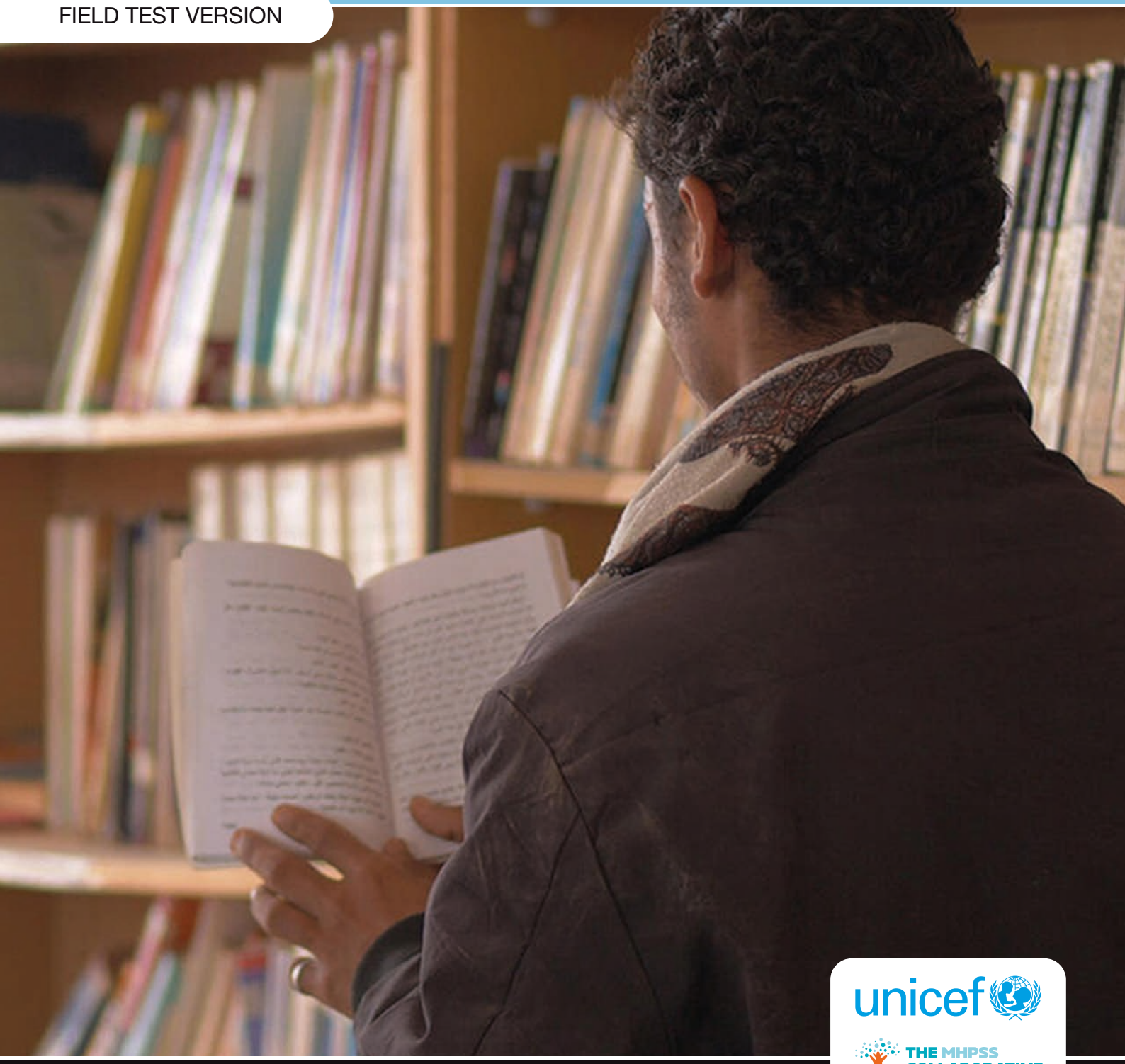
MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN CHILDREN ASSOCIATED WITH ARMED FORCES AND ARMED GROUPS PROGRAMMES

OPERATIONAL GUIDANCE

FIELD TEST VERSION



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THE MHPSS COLLABORATIVE
FOR CHILDREN & FAMILIES IN ADVERSITY

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Front cover photo: Ali (not his real name), 16, reads in a public library in Yemen. In order to support his family, Ali ran away from home to join an armed group. In early 2020, after five months fighting on the frontline, he was released along with 68 other child soldiers by UNICEF and other international organizations. Photo © UNICEF/UN0456829/Fuad

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1 https://www.unicef.org/documents/mental-health-and-psychosocial-technical-note

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The MHPSS in CAAFAG resource package comprises:

- Evidence Review
- Operational Guidance
- Contextualization Guidance
- Dissemination and advocacy package

Abbreviations and acronyms

CAAFAG	Children associated with armed forces and armed groups
ECD	Early childhood development
EQUIP	Ensuring Quality in Psychological Support
GBV	Gender-based violence
IASC	Inter-Agency Standing Committee
ISIS	Islamic State of Iraq and Syria
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
MNS	Mental, neurological and substance use disorders
MSP	Minimum Services Package
NGO	Non-governmental organization
PTSD	Post-traumatic stress disorder
WHO	World Health Organization

Key terms

The following are definitions of key terms used throughout this document. The *MHPSS in CAAFAG Programmes Contextualization Guidance* should be used to ensure that key terms and concepts are appropriate to different contexts.

Adverse childhood experiences Defined as abuse, neglect and household dysfunction that vary in severity, are often chronic, and occur within a child's family or social environment.[2]

Agency The socio-culturally conditioned fundamental human process of intentionally producing certain effects by one's actions.[3] It enables children to be active agents in their own lives and entitled to be listened to, respected and granted autonomy in claiming and exercising their rights, while also being entitled to protection. Agency includes child and adolescent civic engagement, for example being empowered and equipped to make informed decisions.

Caregiver Those responsible for the care of children, and may include mothers and fathers, grandparents, siblings and others within the extended family network, as well as other child caregivers outside of the family network.[4]

Child Any person aged 0–18 years (according to the UN Convention on the Rights of the Child) – i.e. all girls and boys, including LGBTI children; children with protection risks or exposed to serious events; children associated with armed forces and armed groups; and children with disabilities or with mental health or psychosocial conditions or needs.[5]

Child development The process of change in which a child learns more and more complex levels of physical activity, thinking, feeling, communication and interactions with people and objects. This is sometimes expressed as physical, cognitive, emotional, social and spiritual development.

Child wellbeing A dynamic, subjective and objective state of physical, cognitive, emotional, spiritual and social health in which children's optimal development is achieved.[6]

Child-first language Places the child before the label to avoid stigmatization and the reinforcing of identities bound up with discrimination.

Community A network of people who share similar interests, values, goals, culture, religion and/or history – as well as feelings of connection and caring among its members.[7]

Coping The thoughts and behaviours (appropriate to the culture) used to manage the internal and external demands of stress situations.[8]

Culture A set of shared values, beliefs and norms. Culture is dynamic and changes as societies adapt to new information, challenges and circumstances.[9]

Daily stressors The psychological impact of stressful social conditions in conflict and post-conflict settings.[10]

Do no harm One of the six core principles outlined in the IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* that relates to physical, social, emotional, mental and spiritual wellbeing, and implies being mindful to ensure that actions respond to assessed needs, are committed to evaluation and scrutiny, support culturally appropriate responses, and acknowledge

2 Chandler, G. E., Roberts, S. J. & Chiodo, L. (2015). 'Resilience intervention for young adults with adverse childhood experiences'. *Journal of the American Psychiatric Nurses Association*, 21(6), 406–416.

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8 Ito, M. & Matsushima, E. (2017). 'Presentation of coping strategies associated with physical and mental health during health check-ups'. *Community Mental Health Journal*, 53(3), 297–305.

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the assorted power relations between groups participating in emergency responses.[11]

Domains of wellbeing In mental health and psychosocial work, wellbeing is commonly understood in terms of three domains:

- Personal wellbeing: positive thoughts and emotions such as hopefulness, calm, self-esteem and self-confidence;
- Interpersonal wellbeing: nurturing relationships, a sense of belonging, the ability to be close to others;
- Skills and knowledge: capacities to learn, make positive decisions, effectively respond to life challenges, and express oneself.[12]

Evidence-based practice and practice-based evidence A strategy based on practice informed by scientific or systematic evidence and the results of consultative processes as well as knowledge derived from practice, including the knowledge and opinions of experts, and the judgements, insights, experience, history, analogies and local knowledge of people with lived experience. It has been argued that this strategy may be able to improve MHPSS system reform as well as providing MHPSS in a way that is sensitive to local contexts, structural realities, culture and history.[13,14]

Family and kinship Family is a socially constructed concept that may include children who live with one or both biological parents or cared for in various other arrangements such as living with grandparents or extended family members, with siblings in child- or youth-headed households, or in foster care or institutional care arrangements. Kinship indicates culturally recognized relationships defining roles and obligations between individuals and groups. In many contexts, kinship relationships extend far beyond those included in the conventional idea of a 'nuclear family'.[15]

Gender-sensitive approach An approach that is aware of and addresses gender differences.[16]

Intersectionality Intersectionality promotes an understanding of human beings as shaped by the interaction of different social locations ('race'/ ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected power structures power (e.g., laws, policies, state governments, other political and economic unions, religious institutions and media). Through these processes, interdependent forms of privilege and oppression are created and shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy.[17]

Life course A life course approach emphasizes a temporal and social perspective, looking back across an individual's or a cohort's life experiences or across generations for clues to current patterns of health and disease, while recognizing that both past and present experiences are shaped by the wider social, economic and cultural context.[18]

Lived experience The representation and understanding of people's lives and experiences, choices and options; how those factors influence one's perception of knowledge; and why some experiences are privileged over others.[19]

Mental health and psychosocial conditions May include social problems (such as sexual violence or discrimination), psychological distress, mental, neurological or substance use problems, intellectual disability, or any combination of these.[20]

11 Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2017). *A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva.

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16 See UNICEF (2017) *Gender Equality: Glossary of Terms and Concepts*.

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18 International Longevity Centre-UK (2000). *The implications for training of embracing: A life course approach to health*. https://www.who.int/ageing/publications/lifecourse/alc_lifecourse_training_en.pdf

19 Boylorn, R. M. (2008). 'Lived Experience', in Given, L. M. (ed.) *The Sage encyclopedia of qualitative research methods, Vol. 2*, Thousand Oaks: Sage.

20 Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2017). *A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva.

Mental health and psychosocial support Any type of support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder.[21]

Potentially traumatic events Events that involve exposure to threats to life or to physical and/or psychological integrity or witnessing of actual or threatened violence, injury or death.

Prosocial behaviour Sustained, positive, inclusive interactions between individuals, community members and institutions aimed primarily at benefiting another person, such as sharing, helping, comforting, cooperating and supporting others.[22]

Reintegration A long-term process to support CAAFAG to "transition into civil society and enter meaningful roles and identities as civilians who are accepted by their families and communities in a context of local and national reconciliation. Sustainable reintegration is achieved when the political, legal, economic and social conditions needed for children to maintain life, livelihood and dignity have been secured. This process aims to ensure that children can access their rights, including formal and non-formal education, family unity, dignified livelihoods and safety from harm."[23]

Resilience Resources and processes on all social-ecological levels that enable a child to overcome adversity and to positively adapt after challenging or difficult experiences such as exposure to armed conflict.[24]

Sense of belonging Arises from the interactions between individuals, between the resulting human systems, and between these systems and more transcendent elements – such as cultural norms, beliefs and epistemologies.[25]

Stigma The co-occurrence of components of labelling, stereotyping, cognitive separation into 'us' and 'them' groups, status loss, social rejection and discrimination in the context of power differentials that allow one group to successfully devalue another.[26]

Structural violence Violence of injustice and inequity.[27]

Successful reintegration Rebuilds supportive relationships, provides education and livelihood opportunities and access to health services for the child and family, is sustainable, and contributes to building peace.[28]

Suffering A state of individual or collective pain, distress or hardship. Individuals may suffer in unique ways and as a result of a variety of experiences, but also collectively in the face of certain events and social structures (e.g., political, economic and humanitarian).[29]

Trauma-informed good practices Care and treatment that responds to the effects of trauma; emphasizes physical, psychological and emotional safety; and helps survivors rebuild a sense of control and empowerment.[30]

Wellbeing The positive state of being when a person thrives.[31]

21 Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2017). *A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva.

22 Eisenberg, N., Spinrad, T. L., & Knafo-Noam, A. (2015). 'Prosocial development'. In M. E. Lamb & R. M. Lerner (Eds.), Handbook of child psychology and developmental science: Socioemotional processes (pp. 610–656); Zahn-Waxler, C., Radke-Yarrow, M., Wagner, E. & Chapman, M. (1992). Development of concern for others. *Developmental Psychology*, 28, 126–136.

23 The Paris Principles and Guidelines on Children Associated with Armed Forces and Armed Groups, 2.8, February 2007, https://www.unicef.org/emerg/files/ParisPrinciples310107_English.pdf

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26 Link, B. G. & Phelan, J. C. (2001). 'Conceptualizing stigma'. *Annual review of Sociology*, 27(1), 363–385.

27 Rylko-Bauer, B. & Farmer, P. (2016). 'Structural violence, poverty, and social suffering'. *The Oxford handbook of the social science of poverty*, 47–74.

