, CAAFAG studying at higher grade levels, CAAFAG who were Brahman/Chhetri or Janajati. It is important to note that being a Dalit CAAFAG was associated with less support from teachers and less support from political parties. Brahman/Chhetri CAAFAG felt most excluded from NGO support. Also, individuals whose mother tongue is not Nepali were also less likely to receive support overall.

Table 7.1 Demographic Predictors of Reintegration Support of CAAFAG

<table>
<thead>
<tr>
<th>Support</th>
<th>Demographic Predictors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family support</td>
<td>• Janajati (ethnic minority)</td>
</tr>
<tr>
<td></td>
<td>• Mother tongue not Nepali (e.g. Tamang, Kiranti, Tharu)</td>
</tr>
<tr>
<td></td>
<td>• More household facilities</td>
</tr>
<tr>
<td></td>
<td>• Having a higher education level</td>
</tr>
<tr>
<td>Friend support</td>
<td>• More household facilities</td>
</tr>
<tr>
<td></td>
<td>• Unmarried</td>
</tr>
<tr>
<td></td>
<td>• Janajati (ethnic minority)</td>
</tr>
<tr>
<td>Neighbor support</td>
<td>• More household facilities</td>
</tr>
<tr>
<td></td>
<td>• Hindu or Buddhist (not Christian, Muslim, atheist)</td>
</tr>
<tr>
<td>Teacher support</td>
<td>• Being a girl</td>
</tr>
<tr>
<td></td>
<td>• Studying at a higher education level</td>
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<tr>
<td></td>
<td>• Mother tongue is Nepali</td>
</tr>
<tr>
<td></td>
<td>• Not being Dalit (i.e. being 'High' caste or Janajati associates with more teacher support)</td>
</tr>
<tr>
<td>Political Party support</td>
<td>• Not being Dalit (i.e. being 'High' caste or Janajati associates with more teacher support)</td>
</tr>
<tr>
<td>NGO support</td>
<td>• Not being 'High' caste (i.e. Dalit and Janajati perceive more NGO support)</td>
</tr>
<tr>
<td></td>
<td>• Studying at a higher education level</td>
</tr>
<tr>
<td></td>
<td>• Being a girl</td>
</tr>
</tbody>
</table>
7.4.2 Reintegration Difficulties

Community members in interviews and focus groups reported exclusively on negative factors and consequences of children’s association with armed forces and armed groups. Community members often identified CAAFAG as being inferior to other children because of violent experiences and actions, lack of education, lack of control over one’s life and decisions, punishment by hard physical labor, lack of medical care (especially for women’s health needs), consensual and non-consensual sexual experience, and violation of Hindu caste rules for purity (e.g. eating beef, eating with and staying with other castes, eating with and interacting with menstruating women).

Community members described violation of Hindu purity rules as one of the main reasons for discrimination against and exclusion of girls upon return, especially exclusion from marriage. Perceived violations of sexual purity were a primary reason for harassment and stigmatization of returned girls. For many community members, violating Hindu purity and sexual activity were more significant transgressions than committing violent acts.

A woman working an NGO in Western Nepal explained:

Society or community may think that the people, who are already involved in [armed] groups, will always create a problem. Their behavior will never change, and they may be involved in violence. Therefore, the community does not want to make them part of the society.

A woman from a different NGO felt that parents did not want CAAFAG to return home because of the promise of money if children stayed in the armed group:

In my opinion, families play a vital role in making life difficult for returning children. They play a bigger role than the community and political parties. For example, in a Dalit ['low' caste] family with eight family members, all the responsibility was placed upon the eldest son. All the expenses were governed by him. In such a situation, he may join [an armed group] with an expectation of earning money. The family wants to receive money from the son, so they don’t won’t him to come back home until he has a lot of money in hand. It is because they are poor and also scared about the opinion of the society. So, I think family is first thing to be concerned and second is the community and then political parties.
The children also identified main forms of difficulties that they found distressing (see Figure 7.2). CAAFAG said they felt threatened by community members and political parties. They were fearful people enacting vengeance upon them for what their armed group did. CAAFAG also reported they were teased and in general felt that transitioning to civilian life was very difficult. One of the most distressing experiences was the discrimination from within the family. CAAFAG felt that they were second-class citizens compared to siblings who did not join armed groups.

**Figure 7.2 Reintegration Difficulties Identified by CAAFAG.**

A 50-year-old ‘low’ caste female storekeeper with a secondary education explained how other children were kept away from former CAAFAG:

Other children suffer negative effects from the returned children. They want to do the things that they see [CAAFAG] doing.

Comparison with other children was identified as a source of distress, as explained by a 58-year-old male politician with an associates degree:

They compare themselves with other children who are not involved in wars and compare the degree of success. If they feel they are they were not able to acquire more then other kids, then they feel sad and guilt.

We also compared the level of difficulties reported by CAAFAG and those reported by children who did not associate with armed groups. CAAFAG surprisingly reported less family difficulties compared with non-associated children. However, in all other areas CAAFAG had significantly greater levels of difficulties such as from friends, teachers, political parties, and neighbors.
7.4.3 Girls’ Difficulties

Female CAAFAG described a number of difficulties which appeared more common among girls compared with boys (see Figure 7.3). They reported both being neglected as well as physically abused, especially within the family. Girls said that they were often beaten because they did not do housework in a proper manner. The ex-combatant girls were considered “jungle girls” now unable to properly do housework, as explained by a 16-year-old male student:

For the girls' concern to marry, others think such girls had to leave the house. The community thinks that, “The people of jungle cannot work at house.

Girls also said that backbiting by neighbors and other children was also particularly humiliating and emotionally painful.

Figure 7.3 Reintegration Difficulties Identified by Girls’ CAAFAG.

A 17-year-old ‘low’ caste female ex-combatant with a primary education summarized her experiences:

…[we] have problems getting married. Everybody says, "She came back from the Maoists." The neighbors dominate [us], and tease [us]. In school, also, the teacher says bad things about us. Especially, friends dominate us. I don't have friends. [I] don't like to walk with or [spend time with] anybody.

A 39-year-old leader of an armed group, however, felt that returning girl combatants would not encounter any difficulties:
If the women are capable, honest, helping, and understanding all the [political] ideologies, they won't face any problems after returning back to the community because the community people will think that, “Now the women from the Party can give justice if there are fights occurring among villagers. And, the women from the Party can even train other people.”

CAAFAG and were non-CAAFAG were asked about the amount of support they received from different members of the community including their families, friends, teachers, political organizations, neighbors, and NGOs. In 2007, during the study before reintegration support was provided to CAAFAG, we found that there were differences in the level of support between CAAFAG and non-CAAFAG.

### 7.5 Influence of Supports and Difficulties with Psychosocial Wellbeing

Total supports and total difficulties were strongly associated with assessments of severity of depression, psychological trauma distress, impaired daily functioning, and hope, as well as with amount of trauma exposure. Greater levels of total support were associated with lower levels of depression, lower levels of psychological trauma, and less impaired functioning. Greater support was also associated with greater levels of hope. Total support reported was inverse to the amount of trauma experienced; i.e. persons who experienced more trauma reported lower levels of total support. Total difficulties had the opposite relationships with all of the other variables. And, the association of total difficulties with poor psychosocial outcomes was stronger than the association of total support, except in the case of hope which had a strong association with supports.

One of the major questions raised by the first phase of research was “what explains the psychosocial differences between CAAFAG and non-CAAFAG after accounting for trauma?” In that first phase of research, we found that CAAFAG had greater levels of traumatic exposures compared with non-CAAFAG. CAAFAG were more likely to experience bomb blasts, torture, or witness killings and combat. The difference in trauma exposures explained why CAAFAG had greater levels of general psychological difficulties and greater impairment in daily living. However, trauma alone could not explain why CAAFAG had greater levels of psychological trauma and depression. In the second phase of research conducted, we examined if community supports and difficulties could explain the differences that were not explained by trauma alone in psychosocial outcomes. As
reported above, CAAFAG had much lower levels of support compared with non-CAAFAG. CAAFAG had slightly greater, but not significantly greater, levels of difficulties compared with non-CAAFAG. Therefore, we assessed if these differences could explain more than trauma alone. Here are the conclusions drawn from the analyses:

- **Depression**: CAAFAG had greater depression symptoms compared with non-CAAFAG (with a difference of approximately 2 points on the depression self rating scale). However, these differences could all be explained by (i) lower levels of reported total support among CAAFAG, (ii) greater levels of reported total difficulties among CAAFAG, and (iii) greater levels of trauma among CAAFAG. This suggests that trauma and community support and difficulties explain why CAAFAG had greater levels of depression.

- **Psychological trauma**: CAAFAG had greater psychological trauma symptoms compared with non-CAAFAG (with a difference of approximately 9 points on a child psychological trauma scale). Number of traumatic exposures and total difficulties contributed to the severity of psychological trauma. However, total supports did not contribute to the severity of psychological trauma. Even after controlling for level of traumatic exposure and total difficulties in the community, there was still a significant difference between CAAFAG and non-CAAFAG not explained by those variables (approximately 7.6 points of the trauma scale remained unexplained). This suggests that there are other factors contributing to psychological trauma in addition to traumatic exposure and community difficulties.

- **Impaired daily functioning**: CAAFAG had greater impairment in daily functioning compared with non-CAAFAG (with a difference of approximately 1.2 points on the impairment rating scale). However, these differences could all be explained by (i) greater levels of reported total difficulties among CAAFAG, and (ii) greater levels of trauma among CAAFAG. Total supports did not contribute to the severity of function impairment. This suggests that trauma and community difficulties explain why CAAFAG had greater levels of impaired functioning.

- **Hope**: CAAFAG had less hope compared with non-CAAFAG (with a difference of approximately 1.2 points on the child hope scale). However, these differences could all be explained by (i) lower levels
of reported total support among CAAFAG, and (ii) greater levels of reported total difficulties among CAAFAG. Levels of trauma exposure among CAAFAG did not contribute to the amount of hope. This suggests that community supports and difficulties explain why CAAFAG had lower levels of hope.

All of these factors taken together suggest that change in psychosocial wellbeing across a range of measures was associated closely with total difficulties encountered in the community. Persons who reported greater community difficulties were also likely to report lower levels of depression and psychological trauma. They were more likely to report better daily functioning and more hope, as well.

There were a number of interesting findings. For example, with regards to depression and psychological trauma, the level of supports and difficulties predicted who would increase or decrease in their depression or psychological trauma severity over time. Persons with high levels of community difficulties were likely to show an increase in depression and/or psychological trauma distress over time. In contrast, persons with high levels of community supports were more likely to show a decrease in depression and/or psychological trauma distress over time.

7.6 Conclusion

Community discrimination and lack of support, which includes discrimination and lack of support from families, explains in part why CAAFAG have greater psychosocial problems compared with children who did not associate with armed groups. CAAFAG identified not only family discrimination but also rejection by their peers and neighbours as more significant causes of distress. Community perceptions about the violation of Hindu caste purity laws and assumptions about sexual activity during association with armed groups were the main reasons given for discrimination and rejection of the children on return to their community. This applied to both sexes but was more acute as a barrier for girls attempting to re-integrate.

This highlights the need for reintegration programs and NGO support packages to emphasize issues of discrimination related to violation of Hindu purity and sexual activity. These themes should feature in awareness campaigns, community dialogues, and inclusion activities. This is also raises the important point that all staff working with CAAFAG should be aware of their own cultural beliefs and practices that could possibly
reinforce stigmatization during return to communities. Discrimination or support from NGO workers can either amplify existing distress or help ameliorate it.

### KEY CONCEPTS

7.1 The key forms of support identified by CAAFAG were the need for *educational, emotional, and basic needs supports*. Most CAAFAG returned home to restart their education.

