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CROSSING BRIDGES AND NEGOTIATING RIVERS - REHABILITATION AND REINTEGRATION OF CHILDREN ASSOCIATED WITH ARMED FORCES.

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This article is based on my twenty years long experience as programme adviser to Save the Children Norway on children in armed conflict, and also draws on my clinical experience as a child psychiatrist in this context.

I continually use as a reference point for my advisory work, an integrated framework based both upon the legal rights of children and knowledge of child development. This framework suggests that rehabilitation/reintegration programmes should respond to children both as legal subjects as well as developing human beings. Thus, we have constantly to ask ourselves how children's experiences have impacted upon their rights as well as their development. For example, their rights not to be recruited into armed forces, to grow up within their families, and to gain an education, have all been denied. We also need to understand the impact of their experiences upon their physical, psychological and social development. When thinking about developmental issues, I find a 'transactional' model of development very useful. This model recognises that children develop within the social context of their family, community and culture. Each child has unique, genetically endowed, characteristics, such as its temperament and abilities that, over time, influence their caregivers' emotions and behaviour, and affect others who interact with them. Equally, the child's development will be influenced by the behaviours, attitudes and beliefs of their caregivers and other family members, as well as the context in which their family lives. The transactional model emphasises how this dynamic process of interactions between children and their environment influences all aspects of children's development, including the ways in which they behave, how they think and feel about themselves and the world, and the quality of their relationships with others.

REHABILITATION AND REINTEGRATION – CONTEXTUAL ISSUES*:*

I would first like to clarify what I mean by 'rehabilitation' and 'reintegration', words which are inadequate to describe the processes children go through when they return from their time in armed forces. However, as 'rehabilitation' is a word which is firmly entrenched in our 'child soldier' jargon, I will use it here. 'Rehabilitation', as readers will know, basically means to restore the child's functioning to 'as it was' before their experiences – but this will be a well-nigh impossible task in the case of those who have been with armed forces for many years. 'Re-integration' is generally understood

by organisations working in this field as the child being reunited with his/her family and becoming a full member of the community once more.

'Rehabilitation': 'Rehabilitation' I understand to be an organised process which follows children's demobilisation, escape, or capture and then release by another armed force. It is a process of re-orientation, rest, recuperation and reflection which needs to take place in a safe setting, in interaction with people who have received special training to facilitate the re-adjustment process. When talking with children undergoing 'rehabilitation' I often use the metaphor of 'crossing a bridge between the 'military life' to 'life in one's home and community to capture the process they are going through. This journey is not straightforward: there will be times of good progress followed by periods of very slow movement, and also some retracing of steps. Indeed, sometimes there will be a complete halt and even active retreat. Fear, grief, anxiety, anger, guilt and shame, lack of confidence, disease, malnutrition and disability will hamper progress. Determination, good health, the comfort, love and encouragement of others, and hope are the best companions on this journey, which in many cases will be life-long.

Which children need 'rehabilitation'? Children in need of 'rehabilitation' include those who have participated in atrocities, who have severe physical or psychological health problems, including disability; whose behaviour is potentially dangerous to others; whose families have ceased to exist or reject them; girls who have been severely abused, and girls who have become mothers while in armed forces. All such children need a period of intensive assistance from trained social and health workers and teachers, in some form of interim care, before returning to their communities. Children who have participated in committing atrocities are those most likely to be troubled with the more serious post-traumatic manifestations, and are also those most at risk of retaliation and rejection from community members. In African communities, these are the children most requiring some form of "cleansing" to rid them of contaminating evil spirits before they can be accepted into the community again. Naturally the emotional implications are significantly increased when children have been forced to kill, maim or rape family members. Occasionally one also meets children who appear to be in a state of denial concerning their thoughts and feelings regarding atrocities they have perpetrated. They "forget", they "don't feel anything", or they rationalise their acts in terms of "being forced" –but without the usual accompanying tears and regrets.

Rehabilitation does not necessarily guarantee successful reintegration-but the evidence we have suggests a better outcome for those children who have been helped in this way. In our community based research in northern Uganda, community members said that those children who returned home without a period of interim care, were more aggressive, unstable and showed military habits (Jareg and Falk 1999)**.** Children who have escaped or been captured during ongoing conflict are often exhausted and may be confused. They don't know who to trust, are often ill and malnourished, some have serious untreated diseases and disabilities. They may also have drug and alcohol dependency. Above all, they are fearful of re-recruitment..