28 Save the Children UK (2007). *Stolen Futures: The reintegration of children affected by conflict*; Action for the Rights of Children (ARC) 2009. *ARC resource pack: Foundation module 4 – Participation and inclusion*.

29 Kleinman, A., Das, V. and Lock, M.M., Eds. (1997). *Social Suffering*, University of California Press, Berkeley, 1997.

30 WHO (2017). *Responding to children and adolescents who have been sexually abused: WHO clinical guidelines*. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO

31 UNICEF (2021). *Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings (Demonstration Version)*

1. Introduction

The *MHPSS in CAAFAG Programmes Operational Guidance* was developed in response to emerging evidence on the impacts of conflict among children and the identification of significant gaps in evidence-based mental health and psychosocial support (MHPSS) approaches and interventions at all layers of the IASC MHPSS Intervention Pyramid.

This multi-agency operational guidance builds upon a growing body of **evidence-based practice and practice-based evidence** on MHPSS programming for CAAFAG and for children and adolescents affected by conflict more widely. It provides information, explanation and standards for the equitable design of inclusive MHPSS interventions that engage children, adolescents, families and communities to support the mental health and wellbeing of children associated with armed forces or groups (CAAFAG) or who are at risk of recruitment.

Purpose and use of the operational guidance

The purpose of the multi-agency, multi-sector *MHPSS in CAAFAG Programmes Operational Guidance* is to:

- enable fieldworkers, communities and local and national governments to prevent recruitment and support release and reintegration efforts by addressing the mental health and psychosocial needs of children, adolescents, their caregivers and families, and communities;
- contribute to the understanding of the specific MHPSS needs of CAAFAG and children at risk of recruitment, and the implications for effective programming;
- present an operational framework that supports caring and engaged actors across the socioecological system, and which puts children and adolescents at the centre, surrounded by their caregivers and families, their communities and broader society;
- support the development of community-based MHPSS strategies that are locally relevant, comprehensive, evidence based and sustainable;
- provide guidance on evidence-based MHPSS interventions and approaches across all layers of the IASC MHPSS Intervention Pyramid to ensure quality – with the ultimate goal of reducing suffering and improving mental health and psychosocial wellbeing among children at risk of recruitment and CAAFAG.

The operational guidance can be used to develop MHPSS programmes, integrate MHPSS services into larger child protection and/or CAAFAG programmes, and strengthen national and local capacity to manage the mental health and psychosocial needs of children, adolescents, their families and communities.

Who should use the guidance?

This guidance is intended to be used by UNICEF staff and partners and other agencies operating in humanitarian settings, including non-governmental organizations (NGOs), civil society organizations, communities, and local and national governments (including ministries of education, health, child protection and social welfare). The primary audience is front-line child protection and MHPSS workers so that they can better understand the MHPSS needs of children at risk of recruitment into or exiting from armed forces and armed groups. A deeper understanding of this guidance in the field will help to improve coordination across sectors, facilitate referrals to ensure that MHPSS needs are met, and enhance coordinated implementation of effective and culturally sound humanitarian interventions that reduce the potential for further harm.

How the guidance was developed

The guidance was developed following an *MHPSS and CAAFAG Evidence Review*, including a review of grey literature and academic research. In addition, by a series of consultations was held with technical experts and youth with lived experience of being at risk of recruitment or having been associated with an armed force or armed group.[32] Key informants in the technical consultations included researchers and representatives from government, UN agencies, academia, and national and international NGOs from 10 countries with experience in CAAFAG programming or research.

Principles and standards that underpin the guidance

The following table outlines key sources for international principles and standards that underpin the guidance. The *MHPSS in CAAFAG Programmes Contextualization Guidance* should be used to ensure that key local principles and national government principles and standards are included in implementation.

Table 1 Principles and standards that underpin the *MHPSS in CAAFAG Programmes Operational Guidance*

Resource	Principles and standards
Principles outlined in the UNICEF Global MHPSS Framework (2021)	• Wellbeing depends upon the interplay of physical, social, cognitive, emotional and spiritual elements. • MHPSS is critical in creating and supporting conditions for children's optimal development and wellbeing in emergencies. • Engagement and participation of families, caregivers and communities and children themselves is central to ensuring enabling environments for children's development and securing their protection, wellbeing and future potential.
IASC Guidelines for MHPSS in Emergencies (2007)	The purpose of these guidelines is to enable humanitarian actors and communities to plan, establish and coordinate a set of minimum multisectoral responses to protect and improve people's mental health and psychosocial wellbeing in emergencies. **Core principles include human rights and equity, participation, 'do no harm', building on local capacities and resources, integrated support systems, and multi-layered supports.** (See Annex 3.)
Sustainable Development Goals	Human rights principles and standards are strongly reflected in the 2030 Agenda for Sustainable Development that covers a broad set of goals and targets, including: **Target 3.4** By 2030 reduce by one-third premature mortality from non-communicable diseases through prevention and treatment, and promote mental health and wellbeing. **Target 3.5** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. **Target 8.7** Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking, and secure the prohibition and elimination of the worst forms of child labour, including the recruitment and use of child soldiers, and by 2025 end child labour in all its forms. **Target 16.2** End abuse, exploitation, trafficking and all forms of violence and torture against children.
Paris Principles and Guidelines on Children Associated with Armed Forces and Armed Groups (2007)	The Paris Principles include detailed guidelines for protecting children from recruitment and for providing assistance to those already involved with armed groups or armed forces. These guidelines include a **section on Psychosocial Aspects**. (See Annex 4.)

32 See *MHPSS in CAAFAG Programmes Evidence Review* for more detailed methods.

Table 1 Principles and standards that underpin the *MHPSS in CAAFAG Programmes Operational Guidance continued*

Resource	Principles and standards
Minimum Standards for Child Protection in Humanitarian Action (2019)	**Standard 10**: Children and their caregivers experience improved mental health and psychosocial wellbeing. **Standard 11**: All children are protected from recruitment and use by armed forces or armed groups, are released, and are effectively reintegrated after recruitment and use in all contexts of armed conflict. **Key action: 11.1.18**. Establish and support case management services (including referrals to health, education, MHPSS and livelihood services) that address immediate and longer-term needs of children who are vulnerable to recruitment or have disengaged from armed forces or armed groups.
The Inter-Agency Minimum Standards for GBV in Emergencies Programming (2019)	**Standard 4**: Health Care for GBV Survivors **Standard 5**: Psychosocial Support **Standard 6**: GBV Case Management **Standard 8**: Women's and Girls' Safe Spaces
UNICEF Core Commitments for Children in Humanitarian Action (2020)	The Core Commitments for Children in any crises with humanitarian consequences are grounded in an international legal framework that includes sets of global standards and principles, such as:[33] • IASC global norms and standards • SPHERE • Minimum Standards for Child Protection in Humanitarian Action • Minimum Standards for Education in Emergencies • Core Humanitarian Standards • Humanitarian principles

How is the guidance structured?

This MHPSS in CAAFAG Programmes Operational Guidance is part of a package of tools and approaches that includes a suite of four resources:

Tool 1: Operational Guidance for MHPSS in CAAFAG Programmes (this resource)

Tool 2: Evidence Review of MHPSS programming relevant to CAAFAG

Tool 3: Contextualization Guidance for MHPSS delivery in CAAFAG programming

Tool 4: Advocacy and Dissemination Package on MHPSS delivery in CAAFAG programming to drive further development and research.

This resource (**Tool 1: MHPSS in CAAFAG Programmes Operational Guidance**) includes an operational framework to guide the design and implementation of MHPSS services. The operational guidance complements the CAAFAG Programme Development Toolkit Guide developed by the CAAFAG Task Force, aligning with and integrating MHPSS guidance within the design of programmes for children at risk of recruitment and CAAFAG.

This operational guidance consists of two sections:

- **Understanding Children's MHPSS assets and needs**: This section describes the situation of CAAFAG and their diverse lived experiences, focusing on broad patterns of adversity and resilience, including stigma, child rights violations, multiple violence, stress and stressors, agency, dignity, coping and successful reintegration.

33 https://www.unicef.org/emergencies/core-commitments-children

- **Operational Framework for MHPSS for CAAFAG**: This section brings the core approaches of the social-ecological model, life course approach, non-targeted approach, and IASC MHPSS Intervention Pyramid together to create **an Operational Framework** that responds to the mental health and psychosocial wellbeing of conflict-affected children, their families and their communities. This section provides evidence-based and practical operational guidance on how to apply the MHPSS Operational Framework for CAAFAG.
  - Illustrative **interventions across the MHPSS in CAAFAG Operational Framework** and considerations for MHPSS in: 1) prevention of recruitment (and re-recruitment); 2) release; and 3) reintegration of CAAFAG across social-ecological levels, children, family and caregivers, and community, as well as key programme strategies;
  - **Outcome indicators** for monitoring and evaluation of MHPSS programming for CAAFAG;
  - **Key competencies** for capacity building to deliver high-quality safe, supportive MHPSS interventions across a multi-layer, multisectoral continuum.

In addition, seven annexes provide further details on the principles and guidance that underpin the *MHPSS in CAAFAG Programmes Operational Guidance*, information on case management support to child survivors of sexual violence, the framework and related models, and the importance of self-care and staff care for those working in MHPSS for CAAFAG.

2. Understanding children's MHPSS assets and needs

Child-first language

Children associated with armed forces and armed groups, or CAAFAG, is the preferred term in programmatic work for promoting inclusion of all children associated in various roles with armed forces or armed groups, including girls and boys who have not participated directly in hostilities.[34] Although the terms 'child soldiers', 'militarized children' or in some contexts 'children of ISIS' may be more familiar, CAAFAG refers to internationally agreed-upon definitions across several child rights frameworks[35] central to humanitarian, development and peacebuilding action:

> *According to article 2.1 of the Paris Principles, "A 'child associated with an armed force or armed group' refers to 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 children, boys, and girls used as 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."*

When identifying and addressing the **mental health and psychosocial support** (MHPSS) needs of CAAFAG, using child-first language[36] – referring to 'children' rather than 'soldiers' – puts the core principles of human rights and equity into practice to reduce discrimination and **stigma**. Given the Inter-Agency Standing Committee Guidelines on MHPSS in Emergency Settings[37] mandate to 'do no harm', it is also important to remember to remain open and listen to children, caregivers and communities about local ways of referring to CAAFAG, children at risk of recruitment and conflict-affected children that may also be effective and respectful when addressing systemic patterns of exclusion. As one expert put it in the technical consultation: "You don't get contextually grounded approaches unless you listen to young people – they can guide you towards what's relevant…."

MHPSS services should not target specific groups of conflict-affected children such as CAAFAG to avoid the risk of stigmatizing them and creating resentment towards CAAFAG from the host community.[38]

Lived experience of CAAFAG

Children's association with, or recruitment and use by, armed forces and armed groups during conflict is a grave violation of children's rights and international humanitarian law, including civil, political, socioeconomic and cultural rights, including a violation of local customs and traditions that protect children's rights within local norms.[39,40] CAAFAG – including those associated with or exiting from groups engaging in terrorism or violent extremism – may experience multiple rights violations, putting them at serious risk of physical, developmental, emotional, mental and spiritual harm.

As with many conflict-affected children, the lives of CAAFAG are pervasively affected by the combined

34 Hutchison, L. (2021). *How the specific needs of girls associated with armed forces and armed groups should be better taken into consideration*.

35 See the *CAAFAG Programme Development Toolkit* guide for a comprehensive list of child rights frameworks, principles and guidance central to humanitarian development and peacebuilding action for CAAFAG, including the Minimum Standards for Child Protection in Humanitarian Action.

36 Crocker, A. F. & Smith, S. N. (2019). 'Person-first language: are we practicing what we preach?' *Journal of multidisciplinary healthcare*, 12, 125–129. https://doi.org/10.2147/JMDH.S140067

37 IASC (2007). *Guidelines for mental health and psychosocial support in emergency settings*. Geneva: Inter-Agency Standing Committee.

38 *CAAFAG Programme Development Toolkit Guide (field-test version)*.

39 UN (2013). *The Six Grave Violations Against Children During Armed Conflict*, The Legal Foundation

40 Sewpaul, V., Kreitzer, L., and T. Raniga (2021) *The Tensions between Culture and Human Rights: Emancipatory Social Work and Afrocentricity in Global World*.

effects of conflict and **structural violence**.[41] These effects can include loss of home and caregivers, insecurity, displacement, community breakdown, cultural destruction, collapse of social and care systems, **intersectionality** of discriminations and oppressions[42] (such as across gender, age, race, sexual identity, disability, socioeconomic status), health inequalities, and lack of educational and economic opportunities. The combined forces of conflict and structural violence relentlessly narrow the paths available to children, shaping the information they consume and the choices they make, eroding their relationships and exacerbating their needs.[43]

While there is no single factor or set of factors that drives children's engagement with armed groups, the presence of conflict, constrained life chances and armed groups willing to recruit children places all children at risk.[44] Consultations with young Colombian ex-combatants emphasized this point. They noted that many people joined armed groups voluntarily because they felt that the guerrillas' fight against the government for better living conditions was their best available option and that they were treated comparatively well. One young participant explained, "I joined the guerrillas when I was 11 because there was nothing else to do and we didn't even have enough to eat at home."