7.2 Community members and CAAFAG described a range of community difficulties. These related to *fear of revenge and retaliation from security forces and community residents*.

7.3 *Cultural beliefs regarding Hindu purity* were used to explain why girls were the target of discrimination. Girls felt particularly discriminated against in the household.

7.4 The experience of discrimination difficulties and lack of reintegration supports was *strongly associated with poor psychosocial status*. This was as important as exposure to traumatic events during war.

7.5 Interventions should target *promotion of existing supports* and helping to reduce the impact of existing discriminatory practices.
References


Honwana, A. (2006a). *Child Soldiers: Community Healing and Rituals in Mozambique and Angola*: Daiute, Colette (Ed); Beykont, Zeynep (Ed); Higson-Smith, Craig (Ed); Nucci, Larry (Ed).


Psychosocial Support Model for Children Associated with Armed Forces and Armed Groups in Nepal
SECTION - III

Intervention: A District Psychosocial Support System
Psychosocial Support Model for Children Associated with Armed Forces and Armed Groups in Nepal
Chapter 8 Goals – The goals of this chapter are

i. to describe how a Mental Health and Psychosocial (MHPS) mapping activity was conducted to identify resources available for CAAFAG and others in both program districts and Kathmandu

ii. to describe the number and types of organizations providing services in districts as well as the services provided

iii. to describe the most common types of MHPS observed by organizations and providers

iv. to describe the major barriers to providing MHPS care, and

v. to describe the referral process among organizations and between Kathmandu and district facilities.

This chapter addresses the crucial question of “What services already exist in districts where CAAFAG are reintegrating?” This is important so that any new MHPS interventions do not duplicate existing programs, but rather augment existing services and help to fill gaps in services. The findings in this chapter lay the groundwork for the training and intervention programs described in Section III.

8.1 Background, Rationale, and Method: Psychosocial Resource Mapping

In Nepal, there are very few psychosocial resources available to children and their families in districts outside of the capital. Information about government, NGO and private psychosocial services is lacking in most districts of the country. This chapter describes the process of identifying mental health and psychosocial resources, particularly in relation to children and families.

Initial discussions and literature review revealed that many psychosocial referrals arrive in the capital of Kathmandu from districts throughout the country. However, individuals without financial resources—often those who are most vulnerable—may not be able to access resources
in Kathmandu because of the travel and opportunity costs. Therefore, it was crucial to determine what services and psychosocial resources are available within the districts themselves. A rapid survey of Mental Health and Psychosocial (MHPS) services was planned with the aim of identifying existing MHPS service, particularly in relation to the districts where CAAFAG interventions were focused. This was intended to help CPSWs and District Psychosocial Counsellors (discussed in Chapter 9) to aid their clients in accessing local resources and to help CPSWs and counsellors work more closely with local providers. A second benefit of this exercise was dissemination of the findings of the mapping exercise to all MHPS service providers, who took part and therefore strengthen links between them and aid inter-agency referrals.

A literature review informed our development of a research strategy and instrument development for data collection (Greenfield, 1996). Semi-structured interview schedules were developed building on the WHO Assessment Instrument for Mental Health Systems (WHO, 2005) for conducting the interviews. The instrument was reviewed by two mental health advisors and researchers (see Figure 8.1).

![Diagram: Mental Health and Psychosocial (MHPS) Resource Mapping](image)

**Figure 8.1 Mental Health and Psychosocial (MHPS) Resource Mapping**
A research team of three experienced field researchers, were educated on objectives for the mapping exercise. They visited the eight districts of the UNICEF-CAAFAG reintegration programme. Then two psychologists undertook data collection in Kathmandu Valley within the central region.

Data collection took place using ‘snowball’ sampling (Greenfield, 1996, p.149). Initially, member organisations of the CAAFAG Working Group and UNICEF PNGOs were asked to identify organisations they knew who provide social and psychosocial services in the districts where they worked. Researchers interviewed representatives of these district organisations, who in turn, identified other agencies, who were then visited by our researchers. This process was repeated until no further district-level agencies were identified.

Individual interviews were conducted with NGOs working in the social sector, government organisations (e.g. hospitals and health posts) and private organisations (e.g. hospitals and nursing homes). Researchers also met with the TPO District Psychosocial Counsellors, who were based in each of the eight districts. E-mail and telephone collection was made from a few sources but this method was mainly used to clarify information during the data cleaning and inputting stages.

To accomplish data verification, information gathered was verified by sending the inputted data back to the informants to check it for accuracy before analysis could begin. This was done through follow-up e-mails and phone calls. Interview schedules used for data collection in the reintegration districts were all in Nepali. These were translated into English, cleaned and inputted into both a word-processing (Microsoft Word) and a statistical software (SPSS) package.

There were a number of challenges during the mapping exercise. The researchers were undertaking the mapping exercise at the same time as other research activities in the project, within a tight time schedule. This left little time to follow-up on data collected in the districts and check for missing data. This was addressed via e-mail and telephone follow-up however information may have been missed or insufficiently explored. Aside from time pressure due to other research activities, the political situation in the country was very unsettled and data collection was often hampered or delayed by strikes. As a result, initial plans to speak with service-users to gauge the quality of services was dropped from the exercise due to a lack of time.
People interviewed sometimes had different interpretations of the term ‘psychosocial’ and required frequent careful explanation by the researchers. This posed problems for the researchers in that one individual’s definition of ‘psychosocial’ may vary from another’s interpretation. In particular, there appeared to be different definitions between practitioners in Kathmandu and those in rural districts. This makes it more difficult to judge the quality of services in the districts.

8.2 MHPS Services in the Kathmandu Valley and Reintegration Program Districts

Including the Kathmandu Valley and the eight target reintegration program districts, 73 sources of mental health and psychosocial services were identified. Of these 73, 39 were in the eight districts outside the valley and 34 in the Kathmandu valley. Of the 73, 61 were in urban areas including the 39 in the Kathmandu valley and another 34 in district urban centres. Only 12 of 73 service providers (16.4%) were in rural areas. Government agencies (health posts, primary health centres, and government hospitals), private agencies (private clinics, medical colleges, and private hospital) and social sector (NGOs) have been providing MHPS services. In comparison to government and private agencies, NGOs have the largest number of services (52% of the total providing MHPS services).

Table 8.1 MHPS Service Providers by Location

<table>
<thead>
<tr>
<th>Service Providers</th>
<th>Districts (8) N (%)</th>
<th>Kathmandu Valley N (%)</th>
<th>Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government agencies</td>
<td>14 (19)</td>
<td>2 (3)</td>
<td>16 (22)</td>
</tr>
<tr>
<td>Private agencies</td>
<td>7 (10)</td>
<td>11 (15)</td>
<td>18 (25)</td>
</tr>
<tr>
<td>Non Government Organizations</td>
<td>17 (23)</td>
<td>21 (29)</td>
<td>38 (52)</td>
</tr>
<tr>
<td>Personal/Individual</td>
<td>1 (1)</td>
<td>0</td>
<td>1 (1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39 (53)</strong></td>
<td><strong>34 (47)</strong></td>
<td><strong>73 (100)</strong></td>
</tr>
</tbody>
</table>

As expected, there is a much larger number of psychosocial and mental health services within Kathmandu valley compared with districts outside the greater capital area. In some cases there are five times the number of services (e.g. residential services) in the capital area versus the districts. The contrast is more stark when comparing the picture in individual districts with some districts having absolutely no services while others have services nearly comparable to Kathmandu.
Within the Kathmandu Valley, out of 32 different organizations, 22 offered services including inpatient, outpatient, and residential services and care such as psychosocial counselling (individual, group or family), psychotherapy, psychological testing, and psycho-education. Some service providers that are located in Kathmandu (Head office), provide services to severe cases. For instance, Asha Deep Maryknoll Nepal has two day care centres for severe mental illness in Kathmandu and Bhaktapur.

Table 8.2  Percentage of Organizations Providing Services by Location

<table>
<thead>
<tr>
<th>Service available</th>
<th>District organizations providing service</th>
<th>Kathmandu organizations providing service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Examinations</td>
<td>40%</td>
<td>70%</td>
</tr>
<tr>
<td>Medication</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Residential Service</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>Psychosocial Therapies (Psychosocial counseling, psychotherapy, psychoeducation)</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Legal Counselling/ Advocacy</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Outreach Programs (Mental health camps)</td>
<td>8%</td>
<td>30%</td>
</tr>
</tbody>
</table>

In some health posts, medical staff such as Community Medical Auxiliaries (CMA) and Health Assistants (HA) were evaluating and treating patients with mild MHPS problems (see table 8.3). These staff received psychosocial training from different agencies, with duration of training ranging from minimum of one week to a maximum of one month. These medical staff self-reported that they could identify mental health and psychosocial problems. Similarly, in the non-governmental sector, Community Psychosocial Workers (CPSWs) also self-reported that they could identify psychosocial problems and provide psycho-education and psychosocial support to clients. CPSWs received comparable lengths of training ranging from seven to 28 days, and some had the added benefit of refresher trainings.
Two government hospitals inside the Kathmandu Valley provide psychiatric services to persons with severe mental illness. However, only three of eight district have hospitals which provide services for the mentally ill. In all other districts, the district hospitals have no services or personnel who are equipped to care for the mentally ill. Private agencies like medical college clinics have medical doctors. Some of them have more than three years experience on hospital mental health wards. These doctors see patients with moderate to severe mental health problems.

**Table 8.3 Types of Providers Serving Clients with MHPS Problems**

<table>
<thead>
<tr>
<th>Severity of MHPS problems</th>
<th>Service Providers</th>
<th>Eight Districts</th>
<th>KTM Valley</th>
<th>Total (n=73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild MHPS problems (e.g. anxiety, fear, somatic complaints)</td>
<td>Government Agencies (health posts)</td>
<td>12</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Private Agencies (hospitals, private clinics)</td>
<td>7</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>NGOs</td>
<td>16</td>
<td>19</td>
<td>34</td>
</tr>
<tr>
<td>Moderate MHPS problems (e.g. anxiety, conversion disorder, trauma)</td>
<td>Government Agencies (health posts)</td>
<td>4</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Private Agencies (hospitals, private clinics)</td>
<td>6</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>NGOs</td>
<td>12</td>
<td>19</td>
<td>31</td>
</tr>
<tr>
<td>Severe mental illness (e.g. schizophrenia, bipolar disorder, epilepsy)</td>
<td>Government Agencies (health posts)</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Private Agencies (hospitals, private clinics)</td>
<td>5</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>NGOs</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

The key finding from this psychosocial mapping is the tremendous gap in MHPS providers throughout the country. Table 8.4 lists the number of providers in the Kathmandu Valley and the combined number of providers in the districts. In the Kathmandu Valley, there is one psychiatrist per 39,000 people, one psychologist per 126,000 people, one psychosocial counsellor per 35,000 people. The situation is much more dire where there is only
one psychiatrist per 266,000 people and one psychosocial counsellor per
209,000 people; and, there are no psychologists reportedly working outside
of Kathmandu. The number of psychosocial counsellors available within
the reintegration districts ranged from one to three. In four districts there
were no counsellors before TPO began the CAAFAG intervention program.
Out of 39 organisations interviewed outside of Kathmandu valley, there
were no psychologists and a patchy number of psychiatrists (ranging from
none to four working in a district). This is clearly an inadequate number
of skilled staff for the large population served in the low lands (Terai) and
the difficult geographical terrain in the more hilly/mountainous districts,
where travel is very challenging for people. Furthermore, the number of
psychiatrists reported working in districts is artificially inflated because
the same psychiatrist was often working in multiple settings or districts.
For example, the psychiatrist of a zonal hospital also provides service in a
private clinic and was thus counted twice.