Reintegration: The process of re-uniting a child with his/her family and facilitating their community membership is, of course, also a complex process, which is partly dependent on the success of the 'rehabilitation' process. 'Reintegration' eventually becomes indistinguishable from 'rehabilitation' as the child's psychosocial progress is inextricably linked with their once again becoming members of the community.

It is always important to discuss with children, their families and communities what *they* understand by "re-integration". When we have had conversations of this kind with families and communities, the answers we receive revolve around expectations that returning children will conform to certain cultural norms of behaviour, especially those relating to how one should behave to those who are older, and of greater social status, as well as relationships with the opposite sex. Successful re- integration will also be dependent on the child's ability to participate in the intricate systems of reciprocity which characterise people in countries where the only "welfare and security" systems are those which arise out of relationships with others.

When children discuss 'reintegration', they talk of wanting to feel that they belong and that they are loved and accepted, especially by parents and siblings. They also have expectations. For example, they seek very concrete evidence that they are respected in that no-one calls them names (rebel!) which remind them of their past. They want their teachers to treat them well, and they are keen to make new friends and take up with old ones. They are afraid of being seen as "mad" or "damaged", since these terms stigmatise and isolate them, and may have in some cultures, long term social and economic consequences for marriage and land ownership. From their reports, it seems that these children will tolerate some degree of rejection, as long as they have the affection and support of their primary caregivers.

Commonalities and differences amongst children associated with armed groups:

Returning children differ in a number of important ways. Each child will present themselves as the individuals they are, with their own unique personalities, family backgrounds, educational achievements, tribal /caste affinities, religions, age, sex, fears and dreams. Experience from different rehabilitation programmes shows, for example, that children who were previously living with intact families reintegrate more successfully than children who were recruited from the street. Similarly, children with some years of education in their previous life, have a better chance of rejoining school. However, children associated with armed forces share many experiences. Many have been involved collectively in attacks and the committing of or witnessing atrocities. Equally, many have personal experiences of taking other people's lives. When participating in armed forces involved in active combat, children have completely different modes of behaviour and social interaction imposed upon them. Their behaviour becomes driven by military considerations, fear and aggression, all within a strictly hierarchical context. Soldiers will have to obey orders often on peril of death or torture. Rewards will be given on the basis of their performance in destroying others who are perceived as "the enemy", be they civilians or opposing armed forces.

Children participating in armies do so from a range of different motivations and reasons, While the ideologies they have either chosen to fight for, or which are imposed upon them, differ widely, so does the way in which they are treated in different armed groups. (McCallin, 2002). For example, girls fighting with the Liberation Tigers of Tamil Eeelam (LTTE) have in general not been exposed to sexual abuse within these forces. It is vital to any rehabilitation programme to have developed a detailed understanding of the central ideologies of the armed force, the way children have been treated, the motivations behind this, how the armed group's ideology has been explained to them, how atrocities have been justified, as well as specific training children have gone through. This knowledge needs to inform the rehabilitation process, while not intending this to imply a programme of "political correction" such as undertaken by some governments in special programmes for

returnees. An interesting activity of some rehabilitation programmes, and which older children enjoy, are debates - such as they have in school – which allow them to explore differing points of view in a form which is familiar and which they control themselves.

In my experience children and adolescents have in common that they are seldom aware that their rights are being violated when taken into armed forces, although most of course know that crimes are being committed when unarmed civilians are killed and women raped. *All* children recruited into armies have to forfeit the right to education and family care (if they have a family); all risk death or disability on the battlefield, and death, torture and confinement on capture. Children are deprived of food, rest, and normal social relationships with others. Many risk being forced to carry out repeated atrocities against unarmed civilians, including family members and peers, and in so doing, cross a threshold of "no return" in terms of what human beings should and should not do. Girls may be relatively protected in some armed forces, whereas in others they are subjected to years-long sexual enslavement. As soldiers, they risk rape from opposing forces, also when captured.

Children are returning to different contexts and circumstances. Perhaps the majority are demobilised under the terms of cease-fire agreements (as is currently happening in Sri Lanka) or peace agreements (as in Burundi) and Sudan. Others, such as in northern Uganda and to a limited extent in Nepal, are escaping, being released or captured by government army during ongoing conflict, which presents particular challenges regarding protection. Almost all children who have been with armed forces for some time will also experience changes in their families and communities on their return. Rose, 22 years returning from 10 years captivity by the Lord's Resistance Army in Uganda, several months pregnant and with a small child, found that her father had died of AIDS and her mother lay sick with the same –a terrible blow. Others return to families in displacement, that have broken up, fragments of families and estranged, dysfunctional "communities."