While associated with armed forces or armed groups, children are at great risk of **potentially traumatic events** as victim, perpetrator and/or witness to physical, psychological and sexual violence and atrocities.[45] Violent recruitment methods can involve coercion, force, exploitation, abduction and child marriage. Many CAAFAG are beaten, subjected to sexual violence, permanently injured, forced to witness and commit violence, or killed during association.[46] Upon leaving armed groups and reconnecting with communities, CAAFAG and their families face a disproportionately high level of **daily stressors** including stigma, discrimination and socioeconomic adversity.[47] Furthermore, many CAAFAG put into detention by governments and/or rejected by families and communities because of their former association with armed forces or armed groups,[48,49] exposing them to additional protection threats.

Every child who has been associated with armed forces or armed groups has a unique lived experience of managing to survive in coercive and violent environments. Many children with lived experience of violence and adversity, including CAAFAG, have experienced trauma. However, not all CAAFAG will have been traumatized by their experiences, and it is inappropriate and potentially harmful to foster this assumption.[50]

Acknowledging children's individual and collective **agency** in shaping their own **wellbeing**, ability to **cope** and **resilience** is critically important in supporting the prevention of their recruitment as well as their disengagement from armed forces and armed groups and **successful reintegration** into civil society.[51] This point was highlighted in technical consultations. One interviewee noted that CAAFAG may hold positions of power and respect within armed groups and may have a difficult time adjusting to programming that does not treat them with dignity and respect. Children at risk of recruitment and CAAFAG are, like all children, active interpreters and agents who make meaning of their own experiences, deal with adversities, and influence their families and communities. Technical consultations supported the literature in asserting the importance of fostering safe and nurturing environments that provide opportunities for war-affected children to exhibit agency, while simultaneously learning to understand moral complexity and empathy.[52] At the same time, technical consultants also pointed out that the agency of many

41 Medeiros (2019). *Life after armed group involvement in Nepal: A clinical ethnography of psychological wellbeing of former "child soldiers" over time*; Wessells, M. G. (2016). 'Children and armed conflict: Introduction and overview'. *Peace and Conflict: Journal of Peace Psychology*, 22(3), 198.

42 Crenshaw, K. (1989). 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics'. *University of Chicago Legal Forum*: Vol. 1989, Article 8.

43 O'Neil, S. & Van Broeckhoven, K. (2018). *Cradled by Conflict: Child Involvement with Armed Groups in Contemporary Conflict*. New York: United Nations University.

44 UNICEF (2019). *Mental Health & Psychosocial Support – Children Affected by Armed Conflict*

45 UNICEF (2020). *Guidance on CAAFAG in COVID-19*

46 UN General Assembly (2018). *Children and Armed Conflict – Report of the Secretary General*, A/72/865–S/2018/465, 16 May 2018

47 Tonheim, M. (2017). A troublesome transition: Social reintegration of girl soldiers returning 'home'.

48 UNICEF GBViE Helpdesk (2019). *Children Associated with Armed Forces and Armed Groups and GBViE Programming*

49 UNICEF GBViE Helpdesk (2019). *Children Associated with Armed Forces and Armed Groups and GBViE Programming*

50 Consultative interview with MHPSS & CAAFAG technical expert.

51 Hart, J. (2006). 'The politics of "child soldiers"'. *Brown Journal of World Affairs* 13: 217–226; Medeiros, E. (2012). 'De la terreur à l'illumination'. In: M. Pignot (Eds.), *L'enfant-soldat, XIX^e-XXI^e siècle: Une approche critique* (pp. 138–159). Paris, France: Colin; Shepler, S. (2014). *Childhood deployed: Remaking childhood soldiers in Sierra Leone*. New York, NY: New York University Press.

52 Rousseau, C. & Guzder, J. (2008). 'School-based prevention programs for refugee children'. *Child and adolescent psychiatric clinics of North America*, 17(3), 533–549.

children in armed conflict operates within constraints. They may have had little choice but to kill or be killed, for example, while others may assign religious significance to their experience and perceive it, as one young person with lived experience put it, "as part of God's plan".

Implications of adverse childhood experiences

Armed conflict imposes immense suffering on children. Physical attacks on children and their families, unravelling and destruction of their social environments, lack of access to basic necessities and security, loss of important sources of social support, and disrupted educational and occupational opportunities cause tremendous harm to children. The result may be more severe forms of mental health and psychosocial distress, more likely exposure to potentially traumatic events, and heavier burdens of unmet mental health and psychosocial needs.[53] Conflict also drives separation from and loss of caregivers and family members, and increases insecure patterns of child-caregiver attachment, depleting children's resilience, exposing them to more adversity and steering their developmental trajectories further away from positive outcomes. Armed conflict threatens children's **mental health and psychosocial wellbeing** through war-related violence, loss and displacement, and can result in prolonged activation of stress response systems in the absence of protective relationships,[54] also known as toxic stress, which can jeopardize child development. Toxic stress can be harmful to physical, cognitive and psychological development, and studies have shown that it can have long-term serious impacts on children's learning and earning potential, health (including chronic health conditions), mental health and substance use, and relational problems.[55]

Armed conflict also threatens children's mental health and wellbeing through repeated exposure to **daily stressors** in structurally violent environments.[56] These stresses and stressors exacerbate the deleterious effects of children's traumatic experiences. More evidence is needed to understand how these multiple forms of violence, abuse and neglect during childhood broadly as well as during the critical windows of early childhood and adolescence – **adverse childhood experiences** – contribute to **mental health and psychosocial conditions** among children, affect child development in conflict-affected environments, and manifest as changing mental health and psychosocial needs, physical health problems, and learning, employment and relational problems throughout life. Understanding the implications of adverse childhood experiences, including trauma, in humanitarian settings is fundamental to ensuring trauma-informed service delivery.

CAAFAG are at heightened risk of anxiety, depression and severe stress disorders, with notable increases in aggression and hostility. When the psychological wellbeing and problems of CAAFAG are compared with those of children in the same geographic areas who were not directly associated with armed groups but subject to indirect effects of conflict, the results are similar (with the exception of CAAFAG exposed to the most extreme traumatic events and conditions).[57] This suggests that the impacts of direct and indirect exposure to trauma, violence and loss are widespread in areas of armed conflict and have similar effects on both children who were directly associated, and those not associated, with armed groups and armed forces.[58]

Mental health and psychosocial impacts of association with armed forces and armed groups on children

The physical and psychological effects of adversity, potentially traumatic experiences, and ongoing daily stressors that CAAFAG experience during childhood and adolescence have both short- and long-term implications for their mental health and wellbeing. The life-altering experience of being associated with an armed force or armed group can have a monumental impact on mental health and psychosocial wellbeing, albeit in varied and different ways according to age,

53 Wessels, M. (2016). 'Peace and Conflict'. *Journal of Peace Psychology* Vol. 22, No. 3, 198–207. https://psycnet.apa.org/fulltext/2016-38187-002.pdf

54 Ataullahjan, A., Samara, M., Betancourt, T. S. & Bhutta, Z. A. (2020). 'Mitigating toxic stress in children affected by conflict and displacement'. *British Medical Journal*, 371.

55 Nelson, C. A., Bhuuta, Z. A., Burke-Harris, N., Danese, A. and Samara, M. (2020). 'Toxic Stress and PTSD in children: Adversity in childhood is linked to mental and physical health throughout life'. *British Medical Journal* 2020;371:m3048 | doi: 10.1136/bmj.m3048

56 Miller, K. E. & Rasmussen, A. (2010). 'War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks'. *Social Science & Medicine*, 70(1), 7–16.

57 Betancourt, T. S., Simmons, S., Borisova, I., Brewer, S. E., Iweala, U., & De La Soudière, M. (2008). 'High hopes, grim reality: Reintegration and the education of former child soldiers in Sierra Leone'. *Comparative Education Review*, 52(4), 565–587; Blattman, C. & Annan, J. (2010). 'The consequences of child soldiering'. *The review of economics and statistics*. 92: 882–898.

58 Betancourt et al. (2008) (ibid).

gender and developmental stage, as well as the nature of the events experienced. Processes of resilience and vulnerability in the **social ecology** of CAAFAG include "the degree and nature of conflict experiences; indirect effects of violence through loss, insecurity, and displacement; socially-driven effects of stigma or acceptance, community cohesion, or breakdown; and availability of educational/employment opportunities".[59] Children also engage in processes of meaning-making after disengagement from armed forces and armed groups, all of which shape their recovery, reintegration and probability of experiencing either psychosocial wellbeing or mental health and substance abuse disorders or psychosocial distress over their lifetimes.

CAAFAG are diverse and many factors influence how each child reacts to experiences of structural violence, conflict and loss – including the different sets of skills, assets and resources for their resilience and wellbeing linked to their age and developmental stage. Even when exposed to the same types of loss, potentially traumatic experiences and daily stressors, each child will be affected differently – due in large part to variations in their social ecology.

The types of support needed for reintegration after leaving an armed group or armed force vary.[60] Resilience resources and processes may be protective and promotive of CAAFAG wellbeing, particularly among children with continued connection and care from family, friends, and community members.[61] Nevertheless, some CAAFAG will experience mental and psychosocial problems, some of which will persist for years after a conflict has ended. For example, a small percentage of CAAFAG will struggle to function on a day-to-day basis, including children who may have had pre-existing mental health and psychosocial conditions or disabilities prior to their association with armed forces or armed groups, or those who have endured particularly traumatic events or severely distressing experiences. Multi-layered and cross-sectoral MHPSS services are needed to address the range of protection and wellbeing needs among CAAFAG and other conflict-affected children.

How do effective MHPSS responses work?

This operational guidance aims to contribute to the understanding of the varied and complex MHPSS needs of children at risk of recruitment and CAAFAG, and to integrate evidence-based and trauma-informed MHPSS interventions within programmes for prevention of recruitment, release and reintegration. Integrating high-quality MHPSS approaches and interventions for CAAFAG, their caregivers, families and communities reinforces networks of care and strengthens coordinated service delivery across sectors essential to establishing secure environments and addressing the range of intersecting needs.

Effective MHPSS responses:[62]

- Use participatory prosocial approaches in which children are positive agents in their own lives and within their families and communities;
- Strengthen social support and community acceptance over the long term;
- Address themes of identity, dealing with emotions, relationships with peers and adults, conflict and peace, and future planning;
- Combine focused support through case management services, along with community-based psychosocial approaches and interventions;
- Ensure access to integrated and specialized psychological and psychiatric services, established within a multisectoral and multi-layered system of support (in accordance with the IASC Guidelines on MHPSS in Emergency Settings);
- Focus on the totality of the child's experience without an over-focus on ideology, and aim to protect and restore children's wellbeing and minimize stigma and isolation.

59 Medeiros, E., Shrestha, P. N., Gaire, H. & Orr, D. M. (2020). 'Life after armed group involvement in Nepal: A clinical ethnography of psychological wellbeing of former "child soldiers" over time'. *Transcultural psychiatry*, 57(1), 183-196.

60 UNICEF (2019). *MHPSS & Children Affected by Armed Conflict*.

61 Kohrt, B.A., Jordans, M.J., & Morley, C.A. (2010). 'Four principles of mental health research and psychosocial intervention for child soldiers: Lessons learned from Nepal'. *International Psychiatry*, 7, 58–60; Rosenau, W., Espach, R., Ortiz, R. D. & Herrera, N. (2014). 'Why they join, why they fight, and why they leave: learning from Colombia's database of demobilised militants'. *Terrorism and Political Violence*, 26(2), 277–285. https://doi.org/10.1080/09546553.2012.700658; Martuscelli, P. N. & Villa, R. D. (2018). 'Child soldiers as peace-builders in Colombian peace talks between the government and the FARC–EP'. *Conflict, Security & Development*, 18(5), 387–408.