Table 8.4 Number and Ratio of Providers to Population by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
<th>Psychiatrists</th>
<th>Psychologists</th>
<th>Psychosocial Counsellors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eight Districts</td>
<td>2,930,000</td>
<td>11 (1:266,000)</td>
<td>0</td>
<td>14 (1:209,000)</td>
</tr>
<tr>
<td>Kathmandu Valley</td>
<td>1,650,000</td>
<td>42 (1:39,000)</td>
<td>13 (1:126,000)</td>
<td>47 (1:35,000)</td>
</tr>
</tbody>
</table>

8.3 Common MHPS Problems and Barriers to Care

Most service providers reported that anxiety, somatic and mood disorders
were the most common complaints. The most frequently reported problems
were anxiety-related problems.

“People with depression, anxiety and those affected by different
kinds of traumatic events come here ……. for physical treatment.
We know about it when they have physical complaints like
headache, stomach, etc.” (Medical Doctor)

“[The mentally ill patient] complains about loss of appetite,
nightmares, headaches, stomachaches, [and] though medicine is
taken, [there is] no recovery.” (Community Medical Auxiliary
Table 8.5 Common MHPS Problems Identified by Service Providing Organization

<table>
<thead>
<tr>
<th>MHPS problems/complaints</th>
<th>Eight Districts (N=39)</th>
<th>Kathmandu Valley (N=34)</th>
<th>Total (N=73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety (neurotic disorder, nightmares, fear, phobias, conversion disorder, obsessive compulsion disorder, panic attack)</td>
<td>30</td>
<td>21</td>
<td>51</td>
</tr>
<tr>
<td>Mood Disorder (Depression, post-natal depression, bipolar disorder)</td>
<td>27</td>
<td>18</td>
<td>45</td>
</tr>
<tr>
<td>Relationship conflict (with relatives, neighbours, others)</td>
<td>22</td>
<td>17</td>
<td>39</td>
</tr>
<tr>
<td>Trauma (e.g. Post Traumatic Stress Disorder)</td>
<td>24</td>
<td>20</td>
<td>44</td>
</tr>
<tr>
<td>Drug and alcohol abuse</td>
<td>20</td>
<td>21</td>
<td>41</td>
</tr>
<tr>
<td>Somatic complaints (headache, stomach, loss of appetite)</td>
<td>29</td>
<td>20</td>
<td>49</td>
</tr>
<tr>
<td>Psychotic Disorder (Schizophrenia)</td>
<td>11</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td>Mental Retardation/Learning Disability</td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Dementia</td>
<td>9</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Suicidal Tendency</td>
<td>21</td>
<td>17</td>
<td>38</td>
</tr>
</tbody>
</table>

Table 8.6 summarises the barriers, seen from the service provider’s perspective, that prevent people from coming for psychosocial and mental health treatment. The main problem identified was stigma about mental illnesses that prevent the person suffering or their family members from admitting to any mental health difficulties, and so do not seek services. The second major barrier was a lack of human resources, or staff trained who are knowledgeable about identifying and appropriately treating mental health problems.
Table 8.6 Main Barriers to MHPS Care as Identified by Providers

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Eight Districts (N=39)</th>
<th>Kathmandu Valley (N=34)</th>
<th>Total (N=73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma about MHPS problems</td>
<td>15 (20%)</td>
<td>10 (14%)</td>
<td>25 (34%)</td>
</tr>
<tr>
<td>Insufficient MHPS human resources</td>
<td>12 (16%)</td>
<td>4 (6%)</td>
<td>16 (22%)</td>
</tr>
<tr>
<td>Lack of coordination between districts agencies or service providers</td>
<td>2 (3%)</td>
<td>2 (3%)</td>
<td>4 (6%)</td>
</tr>
<tr>
<td>Not enough mental health organizations</td>
<td>8 (11%)</td>
<td>1 (2%)</td>
<td>9 (13%)</td>
</tr>
<tr>
<td>Lack of physical and materials resources – funding, materials, medication etc</td>
<td>5 (7%)</td>
<td>6 (8%)</td>
<td>11 (15%)</td>
</tr>
<tr>
<td>Lack of a mental health policy within government</td>
<td>0</td>
<td>5 (7%)</td>
<td>5 (7%)</td>
</tr>
<tr>
<td>Lack of updated knowledge within the profession</td>
<td>2 (3%)</td>
<td>3 (4%)</td>
<td>5 (7%)</td>
</tr>
<tr>
<td>Others (Difficult to handle patients, burnout, client reluctant to talk, strike, etc)</td>
<td>4 (5%)</td>
<td>10 (14%)</td>
<td>14 (19%)</td>
</tr>
</tbody>
</table>

The perception among community people was that there is no treatment or cure for mental health problems. In Nepal mental illness is a highly stigmatised condition, as in other countries, in part because an individual’s ailments or behaviour effect the whole family, especially in the case of mental illness (Kohrt & Harper, 2008; Kohrt & Hruschka, 2010). For instance, the ‘shame’ of a family member with a mental illness can affect other member’s marriage prospects. Therefore, respondents felt that people hide the simplest of problems. They bring their relative for treatment only when the problem is very serious and can no-longer be hidden.

Alternatively, patients tend to present with physical health problems, as is common in most societies. Many people who present at health services with a physical complaint are finally referred for mental health treatment (Kohrt & Harper, 2008). There is a culture observed in Nepal of medical staff conducting exhaustive tests on a patient before sending them for a psychiatric evaluation. The respondents suggest this is due to a lack of knowledge on how to identify mental health problems among medical
staff. Although it could also be due to the predominance of medicine in the health treatment with few other health professionals (such as clinical psychologists, occupational therapists and psychotherapists) available in Nepal. Because of this, there is a lack of awareness about counselling and its effectiveness in dealing with psychosocial problems. The general population and health staff do not know that mental health problems can lie on a spectrum from mild to severe symptoms. The majority of patients who present with mild to moderate problems and can be treated with counselling.

People with mental health or psychosocial problems do not know what is available for them in their local area, which often is very little. Even when there are resources, people, in some cases even the health workers, did not know about government and non-government MHPS service providers in their districts. The lack of motivation to access resources (due to stigma) combined with a lack of knowledge about what is available, results in people waiting too long before seeking and receiving help. As a result, simple difficulties can become more complex and entrenched and so more difficult to treat.

Raising awareness and educating community members as well as health staff in the districts, which is a role for District Psychosocial Counsellors (see Chapter 9) is likely to help reduce stigma and encourage the early identification and treatment of psychosocial difficulties.

8.4 Referrals from Districts to the Kathmandu Valley

The reason given for why clients are referred for psychosocial care, especially those diagnosed with a severe mental disorder, to Kathmandu is because the doctors available in most districts are not specialized in psychiatry or psychological therapies. The exceptions to this were two districts that had zonal teaching hospitals which include psychiatry departments. While these districts had access to psychiatrists, any care from a psychologist required going to Kathmandu.

Generally, the physical infrastructure and equipment available within the district facilities are greatly inferior to that available in Kathmandu Valley. Perhaps these better resources attract qualified staff to stay in Kathmandu or conversely because of skilled staff in Kathmandu they request and receive resources that are superior. Therefore people with a severe mental illness or disorder are usually referred to Kathmandu Valley. These
findings concur with previous assessments (Regmi et al., 2004; WHO, 2006). Therefore, we followed a strategy of placing a trained counsellor in the districts to provide a therapeutic service (see Chapter 9).

We also found a lack of communication between government and private service providers. Despite the small pool of MHPS service providers in each district, there was little knowledge among service providers about other services within the same district. Government bodies (health posts, district hospitals) tend to refer and communicate only among other government facilities. The same pattern existed among NGOs, who referred within their own organisation if they are large enough (e.g. Advocacy Forum) rather than to locally available resources. The mapping exercise allowed for greater communication and collaboration across agencies, whether government or non-government. Closer referrals will be more economic and convenient for clients. Greater communication across agencies may also create professional cooperation that will be cost effective and professionally supportive, such as hold joint psychosocial training or supervision meetings. Joint psychosocial training between government and NGO human rights protection workers is crucial.

8.5 Conclusion

Prior to this survey, there was no formal information about how MHPS referrals are made in Nepal. This survey gives a baseline picture of MHPS services and referral patterns in the eight programme districts and Kathmandu Valley. Overall, the study found that there was a frightening dearth of services in Kathmandu and especially in the districts. Sadly, the few services also had poor linkage and referral among organizations. The referral system between NGOs and government health facilities was particularly concerning.

Despite the appearance of a good spread of services in the Kathmandu Valley, these services are sporadic because they can disappear when the people who hold the more advanced skills go abroad, so called “brain drain.” These can be expatriate workers leaving Nepal or Nepali health workers going abroad to seek better opportunities. Longitudinal research is needed to assess whether training up health staff and paraprofessionals at the district or community level is more sustainable in the long term or whether they also suffer the same risk of leaving for better opportunities.

The main barrier to care identified was stigma about mental illnesses that prevent the person suffering or their family members from admitting to
any mental health difficulties, and so do not seek services. Secondly, a lack of human resources, or staff trained who are knowledgeable about identifying and appropriately treating mental health problems greatly limits the opportunity for seeking care.

Psychiatrists who are more prevalent in tertiary institutions often take a narrow, traditional view to treatment and focus on medication management of symptoms. Updating their knowledge to include the use of psychological therapies and the use of counsellors within district hospital settings could provide treatment that addresses the causes of the problem in settings that have limited resources.

KEY CONCEPTS

8.1 There is a frightening lack of professional MHPS services both in Kathmandu and in districts of the country where CAAFAG are reintegrating. In the districts the ration of psychiatrists to population is 1:266,000 and the ratio of psychosocial providers is 1:209,000.

8.2 The main MHPS complaints observed by care providers are anxiety-related symptoms. In addition, bodily (somatic) and mood (depression) complaints are also common.

8.3 The main perceived barriers to seeking MHPS care are the stigma associated with mental illness and the lack of MHPS services. In addition, both organizations and individuals have a lack of knowledge about services actually exist.

8.4 Despite the small pool of MHPS services, there is a concerning lack of referral among organizations. Referrals between government health services and NGOs are particularly infrequent.

8.5 Interventions and training should focus on developing district-level MHPS personnel and promoting referrals among existing agencies.
References


Psychosocial Support Model for Children Associated with Armed Forces and Armed Groups in Nepal
Chapter 9 Goals – The goals of this chapter are

i. to describe the culmination of the earlier sections into how an intervention was developed for CAAFAG in Nepal

ii. to explain the development of a psychosocial support system in communities poor in psychosocial resources.

iii. to provide background for adopting social cohesion approaches to intervention

iv. to describe the individual components of the psychosocial support system such as training to key community workers, and psychosocial counsellors

v. to briefly summarize the impact of the psychosocial training and implementation process

vi. to describe the challenges to training and intervention in this context, and

vii. to present future directions for psychosocial support systems.

9.1 Rationale for Developing a Psychosocial Support System

Like other low and middle income countries (LAMIC), there is a lack of mental health and psychosocial (MHPS) resources in Nepal. This is especially true outside of the main urban centres, where very few professionals want to live and work (Jacob et al., 2007; Regmi et al., 2004). In the early phases of our research work, which has been presented in earlier chapters, we found that that 40% of CAAFAG had clinically significant psychosocial problems. These were thought to be the result of the psychosocial distress faced by the children and their families directly and indirectly during the ten years of conflict. This psychosocial distress affects their ability to do school work or work at home or for wages. Therefore the conflict period has placed an additional emotional strain on the majority of people who, due to poverty, struggle to meet their basic needs.