Contrary to the common belief that children are so useful to armies since they "easily learn to kill without conscience, and will do things no adult would do," my experience has been that many children have deep qualms of conscience about their acts, forced or not. Many wish to seek forgiveness, and have ideas of becoming "helpers" to make things good. I remember the words of Marcus in Mozambique, a 16-year old who managed to escape from RENAMO after 4 years of captivity filled with horror: Why did he risk his life to escape? "I am a human being, and I was being forced to do things no human should do, so I had to go".

All of these factors will influence the needs of individual children and also the reactions to them by their families and communities. If 'rehabilitation' and 'reintegration' work, is to be successful, it has to meet the needs of each individual child as well as taking account of shared, common experiences.

REHABILITATION AND REINTEGRATION - PROGRAMMATIC ISSUES

Experience suggests that six programmatic areas should be addressed when planning for the recovery and social integration of children associated with armed forces: restoring family relationships; relationships with the community; children's health –physical and psychological; organised learning opportunities; vocational training and income generation; recreation and play. These aspects of rehabilitation and reintegration need to be integrated within an **holistic** approach based on a 'child

rights and child development framework'. While these programmatic areas are, in some senses, independent of the contextual factors described previously, their implementation will be influenced by the latter factors. Before presenting these issues, however, it is important to recognise three general, cross-cutting, concerns. **First, it is essential that children are encouraged to take active roles in the planning and implementation of their own rehabilitation and reintegration processes**. This is not only their right, but it can help to neutralise the feelings of helplessness, distrust and estrangement often associated with traumatic experiences. It gives life a direction and shape, and goals to work for. Participation completely turns around the ways children have been trained to behave in military environments, where they received orders which were not negotiable. Now they are asked to reflect, plan, explore, discuss – and protest**.** Secondly, different approaches to addressing these issues will need to be developed according to the different cultural, social and political contexts one is working in, and also the phase of the conflict. The security of the war environment will always moderate what can and cannot be done. Thirdly, there are gender implications specific to all the above areas, and an emerging theme is the need for more tailored programmatic responses for girls involved with armed forces, as well as their children born during this time. This is discussed further below (see: A note on girls).

1. Restoring family relationships: The psychological and social issues of family reunion for children who have been socialised into a military hierarchy for many years and, in addition, have been active fighters are, to say the least, challenging. If the separation has been over several years, returning children may be shocked to find changes in their family such as new siblings or separated or re-married parents. Parents may be faced with challenges to their authority, and some children face resentment stemming from circumstances connected to their recruitment. Children may also blame their parents for their inability to protect them. Some will encounter rejection from their families, or from particular members, thus splitting the family.

All these potential difficulties point to the necessity for some form of interim care as part of a community-based programme. This provides time to help both child and family adjust. Without this help, some children simply leave home. Tasks for this stage include preparing the family and young person for problems that may arise. Families may need advice and support in relation to: changes in the child and family and (with their permission) any special difficulties the young person has; resolving family conflict without violence or abusive language; accepting and adjusting to the fact that their daughter returned with children, and being sensitive to the abuse she has undergone. This type of work can be undertaken in a family or group format, so that families can support each other, and young people benefit from sharing experiences with peers. Parents who are active in parent associations are invaluable in this work. Children whose families cannot be found because they have left the area or died, will need counselling and comfort to help them deal with loss, and to help them find alternatives for their future. **Interim care centres need some form of assessment process**, especially for adolescents who have been with armed forces for a long time, to assess the child's "readiness" to go home, and the family's "readiness" to accept him/her. In the Gulu Support the Children Organisation (GUSCO) centre in northern Uganda, such an assessment is carried out in a through combining the observations of the nurse, teacher and social worker on each child.

2. Relationships with the Community: Projects need to have an **on-going dialogue with communities** so as to fully understand community attitudes towards returning children. This will allow an assessment of the investment required to

achieve community partnership and to influence the community positively. This has been found to be of critical psychosocial importance in many countries. Apart from assessing the community's potentially welcoming or hostile reaction to the children, questions to be considered include: which actors have the duty to play important roles in the children's integration, and are they ready for this? Do the returning children have ideas of how they can build good relationships with their neighbours, and can they learn from the experiences of former child returnees now living in communities? Communities are often rightly concerned that all children living in the conflict-affected areas benefit from programmes, and if agreements can be built on this approach then better co-operation may be expected from the community.