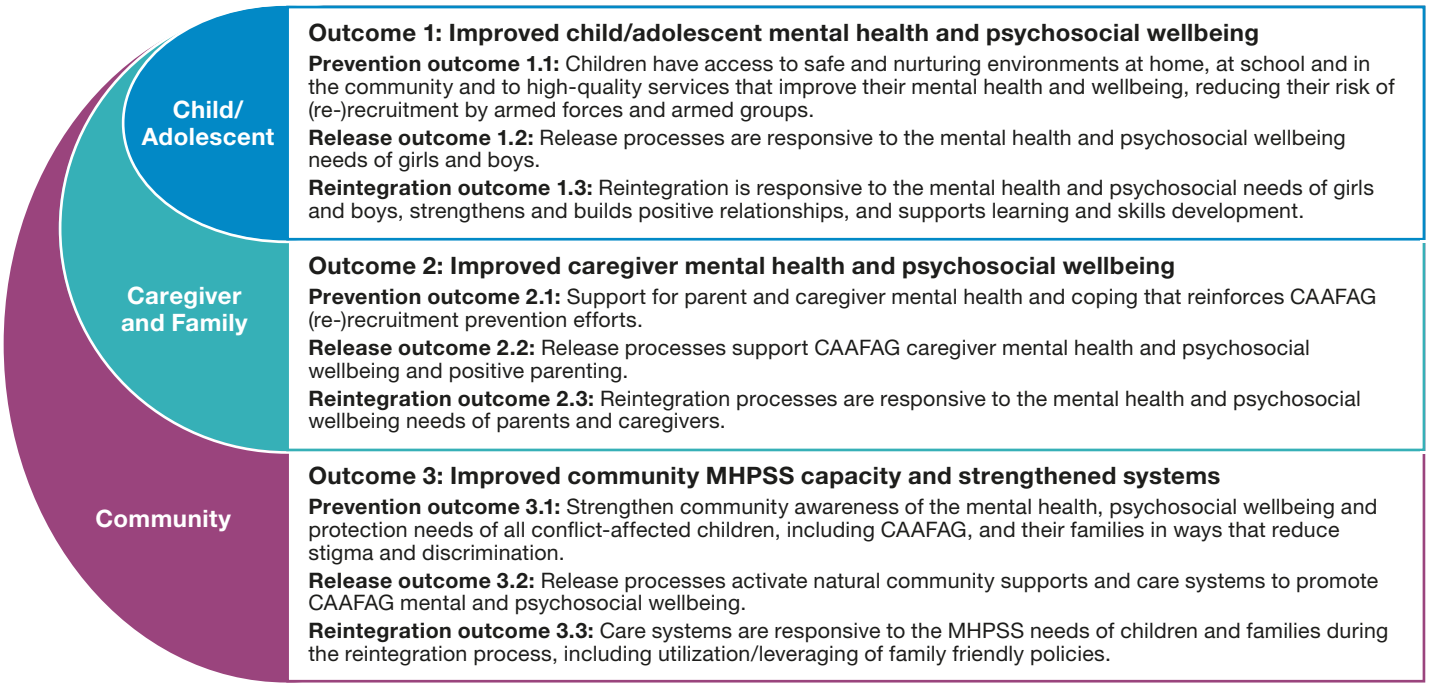
62 UNICEF (2019). *Issue Brief: Evidence Based Reintegration Programming for Children in the Context of Counter-terrorism*

3. MHPSS for CAAFAG Operational Framework

The multisectoral MHPSS for CAAFAG Operational Framework brings together the social-ecological model, IASC Intervention Pyramid and life course approach to create a system that responds to the mental health and psychosocial needs of conflict-affected children, their families and their communities.[63] Each level of the operational framework (child/adolescent, caregiver/family and community) applies the CAAFAG prevention of recruitment and use, release, and reintegration components of the *CAAFAG Programme Design Toolkit*.[64] The intervention tables in this framework (see Tables 5–10 and 12–16 below) include interventions (or activities, depending on the organizational context) that respond to the outcomes and log frame presented in this framework. (See Annex 1 for an overview of outcomes for the operational framework in table format.)

The framework is an application of UNICEF's *Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings*.

Figure 1 MHPSS for CAAFAG Operational Framework: all outcomes



63 *CAAFAG Programme Development Toolkit Guidelines*, Version 11 June. p. 68.

64 Alliance of Child Protection in Humanitarian Action, CAAFAG Task Force (2021). *CAAFAG Programme Development Toolkit Guide (Field-test version)*

Core approaches within the Operational Framework

The Operational Framework reflects the following core approaches that define how MHPSS programming for CAAFAG is operationalized: (1) community based, (2) life course, (3) non-targeted, and (4) multisectoral. All four of these approaches are recommended for successful MHPSS in CAAFAG programme design across all contexts. These approaches align with the cross-cutting approaches recommended by the CAAFAG Programme Development Toolkit Guide and bolster the community-based psychosocial and mental health approach outlined in the UNICEF Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings.

Use a community-based approach

Community-based MHPSS builds on existing individual and community resources, capacities and resilience. It should strengthen natural supports and systems, make use of community knowledge and capacities, engage the community in all phases of the programming, and support and develop a local MHPSS workforce.[65] Community-based approaches to MHPSS also require a thorough analysis of local practices and resources to carry out MHPSS programmes in line with the principle of 'do no harm'. For example, in the youth consultations in Colombia, one young person who was thought to be at risk of recruitment indicated that one of their greatest resources was a neighbour who took them in when they had no other place to go.

Much like the community-level engagement approach described in the *CAAFAG Programme Development Toolkit Guide*, community-based MHPSS prioritizes community-owned and managed activities whether initiated by an external agency or from within the community. A primary aim of community-based MHPSS is to (re-)activate community care systems and practices that safely support the mental health and psychosocial wellbeing of children and families. Community-based MHPSS includes involvement of traditional and religious leaders and recommends actions and key considerations in the IASC Guidelines on MHPSS in Emergencies for:

- Facilitating conditions for community mobilization, ownership and control of emergency response in all sectors;
- Facilitating community self-help and social support; and,
- Facilitating conditions for appropriate communal, cultural, spiritual and religious healing practices.

Community-based MHPSS approaches acknowledge that collective wellbeing and social connectedness are critical elements of an individual's wellbeing. There is a direct interplay between individual wellbeing and the longer-term collective social processes of peacebuilding programmes and wider social transformation. This broad community-based psychosocial perspective responds to the MHPSS needs of the child, her or his caregiver(s) and local community within existing family and community systems. This approach also avoids specific trauma-focused approaches that direct attention to individual-level symptoms of post-traumatic stress disorder (PTSD) and other mental disorders. Focusing only on individual symptoms or traumatic experiences may result in missing the diverse pathways of daily stressors and protective/promotive and risk factors across the social ecology. This is important for MHPSS practice with CAAFAG as some of the pressing challenges in addressing wellbeing and successful reintegration involve stigma, family and community acceptance, social identity, social belonging and collective agency.[66]

65 UNICEF (n.d.) *Operational Guidelines Community-based Mental Health and Psychosocial Support in Humanitarian Settings*

66 Orrnert, A. (2019). *Implications of not addressing MHPSS needs in conflict situations*. K4D Helpdesk Report 582. Brighton, UK: Institute of Development Studies.

Figure 2 Social belonging among CAAFAG in MHPSS perspective

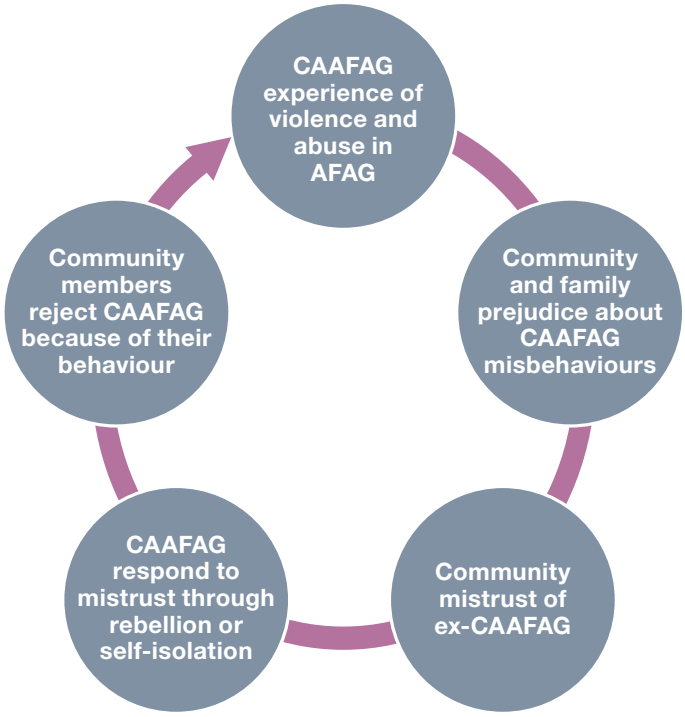
For MHPSS work with CAAFAG, it is crucial to address all three domains of wellbeing. These domains include personal wellbeing, interpersonal wellbeing, and skills and knowledge.[67] The interpersonal wellbeing domain, which refers to a **sense of belonging**, is particularly important to support CAAFAG wellbeing and successful reintegration. This importance is highlighted within the *CAAFAG Programme Development Toolkit Guide*, where social belonging is a standalone domain that includes its own objectives and outcomes within the CAAFAG multisectoral approach (see pages 104–106).

MHPSS has an important role to play in the social belonging domain. For CAAFAG, **support from family members is among the most important protective factors in the psychosocial adjustment and mental health of returned CAAFAG**.

The presence of family and a supportive attitude upon the return of CAAFAG are key determinants in the reintegration process. Rejection and stigmatization from the family or caregivers have a particularly detrimental effect on children's wellbeing. Understanding the diverse reasons for community rejection across cultures and contexts is important. For example, some communities may have spiritual reasons for rejecting CAAFAG (e.g., beliefs that angry spirits of those killed in conflict are carried by CAAFAG and are a potential source of harm).[68]

It is also important to understand that upon leaving armed groups, children and their families often face stigma and discrimination. Significant mental health and psychosocial problems may cause more difficulties with social reintegration. For example, in some contexts, **girls' symptoms of distress such as depression or dissociation can be misunderstood by family and community and lead to, or exacerbate, social exclusion**.[69]

Cycle of stigma and rejection



Source: Child Soldier International: *Guide pratique pour promouvoir l'acceptation communautaire des filles associées aux groupes armés en RDC*

67 UNICEF (2011). *Inter-Agency Guide to the Evaluation of Psychosocial Programming in Emergencies*, United Nations Children's Fund, New York.

68 Ocampo, J. M. F., Audi, M. N. & Wessells, M. (2021). 'Culture bias and MHPSS'. *Forced Migration Review*, (66), 15–17.

69 UNICEF/USIAD Child Protection Alliance in Humanitarian Action (2020). Technical Note. *Girls Associated with Armed Forces and Armed Groups: Lessons Learnt and good practices on prevention of recruitment and use, release, and reintegration*.

It is imperative that local actors such as community members, volunteers, religious leaders, youth leaders, district health and social care workers, teachers and service users are fully involved in the development and implementation of MHPSS components of CAAFAG programmes.[70] This can include women's groups, religious leaders, teachers, parent teacher associations, civil society organizations and many others. Engagement should include:

- **Safe and meaningful participation**: Enable safe and meaningful child and youth participation in MHPSS approaches and interventions, including CAAFAG in programme design, implementation and evaluation. Consideration should be given to facilitating children's participation that is responsive to gender, life course and ability/disability variations in life experiences, community norms, and access to multisectoral CAAFAG programming.[71,72]

- **Safe and meaningful consultations**: Consult children at all stages so that MHPSS actions related to prevention, release and reintegration are in their best interests, take into account their needs and concerns, and reflect their priorities.

Utilize a life course approach

The life course approach builds upon the social-ecological model by linking the developmental stages of children and adolescents to their relationships and interactions at home, at school, and in the community. This approach recognizes the child's evolving capacities related to their age and developmental stage, recognizing two critical 'windows' of opportunity to positively influence both developmental and social, and emotional and cognitive trajectories: early childhood and adolescence. MHPSS programming should consider the following life course groupings: pregnancy and childbirth; infant and toddler (birth–3); young childhood (3–5); middle childhood (6–8); early adolescence (9–14); older adolescence (15–19); and adulthood (18+).

For CAAFAG, programme design should **reflect the age at which the child became associated with the armed group and the age at which they were released**. Specific considerations include:

- Infants, toddlers and young children may have been born and/or raised within the context of armed forces or armed groups, and some may have been conceived through conflict-related sexual violence.[73]

- Children in middle childhood, some as young as six years, may be recruited.

- Armed forces and armed groups are more likely to recruit adolescents, given their physical abilities to work and fight, as well as their developmentally appropriate interest in exploring meaning and belonging.

- Early and older adolescent girls may be CAAFAG. Some may be mothers of children born and/or raised within armed forces or armed groups due to voluntary or forced marriage to fighters through sexual violence.

The MHPSS needs of former CAAFAG vary depending on their age and developmental stage at association and release, as well as other individual and contextual factors (e.g., experiences, capacities, exposure to adversity), and will continue to change throughout their life course. Effective MHPSS services are sensitive to the varying developmental needs of CAAFAG and their particular life circumstances (e.g., adolescent parents) in programme design and delivery.

70 Harrison, S., Chemaly, W., Hanna, F., Polutan-Teulières, N. & Ventevogel, P. (2021). Engagement of protection actors in MHPSS: the need for cross-sectoral cooperation. *Forced Migration Review*. 66, 9–11.

71 Sevenants (2019). *EVALUATION Community-based Reintegration Programme for Children Released from Armed Forces and Armed Groups in Boma State (former Greater Pibor Administrative Area) 2015–2018*.

72 War Child (2019).

73 Denov, M. (2019). 'Children born of conflict-related sexual violence within armed groups: a case study of northern Uganda'. In *Research Handbook on Child Soldiers*. Edward Elgar Publishing.

Ensure a non-targeted approach

MHPSS programming must be careful to **avoid specific targeting of sensitive groups**, such as CAAFAG or survivors of sexual and gender-based violence, in line with the MHPSS core principle of **'do no harm'**. Specific targeting can result in increased societal stigma and further discrimination and exclusion of CAAFAG in communities, placing CAAFAG at risk of further harm, or it may reinforce divisions within a community. Specific targeting also runs the risk of causing inequities in service delivery where all children and families may have been affected by conflict.

Rather, programmes should work towards broad support and advocacy to promote the inclusion and wellbeing of all children and community members, while ensuring that all MHPSS actors are aware of essential referral pathways for those in need of specialist support and follow-up. Conflict-affected children and youth not directly associated with armed forces and armed groups, especially those at risk of recruitment, should also be able to access MHPSS services and supports as appropriate. At the same time, CAAFAG across the life course should be considered to be at risk in humanitarian settings and be proactively included to ensure they can access MHPSS services and activities available to the general population of children.