An unexpected finding from this baseline research was that social rejection was as significant a determinant of psychosocial distress as any direct or
indirect trauma experienced by the children recruited into Maoists or security forces; and this was an important barrier to their reintegration. Services that specifically targeted support for CAAFAG, unfortunately marginalized them further; by making them separate from the rest of the community. In some cases this encouraged resentment because the community (who are often poor and struggling to meet their family’s needs) viewed CAAFAG as dangerous rebels or fighters who were being ‘rewarded’ for their actions by receiving school or vocational education and other reintegration benefits.

To fill the service gap identified at the time, social workers working with UNICEF local partner NGOs were provided with 28 days of training to aid the early detection of psychosocial distress and manage ‘simple’ client cases. This training of ‘community psychosocial workers’ (CPSWs) created a new, skilled, community-based worker.

The emotional support that they offered CAAFAG nevertheless came at a price to them. Feedback from CPSWs showed that they felt the burden of care placed upon them. These workers reported feeling helpless when faced with more severe cases; because they had insufficient skills to manage these cases, and there are insufficient places to refer clients locally to receive more skilled assistance. So, even if psychosocial distress is identified, there was no or limited services for people to be referred to for treatment. This placed CPSWs at risk of burnout (that is becoming exhausted through overwork and feeling powerless at work). This problem is compounded further because these workers do not receive training beyond the 28 days they received; so their knowledge becomes stagnant, and they feel less equipped to manage their workload. This raised the question of what can be done?

Supervision is recognised as an essential component of effective client work, and it represented a missing piece in the previous CPSW training program. Not only for workers to continue to develop professionally and help clients more effectively, but to prevent burnout. Micheal Carroll (1994) identified seven generic tasks of supervision, for ensuring all the important functions of supervision are performed.

1. Establishing a working alliance (trust between the mentor and mentee (in this case the CPSW and supervisor respectively)
2. Teaching – improving the technical knowledge of the mentee
3. Counselling - use of counselling interventions for facilitating the emotional expression of the mentee (CPSW)

4. Monitoring – particularly of ethical practice and ‘damage limitation’

5. Evaluating – assessing the competence and giving positive and negative feedback as well as identifying areas for the mentee’s future development.

6. Consulting – asking about the client and the work being done.

7. Administrating – helping with logistical problems and documentation

This model suggests that all tasks are important and can be used flexibly. The mentor’s personal (e.g. warm communication style) and professional experiences (e.g. knowledge on managing different psychosocial problems) are important in achieving these tasks. In the absence of psychosocial services, or even recognition of it’s value around the country, another task is ‘promoting sustainability’. For this, mentors would need to consider funding issues and how their mentoring work can continue over time, after donor funding for the programme ends. Supervision in the Nepal CAAFAG psychosocial program was conducted by district counsellors who will be introduced later after presenting the concept of ‘social cohesion’.

9.1.1 Social Cohesion

To address the issue of social rejection faced by CAAFAG, a strategy to encourage their social inclusion into the wider community was needed, so any planned intervention would need to ensure that the whole community benefits. This could then reduce the feelings of resentment felt towards CAAFAG; thus indirectly supporting better reintegration. In the other words increasing the social cohesion within the community would counteract the differences felt between the community and CAAFAG and thus allow the community to accept these children.

Social Cohesion is defined here as the flexible bonds between people that unite different parts of a community to bring about mutual support. Systemic ideas of Social Ecology (Bronfenbrenner, 1979, 1994) understand the individual; their problems and strengths, as imbedded within the cultural influences of their family, immediate community and wider society. So to address a person’s individual difficulties their cultural context is taken into consideration. In this way, cultural practices that increase
psychosocial distress can be highlighted for action, while encouraging cultural practices that enhance well-being and productive interactions.

Five dimensions of Social Cohesion, or the glue that holds communities together, has been set out by the Institute for Social Cohesion, a body within the UK Government’s Department of Health (ICOCO, 2009):

1. Material conditions - such as employment, income, health, education and housing. These conditions are necessary to prevent indebtedness, anxiety, low-self-esteem, poor physical health, poor skills and living conditions. It is required for a strong social fabric and social progress.

2. Passive relationships – such as freedom from fear, tolerance and respect for other people is thought to lead to a safe, harmonious and stable society.

3. Active relationship - include positive interactions and exchanges, networks between individuals and communities. This results in mutual support, information, trust and credit in the form of social capital.

4. Inclusion – refers to social inclusion, integration into mainstream institutions of society. This provides a sense of belonging and strength of shared experiences, identities and values between people from different backgrounds.

5. Equality - means social equality or fairness in access to opportunities and material assets such as housing, health, income. This is thought to provide improved quality of life and future chances.

This framework has been adopted in the UK to help public institutions adapt their services to improve social cohesion. In low income settings such as Nepal, dimensions (i and v), material conditions and equality, will require significant resources and infrastructure that are currently not available. Dimensions (ii-iv, passive relationships, active relationships and inclusion) on the other hand could be adopted with relatively few resources.

Fone and colleagues in 2007 defined social cohesion as based on friendships, visiting, borrowing and exchanging favours with neighbours. They found that income deprivation (poverty) was associated with poor mental health, as was low social cohesion within the community. They also found that the effects of poverty on mental health was reduced in areas of high social
cohesion. In contrast the effects of poverty on mental health was greater in areas of low social cohesion at the community level.

Given that Nepal is ranked as one of the poorest countries in the world, social cohesion may well be a useful protective factor against mental health and psychosocial problems. Especially since there is little formal infrastructure to serve these problems. Social Cohesiveness that help to link people together and enable individuals to share with each other both materially and emotionally during times of difficulty or stress. It might be useful at this point to look at what can contribute to as well as reduce stress.

9.1.2 Reducing Psychosocial Risk Factors: The Stress-Vulnerability Model

Stress can be generated from within the person, for instance through unhelpful thinking such as “No one likes me”, These thoughts create tension in the person, which effects how they feel physically (e.g. sweating hands, difficulty breathing) and their relationships with others (e.g. they may avoid going to school, making friends and lead to problems with their parents and teacher).

Stress can also be generated from events that occur from the person’s environment. For example, being physically or verbally threatened. This again results in similar thoughts, physical feelings, emotions and relationship problems as before, which have arisen from feeling under threat.

The Stress-Vulnerability Model emphasises stress (internal and external tension) and vulnerability (susceptibility to problems due to biological weaknesses) as predicting the onset of health problems. So internal or external stresses can combine with an individual’s susceptibility to psychological distress due to genetic factors. More recently, evidence has appeared to show that vulnerability can also arise from poor emotional nurturance in early childhood relationships, such as carers being inconsistent in their care, overly critical or threatening (Holmes, 2004).

In addition to the types of stress and vulnerability considerations, cultural expectations can also predict the type of psychosocial distress we might see in a person. For instance, in cultures where seeing ones dead ancestors is acceptable, there are more cases of people displaying visual hallucinations (e.g. seeing people others cannot) (Bentall, 2002).
Psychosocial and mental health problems can appear when the body is under stress and is unable to manage the stress. Improving social bonds through increasing Social Cohesion reduces stresses in the environment that can bring about psychosocial problems. We know that deliberately creating caring bonds between people is shown to protect healthy development despite environment risk factors (Bernard & Marshall, 2001).

We anticipated that stress for CAAFAG could be reduced by: (i) having a supportive environment in which CAAFAG and others feel included. This would be by helping to remove social barriers and instead encourage understanding between program children and other community members, thus encouraging better relationships and reducing the rejection felt by CAAFAG, (ii) living in a peaceful community, where people have ways of disagreeing without using physical or verbal threats and actions. Both these would have a positive effect on their psychosocial well-being.

Should a stressful event occurs, such as a death in the family or an unplanned pregnancy; having people to go to for comfort or help to think about solutions will greatly reduce the stress felt. The sense of mutual responsibility among community members can help during times of stress, and return people to normal life quicker. So, through better relationships, we could help to strengthen people’s resilience to stress. Social cohesion thus supports psychosocial resilience.

Micheal Rutter (1987) explored ‘protective mechanisms’ to psychological resilience, that is the factors that can prevent mental health problems. These include thoughts and emotions within the individual that may interpret their life experiences as hopeful or hopeless, healthy or unhealthy, stressful or productive, and how they manage their emotions and behavior. These individual thinking, emotional and relating styles are now known to be dependent on the quality of the parent-child early relationships (Fahlberg, 1991). Rutter also found protection came from social mechanisms, so that strengthening the quality of the environment in the family, school and community was important for enhancing resilience.

Other authors add support to this showing that psychosocial resilience that resist psychosocial and mental health problems, is encouraged by (i) creating greater social supports that can be used during times of stress and distress, which can be improved through social skills training (Strain, Guralnick & Walker, 1986) (iii) enhancing a sense of belonging that increases individual confidence (Schofield, 2002).
We know that CAAC and other youth can be influenced by political or criminal groups; making them vulnerable to recruitment or re-recruitment into these groups and takes them away from to school or other work activities that promote their future prospects. Strengthening individual confidence as well as strengthening social bonds may protect CAAFAG from being vulnerable to re-recruitment or exploitation in future.

### 9.2 A Community-Based Psychosocial Support System

In response to our research findings a model for district psychosocial support was developed (TPO-UNICEF, 2008, proposal). This model shown in figure 9.1 below addresses points 2-4 of the ICOCO dimensions mentioned earlier and create an environment for enhancing the protective factors to mental well-being.

![Psychosocial Support pyramid: Holistic Rather than Targeted Approach to Reintegration through Community Strengthening](image)

*Figure 9.1 Psychosocial Support pyramid: Holistic Rather than Targeted Approach to Reintegration through Community Strengthening*

A programme to encourage social cohesion at the community level was designed (i) to address the problem of social rejection of CAAFAG through social cohesion activities (ii) address the lack of psychosocial resources in the districts by providing simple services for people suffering from psychosocial problems (iii) taking a ‘problem prevention’ approach by building psychosocial resilience for CAAFAG and the wider community. The components of this system are described now.
9.2.1 The Social Cohesion Program

Social Cohesion training aimed to stimulate protective factors to psychosocial and mental well-being within the districts receiving reintegration supports. Since there are few formal psychosocial health resources to manage acute distress, enhancing ecological resilience is vital for helping communities to manage man-made and natural crisis; to reduce the effects of the stress and bring about normal functioning more quickly. Greater Social Cohesion between programme children, other children and community members was thought to help to develop a sense of responsibility towards each other and the community. These bonds can also be helpful in the early identification and treatment of psychosocial distress.

Training was provided to teachers, health-post workers and CPSWs. The phase I and II research found that teachers were most influential in swaying community reactions towards CAAFAG either positively or negatively and thus held influence over successful reintegration of CAAFAG. The findings also showed that many female CAAFAG had reproductive health problems that caused them psychosocial problems, which health post-workers with the right skills would be able to manage. Together with the community psychosocial workers (CPSW), these community members were identified as being potentially important for alleviating the psychosocial distress and improving reintegration for CAAFAG.

The objective of the training was to help these key community workers to strengthen and create bonds between different parts of the community to increase Social Cohesion, and thereby benefit CAAFAG and other vulnerable members of the community.

Two different Social Cohesion (SC) training manuals were developed: one for teachers and CPSWs; and the other for Health Post Workers. Training for the teachers and CPSWs was designed to improve understanding about the causes of psychosocial distress in the community and methods for increasing resilience. Such as challenging social barriers, and decreasing conflict, and promoting cooperation. They would also understand the role of adults as role models for children and gain skills for managing children’s negative behaviour without coercion. Additionally, they would understand the importance of networking, making referrals and using
local resources to help solve the psychosocial problems they identify. An outline of the training manual content for teachers and CPSWs is given in Table 9.2 below.