3. Children's health: Both the physical and psychological health of the child have psychosocial implications. Children with disabilities will need help, as will their families, although the solution should not be to institutionalise the child, causing further prolonged separation. The planning and setting up of community-based rehabilitation (CBR) programmes and referral systems for returning children have proved to be of considerable psychosocial benefit (and a child's right). There may also be other health problems which should be screened and dealt with, since apart from poor health, these can also affect the child's psychological state. The most obvious serious health problem of returning girls in particular is that of HIV/Aids (for further discussion, see: A note on girls, below).

Children's psycho-social health can be fostered in a variety of ways that increase their self confidence and esteem. A central issue in helping children readjust is to **fully engage their participation** in developing programmatic responses. Other helpful activities include participating in cultural activities, and also in group debates where, unlike when under military command, they can ask questions and oppose answers. Life planning assistance is of central importance. That is, counsellors and parents who guide them in exploring different choices they may make for their future lives, helping them to be realistic, or to gain the courage to make important decisions. "If you do this instead of that - what are the consequences likely to be? What are the main talents and resources you have to build on, and what could be a first step to realise those?" etc. Domestic issues such as marriage and child bearing are often important additional areas of discussion for girls.

Where children show psychological problems, their severity will be influenced by the nature, intensity and extent of their traumatic experiences as well as the length of time spent in the armed group. Generally, it is those who have had the most intense and lengthy experience that are most at risk of more severe, permanent forms of disturbance. Boys and girls will tend to experience events differently, and the issue of rape or sexual abuse has different implications for both sexes. In general, the issue of rape of boys is extremely taboo and those experiencing such acts have great difficulty in talking about them. It is important to be aware that if it is known that rape of boys has been part of the terror regime of an armed group, such abuse *could* be behind serious behavioural and psychosocial disturbance in returning boys. Some children's difficulties will be compounded by feelings of guilt or shame, and taking the blame for what happened. Difficulties can be exacerbated where children cannot adapt from military to civilian life: e.g. moving from being the commander of a unit to becoming the second sister, a young wife, a pupil in class etc. Initial behavioural difficulties in children can cause negative responses from others which then entrenches their behavioural problems in a downward spiral of negative interactions. In contrast, problems can be ameliorated where children have been able to share

feelings and attain acceptance, friendship, support and trust from within their family and community.

Post-traumatic reactions are common, but not inevitable, in those who have been exposed to the horrors of armed conflict and are “normal” (I prefer saying expected) reactions to extreme, life-threatening circumstances. The most common manifestations are heightened anxiety, “flashbacks” to particularly horrifying scenes, avoidance of everything that reminds one of the events, preoccupation with guilt, an aggressive form of communicating with others which may obviously lead to problems, social withdrawal, and extreme pessimism about the future. There are wide cultural variations in the form post-traumatic reactions take. Fainting, for example, is found among girls in Sri Lanka. The unique inner emotions of each child associated with these stress reactions, are important to understand through sensitive, confidential interviewing with the child by trained counsellors. To be listened to, given feedback, comfort, information on the inevitability of the reactions and assurance that they will gradually subside is important, taken together with all the other efforts described here which collectively try to build up trust and self esteem and restore normality. It cannot be stressed enough that parents/caregivers need to know how they should respond to the distress of their child in ways which do not prolong the reactions or increase their severity, or lead to rejection and humiliation.

Some adolescents may, however, develop more severe disturbances, which then move more into the realm of psychiatric disorder. For example, from having heightened anxiety a young person can develop a paranoid state and become generally suspicious of everybody, feel that they are being watched, followed, their food poisoned, and even have hallucinations –which could be sights, sounds or smells. Children can also move from having natural grief and depressive moods to becoming more deeply depressed and suicidal. **Screening** is needed to help identify those children who need a period of more prolonged help, and possibly referral to more specialised services – if these are available and **knowledgeable about children’s specific needs.** Care must be taken that children are not admitted to adult psychiatric wards, and medication must be given with extreme caution. I am aware of two children undergoing rehabilitation in a centre who were given anti-depressant medication and attempted to commit suicide with the tablets

However, children are also resilient and able to adapt, and it may be anticipated that many adolescents will gradually be able to take up life again with the support of a rehabilitation/reintegration model which addresses the main issues outlined here. Local cultural ways of helping children heal can also be usefully included. In many cultures there are well established cultural traditional and religious practices which children, their families and communities find beneficial. It is very important for children to have access to these as long as they are not harmful to them. Programmes must be fully knowledgeable of the potential of these practices, respect them and in no way undermine them. Rather, they should seek appropriate ways to complement and support all healing forces.