Table 2 provides a quick reference of do's and don'ts for a non-targeted MHPSS programming approach.

Design a multisectoral approach across the Intervention Pyramid

A multisectoral approach[74] to mental health and psychosocial wellbeing for CAAFAG emphasizes that the **services are carried out in coordination across sectors**, over time, and throughout the prevention, release and reintegration phases of CAAFAG programming. In addition, a multisectoral approach emphasizes the layering of services across the IASC Intervention Pyramid in a way that aligns with the core principles of the *IASC MHPSS Guidelines in Emergencies*. (See Annex 2)

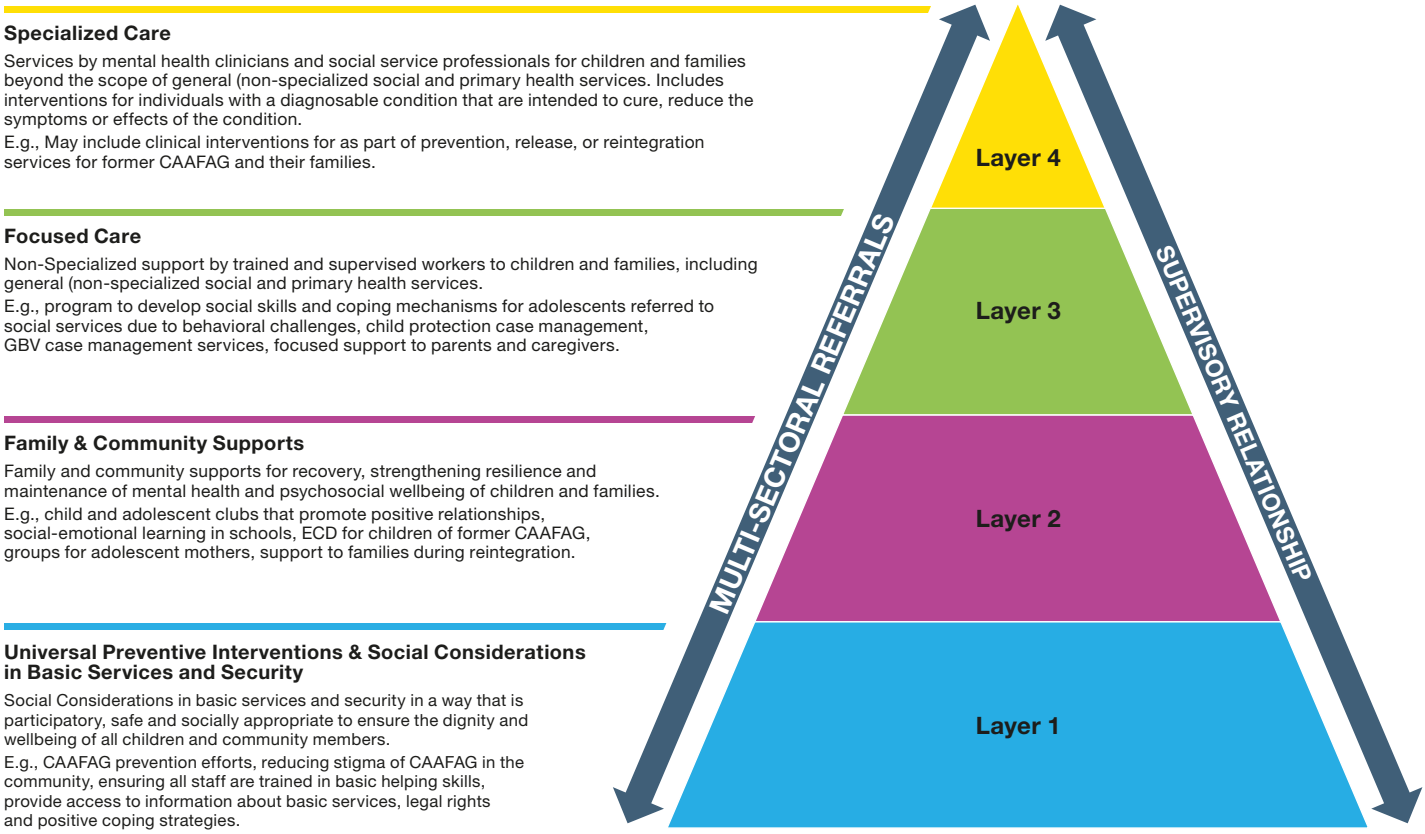
Just as community health and social workers do not operate in isolation from formal health and social service systems, nor do MHPSS actors operate in isolation from specialized mental health, protection and social services, and other systems that support child and family wellbeing. Technical consultations with practitioners emphasized the importance of this cross-sectoral approach with functional referral systems. One service provider stated that they refer specialized services to their partners because, "we don't have MHPSS in our team here. For specialized services, we coordinate with other actors […] These services involve individual sessions with CAAFAG." The respondent noted that their organization is "not able to get much information from CAAFAG ourselves", because they do not have MHPSS expertise but that their partners are able to do so. Although the percentage of CAAFAG

Table 2 MHPSS programming do's and don'ts

MHPSS programming do's	MHPSS programming don'ts
Do work towards broad support and advocacy that promotes inclusion of all children and community members.	Don't specifically target sensitive groups through service delivery that excludes other children, or through programming that names or identifies sensitive groups.
Do provide MHPSS services equitably to all vulnerable children in affected communities.	Don't provide MHPSS services to former CAAFAG only and ignore children at risk of recruitment in conflict-affected situations.
Do implement additional approaches, interventions and steps to adequately recognize and mobilize MHPSS resources for CAAFAG in conflict-affected environments, and meet their needs through strengthening structures and referral resources that benefit the community at large.	Don't create divisions in access to specialized services that exclude children other than CAAFAG who are in need of referral.
Do monitor MHPSS programmes and improve non-targeted approach if CAAFAG become stigmatized through receiving services.	Don't provide MHPSS services in a way that makes the community resent service provision to CAAFAG, or in a way that the community may perceive as rewarding perpetrators of violence.

74 This also aligns with the multisectoral CAAFAG programme approach outlined in the CAAFAG Programme Development Toolkit Guide.

Figure 3 IASC MHPSS Intervention Pyramid: adapted from UNICEF's MHPSS Technical Note[75]



and their caregivers who require focused or specialized services may be small, they are often neglected and disproportionately affected. **Thus, it is important for actors across all sectors to be aware of the continuum of MHPSS needs of children and families, and to ensure functional referrals up and down the layers of the IASC Intervention Pyramid.**

Interventions can best reach children and families, and are more effective, when they are integrated within sectors and structures such as health and protection, rather than as stand-alone programmes (e.g., specialized services without other layers of support). Other structures also serve as entry points, such as schools, social service systems, community centres and safe spaces, and community organizations such as youth clubs, women's cooperatives, and religious organizations. Multiple agencies may be a part of the child's support system, providing complementary and overlapping services. When there is a lack of coordination, these services may at times conflict with each other – reducing the overall benefit to children.[76]

The following documents offer MHPSS-specific guidance for multisectoral collaboration and have relevance for MHPSS programming with CAAFAG.

- *The IASC Guidelines for MHPSS in Emergency Settings* (2007) systematically enables humanitarian actors and communities to plan, establish and coordinate a set of minimum multisectoral responses to protect and improve people's mental health and psychosocial wellbeing.

- In 2019, the IASC principals agreed to treat MHPSS as a cross-cutting issue that has relevance within health, protection (child protection, GBV, mine action, and housing, land and property), nutrition, education and camp coordination and camp management (CCCM) sectors/clusters, in all emergencies.[77]

- A key resource is the *Minimum Services Package (MSP) for MHPSS in humanitarian settings* that presents evidence-based interventions for

75 Hijazi, Z & de Carvalho Eriksson, C. (n.d.) Mental Health and Psychosocial Technical Note. UNICEF. https://www.unicef.org/documents/mental-health-and-psychosocial-technical-note

76 UNICEF's MHPSS Global Framework (under development).

77 Harrison, S., Chemaly, W., Hanna, F., Polutan-Teulières, N., Ventevogel, P. (2021). Engagement of protection actors in MHPSS: the need for cross-sectoral cooperation. *Forced Migration Review*. 66, 9–11.

humanitarian agencies to use in acute emergencies and ongoing humanitarian settings. The MSP applies a multisectoral approach to MHPSS service provision and includes details on key tools and interventions across sectors. The resource, while developed for humanitarian settings, can also be applied to non-emergency contexts.

- UNICEF's MultiSectoral Operational Framework for Mental Health and Psychosocial Wellbeing of Children and Families Across Settings is under development.

Interventions across the MHPSS for CAAFAG Operational Framework

The MHPSS Operational Framework for CAAFAG provides a structure for designing MHPSS components within a CAAFAG programme. The intervention tables presented on the following pages are organised across the core elements of CAAFAG programming: (1) **MHPSS in prevention of recruitment** (and re-recruitment); (2) **MHPSS in release** of CAAFAG, formally and informally; and (3) **MHPSS in reintegration** of (former) CAAFAG. (See also Annex 6 for MHPSS approaches for CAAFAG, based on evidence where available.)

The intervention tables link to the IASC MHPSS Intervention Pyramid. They were informed by findings from the *MHPSS in CAAFAG Programmes Evidence Review* and the draft field test version of the Minimum Services Package (MSP) for MHPSS in humanitarian settings, described in Table 3.

The tables include interventions that involve task shifting. Task shifting is the process of shifting specific tasks and service delivery from mental health professionals with higher qualifications to non-specialists[78] and lay health workers with fewer qualifications and/or creating a new cadre through specific training for the respective intervention.[79] Training and supervision of non-specialists in providing psychosocial support, scalable psychological interventions and talking therapies has increasingly shown success in minimizing the gaps in service provision, supply of treatment, community outreach and psychoeducation.[80] In the often complex political and socioeconomic contexts in which work with CAAFAG and at-risk children is undertaken, and with the recognition of humanitarian workers' often limited access in areas of conflict, task shifting and capacity building of non-specialists is of prime importance. An important aspect of quality control in MHPSS service delivery is to ensure that MHPSS workers are supervised and meet minimum competency criteria for the services they are providing. This ensures safe, high-quality service delivery and increases the likelihood that interventions will be effective. MHPSS workers should receive structured training and supervision (See 'Key competencies for MHPSS in CAAFAG programmes' section below.)

The tables identify which services are included in the minimum services package, which sectors may implement the interventions and how the interventions relate to mental health and psychosocial wellbeing promotion, prevention and care. Table 4 on page 16 illustrates how the tables are structured.

Table 3 The Minimum Services Package (MSP) for MHPSS in humanitarian settings

The MSP is a cross-sector comprehensive package of MHPSS interventions that aims to build on existing MHPSS standards and tools to create a single, comprehensive easy-to-follow intersectoral package for ongoing, protracted and new emergencies. The *MHPSS in CAAFAG Programmes Operational Guidance* is listed as a resource in the MHPSS for At-Risk Groups annex of the MHPSS MSP. At a minimum, CAAFAG and all conflict-affected children in the general population should be offered these core MHPSS MSP activities. In addition, based on the unique stressors, protection concerns and practical circumstances of CAAFAG in specific contexts, additional approaches, interventions and steps described in this operational guidance should be implemented to adequately identify and mobilize children's and adolescents' MHPSS resources in conflict-affected environments and meet their MHPSS needs.

78 Non-specialist includes, but is not limited to, case workers, community leaders, traditional leaders and healers.

79 WHO (2008). *Task Shifting: Rational Redistribution of Tasks Among Health Workforce Teams: Global Recommendations and Guidelines*. https://www.who.int/healthsystems/TTR-TaskShifting.pdf

80 Javadi, D., Feldhaus, I., Mancuso, A. and Ghaffar, A. (2017). 'Applying systems thinking to task shifting for mental health using lay providers: a review of the evidence'. *Global Mental Health* (2017), 4, e14, page 1 of 32. Doi:10.1017/gmh.2017.15

Table 4 Key to intervention tables

Layer 4 **Layer 3** **Layer 2** **Layer 1**	The colours on the left-hand side of the intervention tables correspond to the layers of the IASC MHPSS Intervention Pyramid.
	The icons indicate key CAAFAG programme domains that may be relevant to that intervention.  Health/MHPSS*  Education  Safety and care  Justice  Economic recovery  Social belonging
	The label included inside the box identifies which interventions align with one of the core activities of the MSP MHPSS Minimum Services Package.
PROMOTE **PREVENT** **CARE**	MHPSS interventions include a range of services to support communities in the promotion of mental health and psychosocial wellbeing, and the care and treatment of mental health conditions and psychosocial needs. In some programmes, it may be useful to have interventions further identified across the promotive 'preventive' care continuum. This guidance applies the following definitions as set forth in UNICEF's Mental Health Technical Note: **PROMOTION** of mental health and psychosocial wellbeing; **PREVENTION** of mental health conditions and psychosocial problems; **CARE** and treatment of children, adolescents and caregivers with mental health and psychosocial problems, MHPSS problems, mental health conditions, and/or psychosocial needs.

* The *CAAFAG Programme Development Toolkit Guide* calls one of its programming domains Health/MHPSS. From an MHPSS perspective, we recognize that MHPSS cross-cuts all six of the *CAAFAG Programme Development Toolkit Guide* programme domains as well as the Health, Protection, Education, Nutrition and Camp Coordination/Management sectors.