### Table 9.1 Seven days Social Cohesion Schedule for CPSWs and Teachers

<table>
<thead>
<tr>
<th>Day</th>
<th>CPSWs</th>
<th>Teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- am</td>
<td>• Introduction. • Debriefing of client and other work experiences.</td>
<td>• Introduction. • Basic psychosocial orientation</td>
</tr>
<tr>
<td>1 - pm</td>
<td>• SC pre-evaluation questionnaire • Expectations gathering</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>• Awareness of personal and group resilience; Tree of Life exercise • Introduction to Social Cohesion</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>• Challenging social barriers exercises</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>• Dealing with conflict exercises</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>• Community resource mapping exercise • Encouraging cooperation and mutual support activities</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>• Work planning day with District Psychosocial Counsellors</td>
<td></td>
</tr>
</tbody>
</table>

Social barriers and conflict arising from discrimination and longstanding cultural practices can be the source of psychosocial distress that lead to social, psychological and functional problems in communities. This 7 day Social Cohesion training is designed to help teachers and CPSWs to understand and experience the social barriers, conflict and other blocks to community cooperation. Then to develop plans about how they can enhance community collaboration through their work. The training provides skills for managing conflict and differences of opinion without threat or aggression, which can lead to psychosocial distress. An expected outcome from this training is to help all parts of the community, especially youth, to become connected, responsible for themselves and others. This is hoped to decrease the feelings of disenfranchisement or isolation that can draw youth into groups that do not benefit their future. By creating social links, it can encourage youth and other community members to think beyond their traditional practices towards the wider possibilities for their society. This cooperation can bring opportunities to understand one another’s perspectives and so reduce the potential for conflict. Social cohesiveness can help programme and other children to become aware
about their future potential and the possibility of alternative choices to associating with armed or criminal groups. In this way, help CAAFAG to consider their future in positive ways and avoid being drawn into political conflict. By resisting joining with armed forces in the future; by creating opportunities for them within their community, they can begin to make a positive contribution in their community.

Table 9.2 Five Days Social Cohesion Schedule for Health Post Workers

<table>
<thead>
<tr>
<th>Day</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Psychosocial orientation</td>
</tr>
<tr>
<td>2</td>
<td>Introduction to the bio-psychosocial model</td>
</tr>
<tr>
<td>3</td>
<td>Identification of physical complaints with a psychosocial component</td>
</tr>
<tr>
<td>4</td>
<td>Basic communication skills</td>
</tr>
<tr>
<td>5</td>
<td>Community linking and Social Cohesion work planning</td>
</tr>
</tbody>
</table>

Training for health-post workers, aside from the orientation to psychosocial and Social Cohesion ideas, was geared to understanding the psychological causes behind many physical complaints, how to listen effectively to clients, make appropriate referrals and network to promote health education. The training manual for Health Post Workers (HPW) was developed to enhance the work of HPW by providing basic psychosocial orientation and communication skills, particularly listening skills; introducing the bio-psychosocial model of health (relationship between mind, body and behaviour); looking at common physical complaints that have a large psychosocial component; specific issues for CAAFAG; and lastly better ways of linking into their community.

The aim of the Social Cohesion training is to foster community links in order to promote community resilience. How this is done would vary depending upon the community and the type of professional undertaking this task. The materials were designed to create an experiential and interactive training programme that would be flexible enough to respond to the different social issues that arise within the different districts.

At the end of the training, all participants developed work-plans on how they would incorporate Social Cohesion ideas into their personal
and professional life. These are termed ‘Social Cohesion activities’. Each participant is different and the community they work in will have different needs, therefore the training ended with a day of work planning to help participants tailor the information, they received during training, to fit with their own community needs. During this planning day, the TPO District Psychosocial Counsellor attended so that they could understand the plans being made; to be in a better position to support the Social Cohesion efforts in their districts.

The manuals developed were given to participants after their training as reference for them when they incorporate these new ideas into their work. For instance, the social cohesion training might encourage HPW to provide more outreach services into schools or conduct educational talks about health to parts of their community. We hoped the training would stimulate teachers to create a safe and enjoyable learning environment for their students; setting up support links between students within their own school, and perhaps between other schools and child-clubs. Likewise, we hoped CPSWs would conduct talks and training to women’s groups, parents and other people in their community who could provide help and support to children. The effects of these activities were assessed and are given later in this chapter.

9.2.2 District Counsellor Program

Another key component of the psychosocial support system was to improve the human resources available to the district. This was to done by improving the capacity of existing workers to create an intermediate level of psychosocial professionals, referred to here as ‘District Counselors.’ In many countries counselling is an established profession requiring years of supervised training. In Nepal it is a relatively new profession and the term gets used loosely to mean guidance. So counselling can refer to legal counselling, nutrition counselling, career counselling and so on. For clarity, the term psychosocial counselling will be used here.

In addition to the difficulty with terminology, there is a lack of clarity with respect to the training that people calling themselves ‘psychosocial counsellors’ may have received. The duration of training can vary from 3 days to 5 months (Jordans & Tol, 2003). Training content is not standardised and neither is the quality of training; because organisations
offering training have not been accredited and checked to any national standard. Clearly, this situation is not helpful for anyone. The prospective client may not receive the help they seek and need. The ‘counsellor’ who may find themselves unable to manage the client’s needs competently. Lastly, it is not helpful for the reputation of psychosocial counselling as a new but effective method for alleviating psychosocial distress for mild and moderately distressed people (Werner, 1999, Kohort, 2007).

A five month training course developed in Nepal by Jordans and Tol (2003) provides a robust grounding in counselling principles, ethics and practice, using experiential learning. This provided the foundation for this current training programme. Two main adaptations were made, firstly to include direct experience of psychosocial problems found in the rural districts and secondly to closely integrate teaching with clinical practice. The latter adopted from the British Psychological Society model of clinical psychology training. So rather than a block of teaching and block of clinical practice with supervision, both aspects of learning were brought together each week. This ensured deeper understanding of theoretical information and enabled frequent practice enabling more rapid improvement of clinical skills (Lake, 2002).

Sustainability was also a central consideration in the design of this psychosocial intervention, because in the past some social workers who had received CPSW training could not use their new skills because they were promoted within their organisation or moved into administrative jobs. Therefore a selection process for prospective trainees was introduced to obtain high performing CPSW from the pool of CPSWs in each district for a six month para-professional counselling training. At the end of the six months, the trainee will be known as a ‘district counsellor’ and would be able to add a specialised psychosocial tier to the resources available in each district. As such, they would be able to supervise CPSWs; be able to manage more complex cases that CPSWs have identified and referred; promote psychosocial education and establish links between existing psychosocial resources within their district.

Selecting the ‘district psychosocial counsellor’ from within the district itself, ensured that they were knowledgeable about the psychosocial difficulties in that area. It also increased the chances of that person remaining within their district to sustain these services for the local community; and so
improve the psychosocial capacity of each district to serve its population. How this training was designed and conducted is given later in this chapter.

As stated earlier, CPSWs reported insufficient opportunities, due to lack of services, to make referrals locally for psychosocial cases. Aside from training up district-based psychosocial counsellors, a knowledge of government, non-government and private sources of psychosocial services in each district would be valuable information for the district psychosocial counselors. A mapping exercise for these sources was conducted and documented in Chapter 8. The expectation was that these resources would be shared with the psychosocial counsellors and CPSWs to support clients locally, where possible, and refer out of the district only if necessary. Thus helping the very poor and vulnerable, who would find it hardest to access services outside of the district. It was also thought to, indirectly, help to link service providers together; so that they can refer between themselves. Unfortunately, few psychosocial resources were found within the reintegration site districts, and served to further highlight the need for district psychosocial counselors.

9.2.3 Course Structure

In addition to theoretical knowledge and problem solving in the classroom, the course provided a balance of urban client practice and district-based client practice. In Kathmandu, where the central training took place, weekly supervision was provided by TPO-Nepal course trainers who were experienced psychosocial Counsellors.

Then in their home districts, trainees observed their future role being performed by a TPO-Nepal District Psychosocial Counsellor (DPC). The trainee counsellors worked as an apprentice along side the DCP and received direct supervision of their client cases from the DPC while in the district.

The key program aims for the DPC were to provide a secondary referral point for primary referrers (CPSWs, teachers, HPWs, clients), to improve knowledge and confidence among CPSWs about client work through regular supervision, and to promote psychosocial awareness, education and coordination in the district. The overall structure of the training with learning objectives each month are given in the table below.
Table 9.3 Training Curriculum for District Psychosocial Counsellors

<table>
<thead>
<tr>
<th>Month &amp; Location</th>
<th>Learning Objectives</th>
</tr>
</thead>
</table>
| 1 - Kathmandu    | Refresh content knowledge from CPSW 28 day training (principles, ethics, basic communication skills).  
• Psychosocial care in emergencies.  
• Understand psychological development over a life time.  
• Understand psychosocial difficulties for conflict-affected children  
• Use ‘problem management process’ |
| 2 – Home District| Practice client contact skills  
• Learn to prepare a case-study  
• Learn to prepare a session report  
• Use a documentation form – to monitor client progress  
• Learn to maintain a learning diary  
• Understand the role of the District Counsellor through observation (client work, mentoring CPSWs, conduct psycho-education and district networking)  
• Experience individual supervised learning |
| 3 -Kathmandu     | Review district-based learning  
• Experience individual and group supervised learning  
• Practice supervised client work  
• Practice making presentations  
• Practice goal-orientated therapy, referral and follow-up  
• Become familiar with alternative skills to counselling (diary keeping, drawing, story-telling, use of questionnaires, etc.)  
• Understand mental illness identification on a psychosocial spectrum  
• Practice of group skills (role-play, drama, facilitation)  
• Practice of advanced communication skills (psycho-education, giving feedback and challenging) |
| 4 – Own District | Practice district-based client work including follow-up  
• Prepare case-studies  
• Prepare a session report  
• Monitor client progress using a documentation form  
• Maintain a learning diary  
• Understand the role of the District Counsellor through practicing alongside (mentoring CPSWs, conducting psycho-education, district networking)  
• Experience individual supervised learning |
| 5 & 6 - Kathmandu| Review district-based learning  
• Continue supervised client work and practice endings (completion of work with client, referrals etc.)  
• Continue individual and group supervised learning.  
• Understand how to provide psychological 1st Aid and work with trauma  
• Understand concept of resilience and how to encourage it.  
• Understand Social Cohesion and how to practice community psychosocial work  
• Understand working with specific issues (discrimination, CAAFAG, behaviour modification, conflict mediation, suicide, HIV/AIDS, functional complaints, sexual abuse, domestic violence, substance abuse)  
• Practice mentoring and technical supervision skills |
The course consisted of three learning periods based in Kathmandu and two in the trainee counsellors’ home district. After returning from their district to Kathmandu, the trainee de-briefs; that is share their experiences from their time in the district. The first month in Kathmandu was made up of interactive teaching. The other two stages in Kathmandu were a mixture of interactive teaching and placement time at a Kathmandu-based social NGO. These are NGOs whose beneficiaries required counselling, such as street children or victims of domestic abuse. The trainee’s client work was supervised each week by one of the trainers on the course, who is trained in psychosocial counselling. The table below illustrates how the teaching week was arranged. At the end of the six month period, the trainee psychosocial counsellors returned to their home districts and took up their position as DPC, replacing the TPO counsellor.

These separate component of the psychosocial support system was designed to meet the needs of CAAFAG identified within the eight UNICEF reintegration districts in Nepal. Whether this system was successful in bringing change to these communities and benefit to CAAFAG and other vulnerable children could not be known without evaluating the intervention. The design of this evaluation and it’s findings now follow.

9.3 Impact of Psychosocial Programming

9.3.1 Impact of District Counsellors

The major objective for the District Counsellor role in this project was to establish a sustainable way to improve the quality and coordination of psychosocial services that PNGOs can use to support CAAFAG and other vulnerable groups. For this, a district-based counselling system was proposed: whereby a psychosocial counsellor from TPO-Nepal worked in each of the eight districts while a CPSW from the PNGO in each district was trained on a 6 month counselling course run by TPO-Nepal with the idea of replacing the TPO counsellor after six months. During these six months, District Psychosocial Counsellors had to focus on establishing a range of psychosocial activities, which were absent in these districts and will be looked at separately now.