4. Organised learning opportunities: Learning opportunities provided to children need to match their needs and capacities, which can be assessed by experienced teachers who can then advise children and their parents. During interim care, specially trained teachers and small classes can help children regain confidence – and many who thought they had “forgotten” all they had learnt at school, discover their hidden stores of knowledge. Catch-up education is also relevant to allow

children to join more age-appropriate classes. This can make the difference as to whether or not children rejoin school when they leave the programme.

There also some funding issues. Teachers often request training for managing children, returning from armed forces whose educational and psychological needs differ from other children. However, experience shows that if teachers lack basic educational materials, if they are not paid, and the school roof is falling in, then obviously such training alone is not effective. Although naturally most focus is on supporting primary education, in my experience, some children also need to be supported through secondary education/learning –especially the ones who have been recruited from secondary schools. In general, there is a lack of funding for this, yet these are the children who will in future replace the "brain drain" from many war-affected areas. Thus support for further education needs to be revisited by governments and donors as a policy issue in countries affected by armed conflict.

5. Vocational training/income generation: For those children who cannot return to school, or those who return to find one or both parents are dead, vocational training offers a chance to earn their own livelihoods. It is helpful if programmes can assess the availability and appropriateness of local vocational training facilities, and during interim care help children and their parents make realistic choices. Obviously, systematic learning leading towards some future goal has an enormous psychosocial significance since it gives shape, direction and meaning to children's lives, restoring hope and a sense of control. Small credit schemes, which build on already established local practices, can be invaluable to help children who are on the verge of adulthood, or who are trying to establish themselves following training, as part of a follow-up programme.

6. Recreation and play: Last, but not least, recreational activities such as football and other sports, playing cards, dancing and making music, as well as playing, are essential in rehabilitation and reintegration work. They release and channel energy, bring children into positive contacts with others, are fun and generate one of the most healing sources of all - laughter. These activities are all the better for being more spontaneous. Some programmes invite children to "draw their experiences" in the hope that this will help them to recover - however it must be kept in mind that such drawings are a form of language which needs response, and unless staff are willing to discuss with children the meaning of his/her drawings, drawings by themselves may only be a cry in the dark.

A NOTE ON GIRLS

I wish to say something specific about the issue of girls (see McKay and Mazurana, 2004). Their special needs have been generally ignored in DDR processes, because they are not seen to be in the category of "child soldiers". Girls can have many functions in armed forces. Many experience front-line service, and not infrequently express satisfaction that for the first time in their lives they have power and an equal status with men. Others have years-long experience of being continually abused and forced to bear children with men who treat them brutally. Girls in general return to societies who regard with contempt women who are single mothers, who have had unsanctioned sexual relationships, who can no longer fetch a bride price, and who bring shame upon the family and clan. Pre-occupation with thoughts of suicide are not uncommon among girls who share their feelings with people they can trust, and some take this final tragic step.

Girls need help to regain their self-esteem and confidence, and imaginative steps need to be taken to help them use their resources usefully to support themselves. In northern Uganda, vocational training in subjects not usually offered to girls, such as building and carpentry, is having good results.

Older girls with children resist being viewed as "children" themselves, even those below 18 years, and indeed culturally speaking in many parts of the world they are viewed as adults. Many have played important roles during their recruitment, and gained experience in, for example, health and social work besides their military activities. These factors also need to be taken account of in rehabilitation services.

It is urgent for girls to get effective help with health problems especially related to sexually transmitted disease and reproductive health. A common finding among girls in Uganda was that many had lost their menstrual period due to stress and malnutrition and needed medical assistance to regain it. Girls identified with HIV/aids obviously need to be linked to special services dealing with this. Girls with children may have ambivalent feelings towards them, and this needs to be openly discussed and addressed sensitively. As in all wars, children born to women who have had liaisons with "the enemy" are regarded with suspicion. We know this for example from research into this group of women and their children during the Second World War in Norway. Already one can see in northern Uganda the outlines of second-generation problems in children born in captivity, and it will certainly be the case in other countries presently emerging from armed conflict.

Finally, the importance of long-term follow up of high risk groups cannot be stressed enough. Ways should be found to incorporate this into general programming for all children affected by armed conflict in conflict-affected areas.

We need more long-term research into the factors influencing the process of becoming once more a member of ones family and community after years of exposure to unspeakable experiences. There is no doubt that many children will remain vulnerable for life.

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