MHPSS in prevention of recruitment (and re-recruitment)

While there is limited evidence of MHPSS interventions aimed at the prevention of recruitment and use of children, there is an acknowledged "intimate relationship between the promotion of mental health and psychosocial wellbeing and the protection and promotion of [child] rights".[81] Overall conditions of structural violence and conflict can cause mental and psychosocial distress and can exacerbate existing mental health and psychosocial problems among affected children and adolescents, including those at risk of recruitment by armed forces and armed groups. The conditions of violence as well as the disproportionate burden of distress and suffering in the community limits the capacity of children to assert their rights and for families, youth and communities to claim children's right to protection from the grave violation of recruitment and use of children by armed forces and armed groups.

There is also some evidence that being older and having greater levels of education before affiliation with an armed group may be associated with accessing/receiving greater reintegration support and more improved mental health and psychosocial wellbeing after disengagement.[82]

Addressing the mental health and psychosocial consequences of conflict and violence contributes to protection by strengthening the agency of children, adolescents, caregivers, families and communities to effectively address their protection needs, including from the recruitment and use of children in armed forces and armed groups. CAAFAG programmes can ensure a comprehensive response by ensuring equitable access to multisectoral MHPSS, including safe and supportive school environments for all population groups in conflict-affected settings. This includes former CAAFAG, children at risk of recruitment, their caregivers, families and communities. In this way MHPSS supports children, families and communities to prevent recruitment and use of children.

Consistent with findings from the evidence review, prevention efforts should be informed by what is known about the link between MHPSS and the prevention of recruitment (and re-recruitment) of CAAFAG. MHPSS considerations specific to prevention programming include:

- Children do not normally join armed groups for reasons based on their own mental health status (i.e., because of the presence of a mental health condition or psychosocial problem).[83] However, loss of family members,[84] which can be a potentially traumatic event and stressor for conflict-affected children, is one of the major push factors for children to be recruited by armed forces and armed groups. Caregivers' mental health and psychosocial wellbeing status can also be a risk factor for recruitment.[85]

- There is limited knowledge about how children's mental health and wellbeing is affected by threatened or actual forms of recruitment, such as abduction, threats, pressure, lack of other options for access to resources and relationships, fleeing other violence and oppression, or indoctrination through family, community or social media.

- The risks of re-recruitment among CAAFAG include mental health and psychosocial issues, such as living in violent families, social isolation, traumatic experiences and loss of family members and relatives.[86]

- MHPSS interventions that contribute to the prevention of recruitment and re-recruitment of children into armed forces and armed groups should include strategies targeted at the child, family and community.

81 Harrison, S., Chemaly, W., Hanna, F., Polutan-Teulières, N., Ventevogel, P. (2021). 'Engagement of protection actors in MHPSS: the need for cross-sectoral cooperation'. *Forced Migration Review*. 66, 9–11.

82 Kohrt, B. A., Schafer, A., Willhoite, A., Van't Hof, E., Pedersen, G. A., Watts, S., Ottman, K., Carswell, K. & van Ommeren, M. (2020). 'Ensuring Quality in Psychological Support (WHO EQUIP): developing a competent global workforce'. *World Psychiatry*, 19 (1). http://dx.doi.org/10.1002/wps.20704

83 Wessells, M. G. (2006). *Child soldiers: From violence to protection*. Harvard University Press

84 Wessells (2006) ibid.

85 Tol, W. A., Stavrou, V., Greene, M. C., Mergenthaler, C., Van Ommeren, M., & Moreno, C. G. (2013). 'Sexual and gender-based violence in areas of armed conflict: a systematic review of mental health and psychosocial support interventions'. *Conflict and Health*, 7(1), 1–9.

86 SEED Foundation (2021). *Supporting the Recovery and Reintegration of Former Child Soldiers*. https://www.seedkurdistan.org/supporting-the-recovery-and-reintegration-of-former-child-soldiers/

Special consideration: MHPSS in an online world[87]

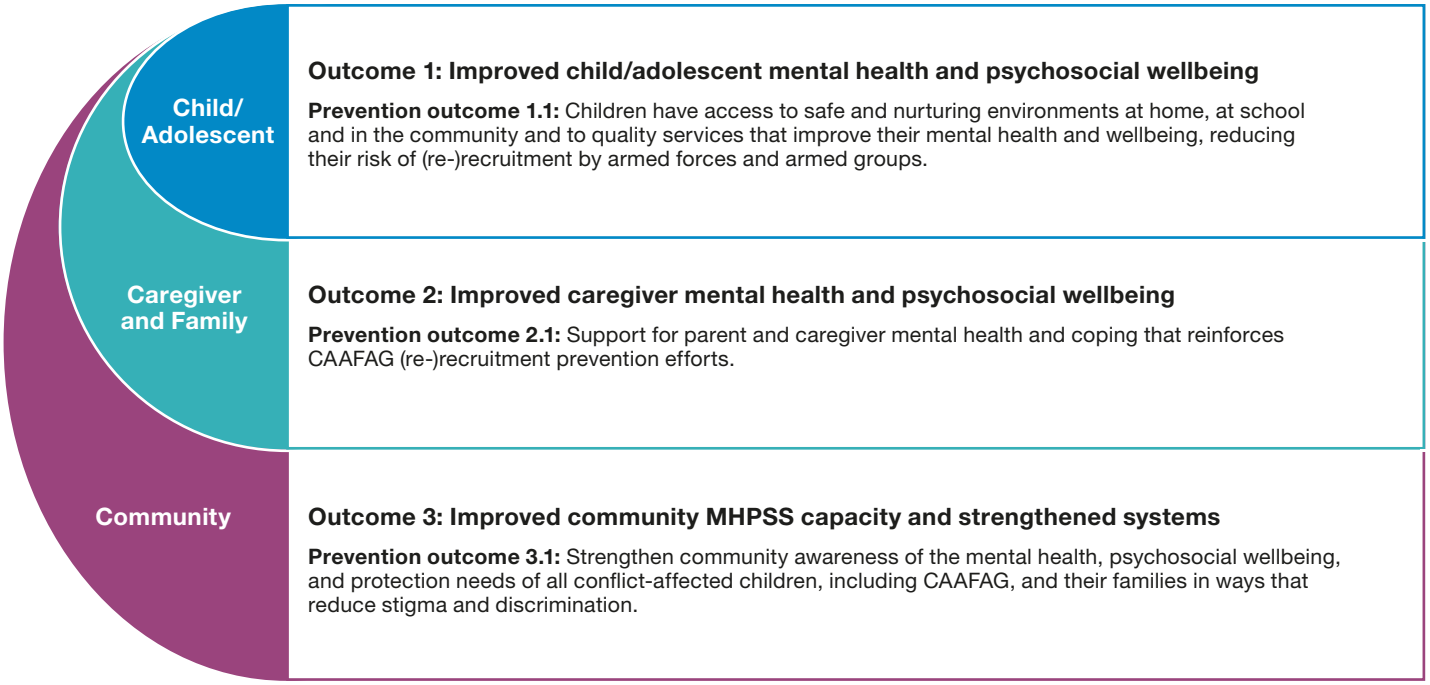
Social connectedness can be a positive indicator of mental health and wellbeing among children, but online engagement that generates cohesion and group identity can also facilitate armed group recruitment. Research examining the relationship between the online recruitment of children by armed groups and mental health and psychosocial wellbeing remains scant. In one example of online recruitment portals, the Islamic State (IS)'s brand identity is viewed by its opponents as one of brutality and terror, while many supporters view the group as representing 'strength, solidarity, … and a utopian paradise'. The messages of strength, meaning and acceptance may be appealing to adolescents who are looking for purpose in life and meaningful group identities, and may be particularly attractive to young people. Rather than top-down, 'marketing to' techniques, IS has adopted a decentralized, 'marketing with' approach that allows for officially approved messages, narratives and memes to be adapted and personalized by a viral chain of supporters that verge on fandom. Allowing supporters to adapt messages, narratives and memes and connect with a chain of other supporters is particularly attractive to young people who are comfortable using digital technology and social media.

Illustrative MHPSS interventions for prevention programming across the MHPSS for CAAFAG Operational Framework

The following tables describe illustrative interventions for prevention of recruitment programming that respond to the MHPSS needs of children, families and caregivers across the social-ecological model. They are linked to the three intermediary outcomes, as shown in the figure below.

Reminder: Children, adolescents and caregivers are affected in different ways by children's association with armed forces and armed groups and require different kinds of support. All layers of the MHPSS pyramid are important and should ideally be implemented concurrently. Although specialized MHPSS services in layer 4 of the pyramid (colour-coded in yellow) appear at the top of the intervention tables, they are not necessarily the services that most CAAFAG will need.

Figure 4 Intermediary outcomes for prevention of recruitment and use programming



87 O'Neil, S. & Van Broeckhoven, K. (2018). *Cradled by Conflict: Child Involvement with Armed Groups in Contemporary Conflict*. New York: United Nations University.

Table 5 Illustrative interventions for prevention of recruitment at child and adolescent level

Outcome 1	Improved child/adolescent mental health and psychosocial wellbeing
Intermediary outcome 1.1	Children have access to safe and nurturing environments at home, at school and in the community and to high-quality services that improve their mental health and wellbeing, reducing their risk of (re-)recruitment by armed forces and armed groups.
	**CARE**: Ensure access to high-quality mental health care by trained mental health providers for children in need of specialized services (e.g., psychological or psychiatric treatment for mental health and psychosocial conditions).
	**CARE**: Develop functional referral systems between specialized mental health services and health, education and protection services at community level.
	**PREVENT**: Strengthen promotive/protective factors for mental health and psychosocial wellbeing among conflict-affected children and address risk factors as part of general public health awareness campaigns for health, protection and education services.
	**CARE**: Initiate or strengthen the provision of mental health care for children at risk of (re-)recruitment in distress, by primary health/general health practitioners trained in mhGAP (Mental Health Gap Action Programme) and supervised.
	**CARE**: Provide MHPSS to children at risk of (re-)recruitment through child protection case management services. Case management services should be provided to all children who are in need of additional support. This is particularly important in communities where traumatic events have occurred.
	**PROMOTE**: Provide early childhood development (ECD) activities to children in communities where there is a risk of recruitment.
	**PROMOTE**: Provide group activities in schools and communities for mental health and psychosocial wellbeing that include children at risk of (re-) recruitment. For example, structured activities that support adolescents with opportunities to establish positive relationships though peer-to-peer groups, such as youth clubs, after-school activities and community engagement activities.
	**PROMOTE**: Raise awareness about children's and adolescents' mental health and psychosocial wellbeing, including risk and protective factors appropriate to their age and developmental stage.
	**PROMOTE**: Provide structured group activities for children's mental health and psychosocial wellbeing, such as through safe spaces for children at risk of (re-)recruitment, children's and youth clubs, clubs for adolescent CAAFAG parents, and safe spaces for girls.
	**PREVENT**: Engage children at risk of (re-)recruitment in social cohesion programmes such as community dialogues, peacebuilding activities and cultural events bringing adolescents together.
	**PREVENT**: Establish programmes for safe and supportive school environments.
	**PREVENT**: Strengthen adolescent leadership skills through youth-led prevention activities at school and in communities.
	**PREVENT**: Promote family life free from violence and provide support to vulnerable families through youth-led strategies to strengthen and support family systems.
	**PREVENT**: Orient humanitarian actors and community members on MHPSS in CAAFAG programmes and advocate for addressing the child-level risk factors for mental health conditions and psychosocial distress among children.

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Table 5 Illustrative interventions for prevention of recruitment at child and adolescent level *continued*

Outcome 1	Improved child/adolescent mental health and psychosocial wellbeing
Intermediary outcome 1.1	Children have access to safe and nurturing environments at home, at school and in the community and to high-quality services that improve their mental health and wellbeing, reducing their risk of (re-)recruitment by armed forces and armed groups.
	**PROMOTE**: Orient frontline workers and community leaders in basic psychosocial support skills for working with children at risk of (re-)recruitment.
	**PREVENT**: Set up safe spaces, including child, youth, women and girls, and baby-friendly spaces (BFS).
	**PROMOTE**: Ensure CAAFAG and other vulnerable children have access to quality basic services and security delivered in safe, equitable, dignified and culturally appropriate ways.

Resources

Compendium of resources are denoted with the resource number.
Additional resources are not numbered and include a link to an associated resource.