District Psychosocial Counsellors in all eight districts provided psychosocial counselling services to programme children and other people in the community, as needed. Clients were referred to the counsellor by CPSWs, teachers, health post workers, community facilitators and by TPO researchers. This helped PNGOs to provide effective and timely services
to children in need of psychosocial support, which was a service found to be lacking in the phase II evaluation.

The majority of clients seen by District Counsellors showed symptoms related to mood; such as sadness, worry, aggressive behaviour or a lack of emotion, others showed functional or physical complaints such as headaches, inability to sleep, nightmares, feeling pain, or weakness and conversion disorder (e.g. nervous anxiety leading to collapse). Some also showed a lack of self-care or were in a confused mental state. After 3-5 sessions all the clients showed an improvement in their way of thinking and improved self-esteem. Within the individual counselling sessions, a range of therapeutic techniques were used including relaxation exercises, deep breathing, re-telling and drawing in the case of children. All clients have expressed that counselling has had a positive impact on them and had helped them to re-build their normal life and regain daily routines. Some clients identified by the counsellor as having a severe mental illness were appropriately referred to a psychiatrist for medication. In these cases, the counsellor was able to provide psycho-education about the client’s condition to the family so that they could understand what would be helpful or unhelpful to the client.

The majority of DPCs saw few individual clients at the beginning of the six months. This is the expected pattern for a new service, as awareness of the service grows either through formal awareness-raising programmes or through the informal ‘word of mouth’ processes. This pattern is seen in all the districts except for Dhankuta. In Dhankuta, the reverse seems to be the case, where numbers of clients start high and drop in the second quarter. This seems to be because a number of clients had already been identified in this district for psychosocial counselling. Once these people had been seen in the first quarter, fewer numbers were seen by the DPC in the second quarter.

The average number of clients over this 6 month period is 60. Four districts had numbers below the average, while four saw clients comfortably above the average. The number of client cases the DPC saw was affected by the start of the Social Cohesion training. DPCs participated in the training taking place in their district and then allocated part of their time for supporting CPSWs, teachers and health-post workers to implement their Social Cohesion workplans.

Referral of clients to the District Psychosocial Counsellors mainly arrived
from CPSWs, then from school teachers and health post workers (who had received the Social Cohesion training). Referrals also arrived from members of the community after receiving psychosocial talks from the DPC or through word of mouth.

In addition to these routes, TPO-Nepal field researchers, using standardised instruments to measure psychological symptoms and well-being among programme children, also referred children who scored above the ‘clinical cut-off’ for requiring psychosocial support. Researchers referred these children to the District Counsellors or Community Psychosocial Workers. Table 9.4 presents the number of children referred for support in this way in each district.

Table 9.4 Research-Referred Cases to District Counsellor and Community Psychosocial Worker

<table>
<thead>
<tr>
<th>Districts</th>
<th># of referring cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dhankuta</td>
<td>02 (3% of total (65) sample)</td>
</tr>
<tr>
<td>Dolakha</td>
<td>13 (21% of total (62) sample)</td>
</tr>
<tr>
<td>Rupandehi</td>
<td>16 (23% of total (70) sample)</td>
</tr>
<tr>
<td>Chitwan</td>
<td>23 (37% of total (63) sample)</td>
</tr>
<tr>
<td>Sindhuli</td>
<td>19 (26% of total (74) sample)</td>
</tr>
<tr>
<td>Kapilbastu</td>
<td>19 (30% of total (63) sample)</td>
</tr>
<tr>
<td>Dhading</td>
<td>12 (18% of total (67) sample)</td>
</tr>
<tr>
<td>Makawanpur</td>
<td>14 (21% of total (67) sample)</td>
</tr>
</tbody>
</table>

Dhankuta had fewer numbers of children reaching clinical cut-off, which is consistent with earlier findings that in this district, children had the fewest reintegration difficulties because they were readily accepted by their communities. Interestingly in Chitwan, which showed lowest number of clients seen individually or participating in Social Cohesion activities, also had the largest number of programme children showing clinical levels of psychosocial distress. Perhaps the low participation numbers for individual counselling in Chitwan was not because of need but due to other factors. These might be because people in Chitwan were dis-interested in this type of help or because the DCP was not sufficiently proactive in mobilising and educating about the new service. It could also be a combination of not having a sufficiently dynamic DCP combined with teachers and health workers who were resistant to changing their practice.
The Social Cohesion training was completed by the second quarter. After this time the District Psychosocial Counsellors focused on providing supervisory support to teachers, CPSWs, health post workers and others who wanted to implement the Social Cohesion activities from their training. Activities such as training community groups on child development, ‘tree of life’ (developing self and community resilience), psychosocial orientation, district level coordination meeting, and psychosocial camp. These activities usually involved large numbers of participants. Which shows the number of people per district involved in Social Cohesion activities over a two and a half month period.

Again we see wide variability between districts in the number of people seen (from 96 to 1071 people), with an average of 291 per district. Chitwan and Sindhuli again showed lower numbers of community people involved in these activities. Perhaps due to lack of community interest, or time available for supervising Social Cohesion work. This was not the case in Kapilvastu, Dhankuta and Dhading, which again showed high participation levels.

The handover was conducted during the first and second week of the January and took three to five days, depending upon the needs of the new counsellors. The handover provided the newly trained counsellors with an overall understanding of their new role. It included details of cases seen by the District Psychosocial Counsellors that required follow up; orientation and coordination of the work conducted in the districts; supervision provided to the CPSWs, and the overall learning and challenges encountered by the District Psychosocial Counsellor in their work setting over the past 6 months. This helped the newly trained counsellor to be well-prepared to take up their new roles.

9.3.2 Evaluation of Social Cohesion Outcomes

The social Cohesion training was conducted in eight districts; however, due to insufficient time only four districts were re-visited for the evaluation research. These districts were Chitwan, Kapilvastu, Dolakha and Rupandehi, which were selected because they included representation of eastern, central and western, hilly and terrai regions for geographical and cultural variation. They also showed high levels of social and gender discrimination, CAAFAG rejection, conflict, trauma and poverty, which
can all contribute to psychosocial distress and which the Social Cohesion training was designed to combat.

Qualitative research method were used to measure the effectiveness of the Social Cohesion trainings, evaluation tools were developed to assess whether there had been behavioural and attitude changes among participants that could be attributed to the Social Cohesion training. Since the Social Cohesion training is designed to promote connectivity we examined whether there was evidence for positive changes to children, parents or other community members who had not attended the training but gained benefits indirectly.

Three separate focus group discussions were held in each district for children, parents and PNGO workers. Each group contained four participants each to find out their views on the newly conducted activities and its impact to them. Participants were selected from places where activities had been conducted. First, Project Coordinators in the respective districts were consulted and advised on which participants were available for selection. Local organizations and community people also helped to find participants for these discussions.

A selection of people who had participated in the training were also invited to complete a post-test (semi-structured) questionnaire, to compare how their perceptions might have changed. The evaluation was interested in knowing the effects of the psychosocial interventions (that is Social Cohesion training and DPC work) on community variables. Such as evidence for (i) increased social links and support, (ii) increased community awareness about psychosocial issues and available supports (iii) increased confidence among CPSWs. (iv) increased awareness about social discrimination and conflict reduction. The pre-post training questionnaire was completed by 81% of participants who took part in the Social Cohesion training to contribute to the evaluation. The Table 9.5 below gives examples of how the training had been used by the participants.
# Table 9.5 Activities Conducted by Teachers, Health Post Workers & Community Psychosocial Workers

<table>
<thead>
<tr>
<th>Teachers</th>
<th>Health Post Workers</th>
<th>Community Psychosocial Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ran a community sensitisation programme on child rights</td>
<td>Circulated information related to health issues through the media</td>
<td>Interaction with CBOs on psychosocial issues</td>
</tr>
<tr>
<td>Intervened to prevent CAAFAG children from community discrimination</td>
<td>Visited schools to provide health education for children</td>
<td>Training provided to child clubs on psychosocial issues</td>
</tr>
<tr>
<td>Provided psychosocial awareness to children in school</td>
<td>Repeated social cohesion discussion with colleagues at the health post</td>
<td>Conducted orientation on social cohesion</td>
</tr>
<tr>
<td>Called District Psychosocial Counsellor into school to manage case of children with mass hysteria.</td>
<td>Discussed within the health worker’s team about psychosocial issues</td>
<td>Conducted community sensitisations on sexual violence</td>
</tr>
<tr>
<td>More watchful for people with psychosocial problems in community</td>
<td>Used listening skills to help clients</td>
<td>Balloon game (expressing emotions) held in child clubs</td>
</tr>
<tr>
<td>Conducted different games that they had learned from the social Cohesion training related to personnel values and strengths, vision for their future, cooperation, social inclusion and exclusion with the school children.</td>
<td>Started to consult with people having psychosocial problems and referred them to proper places</td>
<td>Provided psycho-education to the children affected by armed conflict</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Giving more attention to clients to see whether they have psychosocial problems or not.</td>
</tr>
</tbody>
</table>

1 CBO refers to Community-Based Organisation

Health Post Workers in particular reported incorporating many new activities, which were very different from their usual practice. In particular they were more alert to recognise psychosocial problems than before.
9.4 Inter-Group Communication and Cooperation

Figure 9.1 below shows who the teachers, CPSWs and health workers recruited into participating with them on their new activities, and who supported them to conduct the activities.

Figure 9.2 Support and Participation in Activities Conducted by Teachers, Health Post Workers and Community Psychosocial Workers

A mix of community members participated in implementing the Social Cohesion activities organised by teachers, health-post workers and CPSWs. Activities were run by teachers and parents, child club members, political party representatives, organizations as well as other teachers. The people who had received training supported each other, across professional disciplines; that is teachers, health workers and CPSWs supported one another’s efforts to implement the Social Cohesion activities they had planned at the end of the training. Their efforts were in turn supported by other community members (e.g. students, political leaders, traditional leaders) or organisations (CBOs and journalists) some schools provided sports material and a training venue.

Respondents, reported that the activities conducted after the Social Cohesion training was received positively by community members. There also seemed to be a spirit of cooperation and community action, which the training had hoped to generate.

According to the participants, there was excellent cooperation between mothers groups and children. Most of the work conducted by mothers
groups concerns children’s well-being, so now they discuss about children’s rights and protections issues. Additionally, many of the activities that related to children were going through local CBOs, like mother’s groups, in the community. One of the major components of Social Cohesion training was to deliver the message regarding social harmony and cohesion to CBOs like women’s groups. The participants felt it was now easier to communicate within the community using their knowledge from the Social Cohesion training.

We see a great deal of inter-group cooperation and the inclusion of community groups who were not part of the original Social Cohesion training. Also children and parents in the focus group discussion, mentioned examples of the Social Cohesion activities conducted by teachers, HPWs and CPSWs (such as the Tree of life, Spider web (makura ko jalo) and the ‘inside outside game’ (antarik bahiri khel). These reports by beneficiaries, verifies teachers’ reports of using these activities in school. It also suggests that children are sharing this learning with their parents, which is encouraging behaviour. We are not sure whether to there has been improved communication between children and parents because of the Social Cohesion activities or if this level of communication was present before the programme. This was not explored directly during the focus group discussions.