Strategies and Approaches
Resource 2.25 Inspire to end violence against children: See Approaches, Counselling and therapeutic approaches, TF-CBT
Helping Adolescents Thrive Toolkit: Strategy 4, Adolescent Psychosocial Interventions, including, group focused CBT & Trauma focused CBT

Guidelines
Resource 2.14 Guidelines for Child Friendly Spaces in Emergencies
Resource 2.24 Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for teachers, parents, and children in conflict and post conflict areas.
Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children
Resource 5.1 MHPSS and Participation Guidance
Resource 5.2 Engaged and Heard! Guidelines for Adolescent Participation and Civic Engagement
Resource 5.4 Mainstreaming psychosocial care and support through child participation
Resource 6.7 Evaluation of Child Friendly Spaces: Tools and Guidance

Programme Guidance
Resource 2.5 Move On & Engage
Resource 2.6 Working with Children and Their Environment
Resource 2.7 Children/Youth Resilience Programme
Resource 2.13 Toolkit for Child Friendly Spaces in Humanitarian Settings
Resource 2.15 Safe Healing and Learning Spaces
Resource 2.16 Psychosocial Support for Youth in Post-Conflict Situations
Resource 2.29 Baby Friendly Spaces (BFS): A Holistic Approach for Pregnant, Lactating Women

Training
Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers
Resource 3.3 Lay Counselling Trainer's Manual
I Support My Friends: A training for children and adolescents on how to support friends in distress
Helping Adolescents Thrive Toolkit: Strategy 4, Adolescent Psychosocial Interventions, including, group focused CBT & trauma focused CBT

Modules from the Evidence Review
Youth Forward
Sugira Muryango (Strong Families, Thriving Children/Family Talk): Model tools and assessment tools
Teaching Recovery Techniques
Welcome to Therapy: TF CBT

Table 6 Illustrative interventions for prevention of recruitment at caregiver/family level

Outcome 2	Improved caregiver mental health and psychosocial wellbeing
Intermediary outcome 2.1	Support for parent and caregiver mental health and coping that reinforces CAAFAG (re-)recruitment prevention efforts
	**CARE**: Ensure access to high-quality mental health care by trained mental health providers for caregivers and families of CAAFAG at risk of (re-)recruitment (including CAAFAG who are themselves parents) and in need of specialized services (e.g., psychological or psychiatric treatment for mental health and psychosocial conditions).
	**CARE**: Develop functional referral systems between specialized mental health services for CAAFAG at risk of (re-)recruitment and health, education and protection services at community level.
	**CARE**: Provide mental health care for caregivers, parents and teachers of children at risk of (re-)recruitment in distress, by primary health/general health practitioners trained in mhGAP and supervised.
	**CARE**: Initiate or strengthen the provision of psychological interventions to caregivers, parents and teachers in distress who care for and support children at risk of (re-)recruitment.
	**CARE**: Provide MHPSS through protection case management services to caregivers, parents and families of children at risk of (re-)recruitment.
	**CARE**: Provide focused individual or group psychosocial support for mental health and psychosocial conditions among caregivers of children at risk of (re-)recruitment.
	**PREVENT**: Improve safe and nurturing environments for vulnerable caregivers, parents and families of children at risk of (re-)recruitment through MHPSS in case management services.
	**PROMOTE**: Parenting support for caregivers of children at risk of (re-)recruitment, including key topics: caregiver wellbeing, positive parenting methods, child development, right to and benefits of education, impacts of recruitment on children, etc.
	**PREVENT**: Link family/caregiver livelihoods and cash-based interventions with sustained family and community MHPSS supports.
	**PROMOTE**: Provide structured group activities for caregiver and parent mental health and psychosocial wellbeing, such as through safe spaces for caregivers and parents of children at risk of (re-)recruitment, including safe spaces for women and girls, parent clubs.
	**PREVENT**: Orient humanitarian actors and community members on MHPSS in CAAFAG programmes and advocate for addressing caregiver/family level risk factors for mental health and psychosocial conditions and among children and their caregivers.
	**PROMOTE**: Orient frontline workers and community leaders in basic psychosocial support skills for working with caregivers, parents and families with children at risk of (re-)recruitment.

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Table 6 Illustrative interventions for prevention of recruitment at caregiver/family level *continued*

Resources
Relevant resources from the compendium
Strategies and Approaches Resource 2.25 Inspire to end violence against children: See Approaches, Counselling and therapeutic approaches, TF-CBT **Guidelines** Resource 2.24 Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for teachers, parents, and children in conflict and post conflict areas. Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children **Programme Guidance** Resource 1.7 REPSSI Mainstreaming Psychosocial Care and Support Services Resource 2.10 A toolkit for Community-Based Psychosocial Support Children and Adolescents in South Sudan Resource 2.20 IRC Parenting Skills Training Resource 2.35 Self-Help Booklet for Men Facing Crisis and Displacement Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.2 Broken Links: Psychosocial Support for People Separated from Family Members Resource 3.4 Psychological First Aid Training Manual for Child Practitioners Resource 3.6 Problem Management Plus (PM+): Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity mhGAP Humanitarian Intervention Guide mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings **Training** Resource 2.22 Psychosocial Training Manual for Teachers Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.3 Lay Counselling Trainer's Manual

Table 7 illustrative interventions for prevention of recruitment at community level

Outcome 3	Improved community MHPSS capacity and strengthened systems
Intermediary outcome 3.1	Strengthen community awareness of the mental health, psychosocial wellbeing and protection needs of all conflict-affected children, including CAAFAG, and their families in ways that reduce stigma and discrimination
	**CARE**: Build capacity of specialized mental health service providers to identify and manage mental health and psychosocial conditions among children at risk of (re-)recruitment and their caregivers.
	**PREVENT**: Build and strengthen functional referral systems between specialized and community-based MHPSS services across sectors, including health, protection and education sectors.
	**PROMOTE**: Orient specialized mental health service providers (e.g., psychologists) to CAAFAG MHPSS needs, and risk of and protective factors for (re-)recruitment, and implications for design of care and treatment for mental health and psychosocial conditions among children at risk of (re-)recruitment for MHPSS.
	**CARE**: Build capacity of health care workers to provide stigma-free mental health care to children at risk of (re-)recruitment and their families by primary health/general health practitioners trained in mhGAP and supervised.

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Table 7 illustrative interventions for prevention of recruitment at community level *continued*

Outcome 3	Improved community MHPSS capacity and strengthened systems
Intermediary outcome 3.1	Strengthen community awareness of the mental health, psychosocial wellbeing and protection needs of all conflict-affected children, including CAAFAG, and their families in ways that reduce stigma and discrimination
	**PREVENT**: Build capacity of public health and protection/social service systems to strengthen promotive/protective factors for mental health and psychosocial wellbeing among conflict-affected children and address risk factors.
	**CARE**: Orient case management providers to CAAFAG MHPSS needs and risk and protective factors for (re-)recruitment, and implications for mental health and psychosocial wellbeing and MHPSS approaches of children at risk of (re-)recruitment.
	**PROMOTE**: Activate and mobilize communities to strengthen promotive/protective factors for mental health and psychosocial wellbeing among conflict-affected children.
	**PROMOTE**: Disseminate key acceptable messages to promote the mental health and psychosocial wellbeing, safety and inclusion of conflict-affected children and caregivers.
	**PROMOTE**: Support community-led MHPSS activities and social supports engaging children at risk of (re-)recruitment.
	**PREVENT**: Organize social cohesion programmes that include youth, such as community dialogues, peace building activities, and cultural events that bring young people together to contribute to a safer environment.
	**PROMOTE**: Incorporate women's voices and knowledge in MHPSS promotion and prevention activities, given that they typically have front-line interaction with CAAFAG and other children affected by conflict and their families. Also ensure equitable inclusion of men in MHPSS promotion and prevention efforts, particularly in remote and patriarchal societies.
	**PROMOTE**: Engage children and adolescents in identifying problems and solutions and dialogue with decision makers as part of MHPSS prevention activities to raise awareness and reduce stigma. This should include empowering former CAAFAG within community prevention and promotion services.
	**PROMOTE**: Enable connections between CAAFAG and community members to tackle structural barriers to their inclusion and wellbeing and create transformative change.
	**PREVENT**: Engage communities in identifying and supporting vulnerable children and families in need of MHPSS, protection and other support.
	**PREVENT**: Understand and map existing national and local capacities on MHPSS – moving beyond line of ministries health, education, child protection, disaster management, etc to include ministries responsible for social cohesion and peace.
	**CARE**: Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions in all prevention of recruitment and use activities.
	**CARE**: Orient frontline workers and community leaders in basic psychosocial support skills for children at risk of (re-)recruitment and their caregivers and families.

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Table 7 illustrative interventions for prevention of recruitment at community level *continued*

Outcome 3	Improved community MHPSS capacity and strengthened systems
Intermediary outcome 3.1	Strengthen community awareness of the mental health, psychosocial wellbeing and protection needs of all conflict-affected children, including CAAFAG, and their families in ways that reduce stigma and discrimination
	**PREVENT**: Mitigate risks of stigma or unintended psychosocial harm to children at risk of (re-)recruitment in the delivery of humanitarian assistance (e.g., basic services and provisions).
	**CARE**: Coordinate with other agencies and across sectors to keep MHPSS service mapping and child-friendly referral pathways updated.
	**PREVENT**: Train frontline workers in safe identification and referral for MHPSS among children at risk of (re-)recruitment.
	**PREVENT**: Orient humanitarian actors and community members on MHPSS in CAAFAG programmes and advocate for addressing community-level risk factors for mental and psychosocial distress among children.

Resources
Relevant resources from the compendium
Strategies and Approaches Resource 2.25 Inspire to end violence against children HAT Toolkit SAFE Model: Child Protection Rights-Based Situation Analysis **Programme Guidance** Resource 1.7 REPSSI Mainstreaming Psychosocial Care and Support Services Resource 2.2 Adolescent Kit for Expression and Innovation Resource 2.4 You Create Art Resource 2.5 Move On & Engage Resource 2.10 A Toolkit for Community-Based Psychosocial Support for Children & Adolescents Resource 2.31 IOM Manual on Community-Based Mental Health and Psychosocial Support in Emergencies Resource 3.5 Psychological First Aid: A Guide for Field Workers **Training** Resource 1.1 Six Orientation Seminars to Disseminate and Implement the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings Resource 2.12 Resource Training Package on Child Friendly Spaces I Support My Friends: A training for children and adolescents on how to support friends in distress **Modules from the Evidence Review** SAFE Model: Child Protection Rights-Based Situation Analysis KIDNET: A specific type of Narrative Exposure Therapy tested with CAAFAG Community-based participatory action research tool with CAAFAG Youth Forward Sugira Muryango (Strong Families, Thriving Children/Family Talk): Model tools and assessment tools Teaching Recovery Techniques Welcome to Therapy: TF CBT

MHPSS in release

It is recommended that MHPSS services are incorporated throughout all stages of reintegration, including release.[88] CAAFAG should be given immediate equal access to MHPSS support without discrimination or judgement based on the nature of their involvement in conflict.

During release, MHPSS-related response and protection needs should be met through:

- Ensuring safe, trauma-informed environments (especially in any institutional spaces like transit, interim care and release centres) and safe and dignified access to basic services (e.g., shelter, health/reproductive health services, basic material needs);
- Facilitating (re-)connection to caregivers/families, as appropriate, for communication during release processes;
- Provision of basic psychosocial support, including psychological first aid;
- Initial assessment and referral to specialized MHPSS and case management services, as needed, as well as links to less formal psychosocial support.

Those CAAFAG who are in conflict with the law or who are living with pre-existing mental health and psychosocial conditions may have urgent needs for referral to focused MHPSS services or specialized mental health care (e.g., psychological or psychiatric) as appropriate. MHPSS staff involved in release programming must advocate for and work to create and stabilize emotionally safe, supportive and caring release processes for all CAAFAG.

Gender is another key consideration during release. A **gender-sensitive approach** must be adopted in conflict-affected communities involved in release. This includes ensuring that female personnel are trained on how to safely and sensitively deliver MHPSS services to girls. It also includes how to handle disclosure of sexual abuse, an understanding of the specific MHPSS needs of survivors of sexual and gender-based violence without further victimizing them, how to empower girls to build on any psychosocial skills they learned during the period of association, and to support them with necessary services (including reproductive health services), while ensuring confidentiality. It is important to remember that boys may also be survivors of sexual violence, and consideration should be given to their safe and culturally appropriate care and support.

Illustrative MHPSS interventions for release programming

The following tables describe illustrative interventions for release programming that respond to the MHPSS needs of children, families and caregivers across the social-ecological model. They are linked to the three intermediary outcomes, as shown in Figure 5 on page 26.

Reminder: Children, adolescents, and caregivers are affected in different ways by children's association with armed forces and armed groups and require different kinds of support. All layers of the MHPSS pyramid are important and should ideally be implemented concurrently. Though specialized MHPSS services in layer 4 of the pyramid (color-coded in yellow) appear at the top of the intervention tables, they are not necessarily the services that most CAAFAG will need.

88 Alliance for Child Protection in Humanitarian Action (2020). *Key Messages and Considerations for Programming for Children Associated with Armed Forces or Armed Groups During the COVID-19 Pandemic, Version 1*, May 2020.