9.5 Community Awareness of Psychosocial Issues and Supports

An element of the Social Cohesion training was to raise knowledge about psychosocial issues and encourage appropriate referrals to CPSWs and District Psychosocial Counsellors. The table below summaries community responses to the question ‘what psychosocial support are you aware of?’
Table 9.6 Community Perceptions about Psychosocial Support Provided by the District Psychosocial Counsellors

<table>
<thead>
<tr>
<th>Parents</th>
<th>NGO People</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Awareness about availability of psychosocial services</strong></td>
<td><strong>Awareness about availability of psychosocial services</strong></td>
<td><strong>Awareness of the existence of psychosocial services</strong></td>
</tr>
<tr>
<td>• Parents in all districts except Dolakha reported knowing about the presence of DPCs.</td>
<td>NGO workers in all districts apart from Rupandehi and Chitwan knew about a psychosocial counselling service provided through DPC</td>
<td>• Children in all districts knew about the presence of the DPC</td>
</tr>
<tr>
<td></td>
<td><strong>knowledge of what the services involve:</strong></td>
<td>• They were aware of a meeting of counsellors in their district.</td>
</tr>
<tr>
<td></td>
<td>• Talking with DPC in a private place</td>
<td>• They had learned about psychosocial issues from the counsellors and taught what we have learnt in the community.</td>
</tr>
<tr>
<td></td>
<td>• Meeting with children regularly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide training to parents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Solve emotional problems like being lonely, or too much fear.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Solving psychological problems of children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Creating awareness related to psychosocial problems in the community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Conduct psychosocial orientation in schools</td>
<td></td>
</tr>
<tr>
<td><strong>Suggestions for improvement</strong></td>
<td><strong>Suggestions for improvement</strong></td>
<td><strong>Suggestions for improvement</strong></td>
</tr>
<tr>
<td>• More psychosocial services needed</td>
<td>• The counsellors should have knowledge of local mother tongue</td>
<td>• District Psychosocial Counsellor should be familiar to the people in the community</td>
</tr>
<tr>
<td>• More follow-ups needed</td>
<td>• There should be counselling camps.</td>
<td>• Media should inform about counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• There should be more psychosocial counsellors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Refresher training for counsellor is needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Counsellor should be of helpful nature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• District Psychosocial Counsellor should be familiar to the people in the community (specific comment to Kapilvastu district)</td>
</tr>
</tbody>
</table>

Among NGO staff, there was more emphasis on the Social Cohesion activities than the counselling available from DCPs. This perhaps reflects the area in which they were most involved with during the programme period. Most people knew there was a District Psychosocial Counsellor, apart from some of the NGO people in Rupandehi and Chitwan. This fits
with the earlier finding of low numbers of clients seen by counsellors in Rupandehi & Chitwan. However, parents and children talked freely about the work of DPC as having given useful advise or provided effective psychosocial support. Some comments suggested that the DPC should come from the local community and speak the local languages as well.

9.6 Increased Confidence Among CPSWs

The pre-post test results show that Community Psychosocial Worker’s confidence has improved in the previous 4 to 5 months. This was predicted to be the result of receiving mentoring support from the District Psychosocial Counsellors to develop the CPSWs skills and knowledge. This result is verified by CPSWs’ own reports.

Table 9.7 Measurement of Confidence and Anxious Thoughts Among Community Psychosocial Workers

<table>
<thead>
<tr>
<th>SN</th>
<th>Anxious Thought</th>
<th>CPSWs (pre-test)</th>
<th>CPSWs (post-test)</th>
<th>Teachers (post-test)</th>
<th>HPWs (post-test)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>1</td>
<td>I think I am a failure.</td>
<td>0.84 (0.51)</td>
<td>.68 (.63)</td>
<td>.70 (.53)</td>
<td>.66 (.62)</td>
</tr>
<tr>
<td>2</td>
<td>When looking to my future work, I give more thoughts to the negative things than the positive things that might happen to me.</td>
<td>1.00 (0.69)</td>
<td>.77 (.68)</td>
<td>.83 (.83)</td>
<td>.66 (.54)</td>
</tr>
<tr>
<td>3</td>
<td>I worry about saying or doing the wrong thing with clients (e.g. children and families).</td>
<td>1.41 (0.97)</td>
<td>.91 (.91)</td>
<td>1.40 (1.06)</td>
<td>1.25 (1.05)</td>
</tr>
<tr>
<td>4</td>
<td>I worry about my abilities not living up to other people’s expectations.</td>
<td>1.72 (0.93)</td>
<td>1.28 (.92)</td>
<td>1.43 (1.0)</td>
<td>1.40 (.97)</td>
</tr>
<tr>
<td>5</td>
<td>I worry that I cannot control my responses and behaviour with clients.</td>
<td>1.49 (0.98)</td>
<td>.77 (.80)</td>
<td>1.46 (1.0)</td>
<td>1.33 (1.07)</td>
</tr>
<tr>
<td>6</td>
<td>I worry that people don’t like me.</td>
<td>1.09 (0.92)</td>
<td>1.00 (1.0)</td>
<td>1.20 (.92)</td>
<td>1.14 (.98)</td>
</tr>
<tr>
<td>SN</td>
<td>Anxious Thought</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I take disappointments so keenly that I can’t put them out of my mind.</td>
<td>1.14 (.97)</td>
<td>.91 (.98)</td>
<td>.76 (.85)</td>
<td>.92 (1.03)</td>
</tr>
<tr>
<td>8</td>
<td>I get embarrassed easily.</td>
<td>0.86 (.58)</td>
<td>.74 (.74)</td>
<td>.83 (.74)</td>
<td>.55 (.80)</td>
</tr>
<tr>
<td>9</td>
<td>I worry about my failure and my weaknesses.</td>
<td>1.44 (.97)</td>
<td>1.31 (.96)</td>
<td>1.40 (.85)</td>
<td>1.44 (.89)</td>
</tr>
<tr>
<td>10</td>
<td>I worry about not being able to cope in work as adequately as others seem to.</td>
<td>1.09 (.92)</td>
<td>.82 (.95)</td>
<td>1.13 (.89)</td>
<td>.96 (.89)</td>
</tr>
<tr>
<td>11</td>
<td>I worry about making of fool of myself.</td>
<td>0.80 (.79)</td>
<td>.62 (.87)</td>
<td>.86 (1.04)</td>
<td>.74 (1.02)</td>
</tr>
</tbody>
</table>

Coding scale: 0 = Never; 1= Sometimes; 2= Often

Adapted from A. Wells, (1997) Anxious Thoughts Inventory (AnTI)

The above figure illustrate that confidence among Community Psychosocial Workers had improved consistently in all areas of the anxiety checklist given above. This is very encouraging and occurred after a relatively short period of time.

## 9.7 Conflict Reduction

It was reported by participants that there were different causes of conflict in the community. Some of them emerged from social structures, some of them from political instability and some of them from people’s attitudes. Socially generated causes of conflict hampers not only professional life but also people’s personal life. Women reported gender discrimination which is common in their community. They felt that conflict in the community would remain until these attitudes and practices are eradicated. Participants gave their view of why social exclusion comes about in their pre-training questionnaire and below are some examples.

- A mother from Rupandehi said, “Daughter should not be allowed to go to school because once they start to read and write they will write love letters and may run away (Poila ganche).”
- Community Psychosocial Worker from Dhading said, “A girl
called kanchi went to the school but other children teased her calling her names like ‘low caste girl’ and criticising her torn clothes so she stopped going to school after 2 days.”

- Health Post Worker in Kapilbastu noted that, “Dalits are not allowed to enter temples by Brahmans.”

- Community Psychosocial Worker from Sindhuli, “Uneducated people cannot make decisions during school activities. Also, poor people have to struggle to earn their daily bread so, they have no time to engage in social programmes”

Teacher from Sindhuli said, “A brahmin girl who marries a man who is dalit and poor will step down to the lower caste and she is not allowed to go to her parents house. Dalits do not have rights to take decisions in the community and women have no spare time to participate in social programmes”

9.8 Improvements for Children

All of the focus group members (who were not direct beneficiaries of the Social Cohesion training) agreed that activities such as training, orientation and the games made children relaxed and also enhanced their learning capacity. They said that these activities were helpful for the children who belonged to poor, under privilege and Dalit groups. They reported that that children and other people in the community, have now started to share their feelings and emotions with others. They added that people now realized that things in their ‘mind and heart’ should not be kept inside.

Community Psychosocial Workers reported noticing teachers that, after undertaking the Social Cohesion training, have changed their behaviour towards school children. For instance, they used to punish children for any wrong-doing by beating them but now they see teachers offering these children advice and explaining why their behaviour or action is not acceptable. They also reported seeing children, who did not like to go to school before, have started to happily go to school. They also noted that children in the school were behaving well towards CAAFAG. The CPSWs believed these changes were possible because of improved teaching skills among teachers resulting from the impact of training.

Everyone who participated in the Social Cohesion training felt that children benefited most from the activities. Teachers conducted games, orientation to children, Health Post Workers visited schools to provide
health and psychosocial education. Similarly, CPSWs also conducted activities in child clubs and held children as direct beneficiaries of their work. After children, they felt that women, teachers, health workers and family members of CAAFAG children benefited from the Social Cohesion activities.

Although the people who took part in the training may have believed that their actions benefit children, we needed to find out if this was how children perceived it too. Below is a list of changes that children had noticed since the Social Cohesion activities had began:

- Teachers encourage children to study
- Teachers tell children about the risks of playing on roads and teaching them traffic rules
- Teachers are treating all students equally
- Teachers have developed a helpful attitude towards children
- CPSWs follow-up with students whether they were psychologically fine or not.
- Teachers punish those who mistreat CAAFAG
- Teachers discourage children from keeping bad company
- Teaching skills are enhanced (teaching with lot of games)
- Teachers do not punish the students, they advise them
- Teachers have become disciplined too
- Government schools also have the atmosphere of ‘boarding schools’ because of the changes in teacher’s behaviour

Another important area was related to the existing resources children had for psychosocial well being and mental health. This section describes existing community support (e.g. family, neighbour, friends, teachers etc). The figure below illustrates different levels of support identified from different sources by returned CAAFAG and Community Children.

Figure 9.3 Community Support Perceived by CAAFAG and Community Children at Time 1 and Time 2
The above figure illustrates that CAAFAG perceive a large positive change in the level of support they receive, from the people around them, compared to a year ago. The children reported fewer difficulties from neighbours, family and friends than one year ago. This change may be attributed to the efforts of the psychosocial programme or might be due to a natural process of acceptance of the children that would have taken place gradually over time anyway. To know which it is, comparison data is needed from districts in which children received reintegration interventions without the psychosocial component.

Interestingly, this improved perception of support is also found among the community control children. The positive effect among community control children should be interpreted with caution. It could be due to greater social support perceived by both CAAFAG and community children due to the Social Cohesion activities, as the programme had been designed to do. However, it could be the result of greater attention given to both CAAFAG and community children over the past year when interviewing them and showing interest in their progress. It could be the result of social desirability factors, in which participants express improvement in order to please interviewers. Finally, the result could also indicate a process of “regression to the mean” wherein results that are particularly high or low change in a follow-up assessment. More work is necessary in order to understand this result fully.

Qualitative interviews with CAAFAG showed that 90% shared their feelings and emotions with their family and friends. Of the 10% of children who still felt that there was no one that they could share their problems with, the majority came from Chitwan. This was also the district with the lowest client numbers for individual counselling and fewer Social Cohesion activities undertaken. It would be useful to explore further whether specific cultural practices in this district prevented help-seeking communication, or whether the CPSWs & DPC in this district were not successful in finding a way to reach the population in Chitwan. In contrast, children in Dhankuta, Sindhuli and Dolakha districts reported that they always shared their feeling to their friends.

9.9 Implementation Lessons and Recommendations

9.9.1 Insufficient Time to Show Changes

Due to limited time and resources only four of the eight districts were evaluated, however, these represented a range of geographical, regional
and social variation. Participants from Chitwan and Rupandehi districts had five months and those from Dolakha and Kapilvastu had four months to incorporate social Cohesion and the psychosocial thinking into their ordinary work before the evaluation team arrived back in their districts. Therefore not very much time for those communities to change their culture of practice. Participants reported that there was so much potential to the Social Cohesion activities and tips that they could have applied had they had more than 4-5 months to apply them all. It is recommend that the districts are re-visited after one year to access the sustainable changes within these communities.

9.9.2 Low Female Participation

Representation among female teachers was low in all districts. This may have implications on how the social inclusiveness activities designed to create more support for girls in school are implemented. Sindhuli may be particularly vulnerable to this problem because this district had no female teachers and only two female CPSWs attending the training. A similar pattern of low female participation was seen in the HPW training, with the exception of Dhankuta which had higher numbers of female participants. Future trainings should consider incentives and arrangements to enable better female participation.

9.9.3 Inter-Professional Linking During Training

Specific emphasis was placed on planning the training so that the skills and knowledge that participants learned during the training get used in their work setting and their wider community. To facilitate this process the last day of training was dedicated to developing an action plan. In addition, this planning day took place with workers who would provide technical support for implementing the plans. District Psychosocial Counsellors attended the planning day because they would support all three sets of participants in their respective jobs; to incorporate some of the ideas gained from the training and integrate them into their work and personal lives. Including District Psychosocial Counsellors within the CPSW and teacher training; and CPSWs within the HPW training, created an opportunity for staff from different professional backgrounds (DPCs, PNGO staff/CPSWs; teachers and HPWs) to develop working relationships.

9.9.4 Practical Training Benefits

The training was interactive and practical, which participants valued. The
development of action plans at the end of training was useful because it enabled participants to think through concrete actions to implement their new learning. Presence of District Psychosocial Counsellors and CPSWs, on the planning day was useful to help make the plans more realistic.

9.9.5 Loss of Skilled Workers

Some CPSWs had already been lost to the programme before the project started and replaced with SWs who had no psychosocial training. Therefore fewer referrals to DPC and less Social Cohesion activities occurred in some districts.

9.9.6 Per Diems

A culture of receiving per diems (daily subsistence costs) regardless of whether food and accommodation costs are covered by the trainers, lead to disappointment and some resentment among the participants. This was particularly intense among government staff where there are clear expectations for per diems. Future training should have per diems in-keeping with government rates to avoid disappointment among participants and enable them to engage fully in the training.

9.9.7 Selection Bias on Social Cohesion Evaluation

Participants invited for the focus group discussions to evaluate effects of the Social Cohesion training in the community were selected from places where activities had been conducted. These participants will have known about the services that CPSW and DPC provide than people from other parts of the district. Also, Project Coordinators of PNGOs in the respective districts were consulted and identified prospective participants. This may have skewed selection towards people who were more knowledgeable and positive about the project activities than randomly selected community people. The anxiety questionnaire was not given to Health Post Workers and Teachers. So although, we have anecdotal reports of their improved work skills and confidence, quantitative evidence is not available. In hindsight it would have been useful to look at confidence levels of health post workers and teachers as well, to see whether the Social Cohesion training and subsequent activities would have increased their professional confidence too. We have health post workers reports of increased skills in identifying psychosocial problems with clients and making referrals. We also have reports from students of improved teaching methods and child management among teachers, so it is possible that their confidence could have improved too, but the evidence remains anecdotal.
9.10 Conclusion and Future Directions

Coordination between service providers that work for Mental Health and psychosocial care within the same district will help more efficient referral of clients. The information that TPO has collected during the mapping exercise set out in chapter 8, will be disseminated to UNICEF-PNGOs. In this way the 6-month trained District Psychosocial Counsellors can refer their client to the nearest and most appropriate service provider. It is recommended that to keep this information useful for refers it should be kept updated, perhaps by conducting quarterly meetings of all the psychosocial counsellors from different PNGOs, TPO-Nepal, CACWG members and other interested parties.

PNGOs in the 8 districts should consider the cost for the client when referring their cases. Transport, daily food and accommodation, registration and follow-up session charges, are all important to calculate and discuss with the client and their family before referring out of the district.

Training on Mental Health and psychosocial care is needed for Health staff (e.g. CMA, ANM, FCHV, HA, Nurses) in Sindhuli and Dhanding districts where there is little government, NGO or private psychosocial provision. This would help health workers identify psychosocial problems and refer the patient to an appropriate service provider out of their district. In addition, wider Social Cohesion training of community workers would be useful to help prevent psychosocial problems from arising.

When funding to PNGOs end there is a danger that the DPC and CPSWs system will be adversely affected. District Psychosocial Counsellors are a new concept in Nepal. UNICEF should be credited for being willing to move from a narrow targeted approach to a more holistic approach to psychosocial care and allow the piloting of the type of psychosocial provision set out in this chapter. Nevertheless, because this was a pilot project, the budget available was restricted to only allow one person to be trained per district, even though we anticipated from the start that this would be logistically challenging for the DPCs. It can take days to travel between VDCs in the hilly terrain of the northern half of Nepal, therefore not practical for one person to move around to undertake clinical work, or for people to travel to see the DPC.

Ideally, a DPC per 100,000 people could be the aim; incorporated within the government health system. This would be more sustainable and not
only improve psychosocial services for the population but also provide an opportunity for medical staff to understand psychosocial methods of treating mental distress. However, before this can happen para-professional counselling courses such as the one developed for this programme will need to be accredited and recognised by government. Para-medical services have become a solution to health needs in some low income countries (BBC, 2008), which like Nepal, share problems of insufficient number of health professionals who can be retained within the country or willing to work in remote areas. Historical recognition of psychiatry and medical approaches to mental health might require a radical shift before para-professional counsellors will be accepted within government hospitals. Thus the dual NGO-government routes for mental health services is likely to continue. Greater communication between government and non-government agents in the districts will help to create mutually beneficial solutions. For instance, DPCs based in and part-funded through district hospitals. Training of additional HPWs in districts; or CPSWs part-funded through district health office.

KEY CONCEPTS

9.1 In settings of limited resources, the developed of psychosocial support systems is crucial to develop MHPS support services, including for CAAFAG.

9.2 A Social Cohesion approach helps to maximize existing resources and reduce risks in existing social practices that may endanger children.

9.3 Individuals can easily be trained-up to different levels of psychosocial providers such as Community Psychosocial Workers (CPSWs) and District Psychosocial Counsellors (DPC).

9.4 The psychosocial support system described here helped to reduce CAAFAG distress while simultaneous augmenting psychosocial resources for the community in general.
References


http://news.bbc.co.uk/2/hi/7632361.stm


Family Health International (2005). *Establishing Referral Networks for Comprehensive HIV Care in Low-Resource Settings*


The context in many low income countries such as Nepal is that they are often more prone to conflict or have recently emerged from a period of internal conflict. In the past, emergency aid in response to this conflict has focused on the immediate physical needs and subsequent economic needs of the effected population. Only recently has their psychosocial needs been considered.

This book is the result of 4 years of work, to research and then design and implement a suitable programme to help UNICEF to support children affected by armed forces and armed groups (CAAFAG). The drive to reintegrate CAAFAG provided an opportunity to examine the needs of this population and obtain responses to previously unanswered questions. In reading this book we hope we have answered questions such as:

- What are the reasons why CAAFAG join with armed forces or armed groups? What ideas does this give us for minimising conscription in the future?
- How are the experiences between CAAFAG different during their conscription?
- How can programmes for CAAFAG be tailored to meet these differences?
- What are the differences in experience for CAAFAG upon reintegration?
- How can we use this knowledge, of barriers and aids to reintegration, to help CAAFAG?
- Do CAAFAG show more psychosocial distress compared with other children?
- In what way does this effect their reintegration prospects?
- Can psychosocial support during the reintegration period be beneficial to the process?
Can psychosocial support help to assist the short-term reintegration and long-term thriving of CAAFAG?

Do these approaches work in practice?

These are important questions in Nepal but also hold relevance to programme developers trying to meet the needs of similar children and populations in other countries who have suffered conflict. Each chapter in this book is followed by a list of recommendations, which future programmers are likely to find useful.

Chapters 1 and 2 set out the existing knowledge and guidelines for incorporating psychosocial approaches when working in emergency settings. In particular, the relevance of taking a systemic or ecological perspective when working with CAAFAG, or with any population who have experienced distress. This approach allows potential helpers to understand the individual’s difficulties as imbedded within the context of their family, immediate neighbourhood, religious and other cultural influences and then wider society and global climate. These levels within a social hierarchy influence and impact on individuals in different ways. This awareness helps us to avoid lumping individuals who have shared one common experience together and work with them as if they are all the same.

Incorporating psychosocial approaches in emergency or development programmes is still new. There is little expertise available, so there is a danger that the work might be done incorrectly and cause harm or inadequately (e.g. leaving too soon before the community can manage alone).

Chapters 3 and 4 offer details and provides guidance on conducting research in emergencies and complex settings; using both quantitative and qualitative methods to combine two very different traditions of research to give a fuller picture.

The next four chapters move through the main research findings. Including the ‘push’ and ‘pull’ factors of why children join armed forces and armed groups. We see children are not always passive players in recruitment, as is often portrayed, but make choices to join; either to escape or attempt
to change environments of social injustice in which they live. To prevent child recruitment we not only need to enforce codes of war designed to protect minors, but also address the social inequalities that lure them into fighting.

Another new finding is the role that the community from which the child combatants come from, play in their psychosocial well-being during their reintegration after war. Religious as well as political beliefs within a community are significant in determining whether children are rejected or accepted back into their community, which has a direct bearing on their psychosocial well-being. Communities that are Hindu and closely adhere to notions of purity see unsupervised absence from home as resulting in the child being impure and therefore less acceptable; even when the child was forced to join the armed group. These beliefs serve to alienate the child on their return; either by their community rejecting them or the child alienating themselves and not returning home. Communities from other religious groups seemed more likely to welcome their children back into the community and these children showed better psychosocial adjustment.

Reintegration programmes have traditionally looked at the educational and economic requirements of returnee children and their immediate family. These, while being important, without addressing community perceptions towards returnee children, we see they stigmatise and isolate the children from their peers and wider community.

An analysis of the socio-economic and cultural context in which the children were in before, during and after their association with warring parties shows how these ‘every day’ factors play as much of a part in predicting their psychosocial well-being as their experiences of war. This finding moves us away from a time-bound approach to programme intervention (for instance withdrawing six months to one year after an emergency) towards a ‘needs bound’ approach. The latter would ensure that once a community has it’s basic needs met, which include ways to sustain their psychosocial well-being, this would be the time for external assistance to be withdrawn. As we see in the final chapter, this does not have to be costly for external agents; in terms of time, money or human resources. It does however, require good initial knowledge of the context, an assessment of needs as seen by the potential beneficiaries, and programme design that incorporates resilience-building for the individual, family and wider
spheres of community. In this way, the external withdrawal of resources does result in empowerment of the community to cope with future stressful events. Low intensity approaches that build community resilience, such as the newly developed approaches from Australia, Collective Narrative Practices (Denborough, 2008) have been shown to be effective because they are flexible and designed to work with the beliefs and practices within different cultures.
This book is the result of four years of work by the Transcultural Psychosocial Organization (TPO Nepal), to research and subsequently design and implement a suitable psychosocial support program for children associated by armed forces and armed groups in Nepal. The drive to reintegrate children associated by armed forces and armed groups provided an opportunity to examine the needs of this population and obtain responses to previously unanswered questions. What are the reasons why children join with armed forces or armed groups? Do children associated by armed forces and armed groups show more psychosocial distress compared with other vulnerable children? What are obstacles to successful reintegration? Can psychosocial support during the reintegration period be beneficial to the process? The book presents research into these questions as well as a description of the developed psychosocial support system.