Figure 5 Intermediary outcomes for release programming

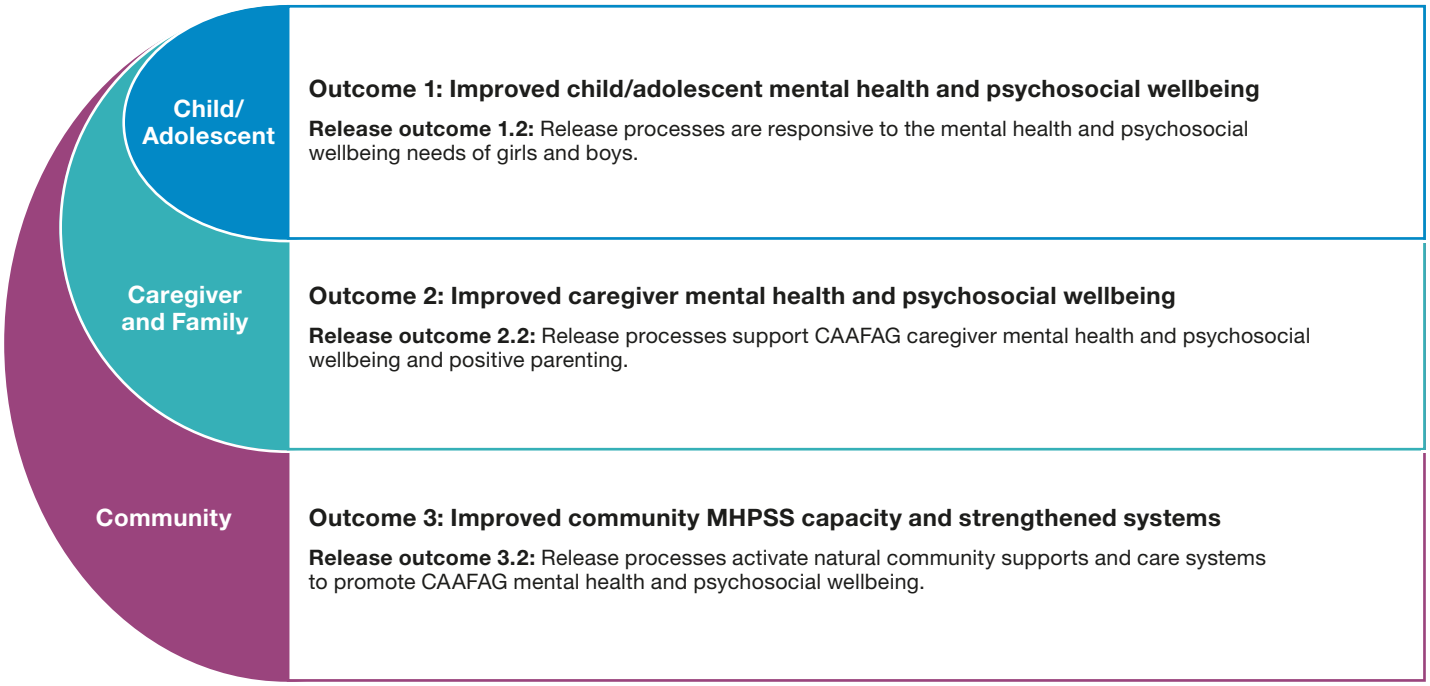

Table 8 Illustrative interventions for release at child and adolescent level

Outcome 1	Improved child/adolescent mental health and psychosocial wellbeing
Intermediary outcome 1.2	Release processes are responsive to the mental health and psychosocial wellbeing needs of girls and boys
	CARE: Ensure access to high-quality mental health care by trained mental health providers for children in need of specialized services (e.g., psychological or psychiatric treatment for mental health and psychosocial conditions).
MSP	**CARE**: Develop functional referral systems between specialized mental health services and health, education and protection services at community level.
MSP	**CARE**: Provide confidential MHPSS services through clinical care for survivors of sexual violence and intimate partner violence that can serve as safe spaces for female CAAFAG, especially those with children, to self-identify for connection to multisectoral release services.
MSP	**CARE**: Provide confidential MHPSS services and clinical care for boy survivors of sexual violence, recognizing that boy survivors will likely not seek support or treatment via traditional GBV service providers.
MSP	**CARE**: Provide confidential mental health care and psychosocial support through general health care by primary health/general health practitioners trained in mhGAP and supervised, that can serve as safe spaces, especially for female CAAFAG and those with children, to self-identify for connection to multisectoral release services.
MSP	**CARE**: Provide MHPSS through protection case management services to CAAFAG released formally or informally.
MSP	**CARE**: Provide training on basic psychosocial support skills for staff interacting with CAAFAG in detention centres.
MSP	**CARE**: Provide gender-sensitive MHPSS services for CAAFAG, especially to child mothers and single mothers, such as stress management for adolescent mothers.

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Table 8 Illustrative interventions for release at child and adolescent level *continued*

Outcome 1	Improved child/adolescent mental health and psychosocial wellbeing
Intermediary outcome 1.2	Release processes are responsive to the mental health and psychosocial wellbeing needs of girls and boys
	**CARE**: At release centres, use a gender-sensitive approach to train personnel to provide basic psychosocial support services for girls and boys.
	**CARE**: Provide basic psychosocial support for children during the release process.
	**PROMOTE**: Provide early child development (ECD) approaches for the children of CAAFAG at release-related centres or sites (e.g., release centres, interim care centres, transit centres, detention centres) Stakeholder engagement
	**PROMOTE**: Provide group psychosocial structured activities for CAAFAG mental health and psychosocial wellbeing at transit centres or sites (e.g., release centres, interim care centres, transit centres, detention centres)
	**PROMOTE**: Prepare caregivers of CAAFAG to promote the mental health and psychosocial wellbeing of their children once they are released.
	**CARE**: Psychosocial competence building for family and caregivers in preparation to support CAAFAG during reintegration.
	**PROMOTE**: Raise awareness about CAAFAG mental health and psychosocial wellbeing.
	**PROMOTE**: Support caregivers of CAAFAG to connect with their children and welcome them home.
	**PREVENT**: Integrate MHPSS considerations into all centres or sites (e.g., release centres, interim care centres, transit centres, detention centres) that CAAFAG enter to promote safe, nurturing environments.
	**PREVENT**: Ensure identification and verification processes are safe, especially among girls and boys who have exited informally.
	**PREVENT**: Mitigate stigma of children's association, especially girls' association through the role of 'wife' of a fighter, particularly if they have children.
	**PREVENT**: Ensure transit centres or sites (e.g., release centres, interim care centres, transit centres, detention centres) have functional MHPSS referral pathways.
	**PREVENT**: Ensure basic needs (shelter, food, WASH) are provided in ways that respect culture, dignity and agency.
	**PROMOTE**: Provide access to important information about basic services, loved ones, legal rights and positive coping strategies to CAAFAG being released and their caregivers.

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Table 8 Illustrative interventions for release at child and adolescent level *continued*

Resources
Relevant resources from the compendium
Strategies and Approaches Resource 2.25 Inspire to end violence against children: See Approaches, Counselling and therapeutic approaches, TF-CBT Helping Adolescents Thrive Toolkit: Strategy 4, Adolescent Psychosocial Interventions, including, group focused CBT & Trauma focused CBT **Programme Guidance** Resource 1.7 REPSSI Mainstreaming Psychosocial Care and Support Services Resource 2.10 A toolkit for Community-Based Psychosocial Support Children and Adolescents in South Sudan Resource 2.20 IRC Parenting Skills Training Resource 2.35 Self-Help Booklet for Men Facing Crisis and Displacement Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.2 Broken Links: Psychosocial Support for People Separated from Family Members Resource 3.4 Psychological First Aid Training Manual for Child Practitioners Resource 3.6 Problem Management Plus (PM+): Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity Resource 4.1 mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings **Training** Resource 2.22 Psychosocial Training Manual for Teachers Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.3 Lay Counselling Trainer's Manual I Support My Friends: A training for children and adolescents on how to support friends in distress **Models from the Evidence Review** KIDNET: A specific type of Narrative Exposure Therapy tested with CAAFAG Community-based participatory action research tool with CAAFAG Youth Forward Sugira Muryango (Strong Families, Thriving Children/Family Talk): Model tools and assessment tools Teaching Recovery Techniques Welcome to Therapy: TF CBT

Table 9 Illustrative interventions for release at caregiver/family level

Outcome 2	Improved caregiver mental health and psychosocial wellbeing
Intermediary outcome 2.2	Release processes support CAAFAG caregiver mental health and psychosocial wellbeing and positive parenting
	**CARE**: Ensure access to high-quality mental health care by trained mental health providers for caregivers and families of CAAFAG in need of specialized services (e.g., psychological or psychiatric treatment for mental health and psychosocial conditions) during CAAFAG release.
	**CARE**: Orient providers of clinical care for survivors of sexual violence and intimate partner violence about MHPSS issues among caregivers of CAAFAG during release.
	**CARE**: Orient general health services providers about MHPSS issues among caregivers of CAAFAG during release.
	**CARE**: Provide focused psychosocial interventions to distressed caregivers of CAAFAG preparing to welcome their child home.

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Table 9 Illustrative interventions for release at caregiver/family level *continued*

Outcome 2	Improved caregiver mental health and psychosocial wellbeing
Intermediary outcome 2.2	Release processes support CAAFAG caregiver mental health and psychosocial wellbeing and positive parenting
	**CARE**: Provide MHPSS to caregivers of CAAFAG who have been linked to protection case management services as part of the release process.
	**PROMOTE**: Support caregivers of CAAFAG to promote the mental health and psychosocial wellbeing of their children
	**PROMOTE**: Prepare caregivers and families with MHPSS skills to welcome CAAFAG back home.
	**PREVENT**: Enhance the protective family environment through case management, parenting skills and family support programmes.
	**PREVENT**: Mitigate the stigma for families correlated with children's association with armed groups and armed forces.
	**PROMOTE**: Family/caregiver access to important information about basic services, loved ones, legal rights and positive coping strategies.

Resources
Relevant resources from the compendium
Strategies and Approaches Resource 2.25 Inspire to end violence against children: See Approaches, Counselling and therapeutic approaches, TF-CBT HAT Toolkit **Programme Guidance** Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.2 Broken Links: Psychosocial Support for People Separated from Family Members Resource 3.6 Problem Management Plus (PM+): Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity Resource 4.1 mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings **Training** Resource 2.22 Psychosocial Training Manual for Teachers Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.3 Lay Counselling Trainer's Manual I Support My Friends: A training for children and adolescents on how to support friends in distress

Table 10 Illustrative interventions for release at community level

Outcome 3	Improved community MHPSS capacity and strengthened system delivery for CAAFAG
Intermediary outcome 3.2	Release processes activate natural community supports and care systems to promote CAAFAG wellbeing
	**CARE**: Build capacity of specialized mental health service providers to identify and manage mental health and psychosocial conditions among children being released and their caregivers.
	**PREVENT**: Build and strengthen functional referral systems between specialized and community-based MHPSS services across sectors, including health, protection and education sectors.
	**CARE**: Support capacity-building of providers of clinical care for survivors of sexual violence and intimate partner violence to provide confidential MHPSS services to CAAFAG who have not yet disclosed their release and/or who are exiting through formal processes
	**CARE**: Train health professionals on how to sensitively handle disclosure of association and sexual abuse, and have MHPSS helpers and social workers available on site.
	**CARE**: Support capacity-building of care systems and general health care system to provide confidential MHPSS services to CAAFAG who have not yet disclosed their release and/or who are exiting through formal processes.
	**CARE**: Support capacity-building of community-based focused psychosocial intervention in communities involved in release processes to provide safe, effective MHPSS services to conflict-affected children, youth and families in distress
	**CARE**: Support capacity-building of case management systems to provide safe, effective basic psychosocial support services to CAAFAG during formal and informal release, and knowledge of how and when to refer.
	**PROMOTE**: Disseminate key messages (via mass media, FM radios and, as appropriate, social media campaigns) to the community about CAAFAG release process and how to welcome them home.
	**PROMOTE**: Support community leaders and caregivers of CAAFAG to promote the mental health and psychosocial wellbeing of their children.
	**PROMOTE**: Support community-led MHPSS activities and social supports for caregivers of CAAFAG.
	**PROMOTE**: Use community-based mechanisms to ensure access to MHPSS services among all children and adolescents including CAAFAG, whether or not they formally disclose their association to armed groups.
	**PROTECT**: Support community dialogues about mental health and wellbeing concerns related to the return of CAAFAG to communities

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Table 10 Illustrative interventions for release at community level *continued*

Outcome 3	Improved community MHPSS capacity and strengthened system delivery for CAAFAG
Intermediary outcome 3.2	Release processes activate natural community supports and care systems to promote CAAFAG wellbeing
	**PREVENT**: Orient humanitarian actors and community members involved in CAAFAG release on MHPSS and advocate for MHPSS considerations and actions.
	**PREVENT**: Orient humanitarian actors and community members involved in safe identification and referral on MHPSS considerations and actions.
	**CARE**: Orient frontline workers and community leaders in basic psychosocial support skills to serve as supports for CAAFAG who have disclosed their association with an armed group or armed force.
	**PREVENT**: Advocate for MHPSS considerations and actions that support community members to welcome CAAFAG

Resources
Relevant resources from the compendium
Strategies and Approaches Resource 2.25 Inspire to end violence against children HAT Toolkit **Guidelines** Resource 2.14 Guidelines for Child Friendly Spaces in Emergencies Resource 2.24 Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for teachers, parents, and children in conflict and post conflict areas. Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children Resource 5.1 MHPSS and Participation Guidance Resource 5.2 Engaged and Heard! Guidelines for Adolescent Participation and Civic Engagement Resource 5.4 Mainstreaming psychosocial care and support through child participation Resource 6.7 Evaluation of Child Friendly Spaces: Tools and Guidance **Programme Guidance** Resource 1.7 REPSSI Mainstreaming Psychosocial Care and Support Services Resource 2.7 Working with Children and Their Environment Resource 2.10 A toolkit for Community-Based Psychosocial Support Children and Adolescents in South Sudan Resource 2.13 Toolkit for Child Friendly Spaces in Humanitarian Settings Resource 2.15 Safe Healing and Learning Spaces Resource 2.16 Psychosocial Support for Youth in Post-Conflict Situations Resource 3.4 Psychological First Aid Training Manual for Child Practitioners

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Table 10 Illustrative interventions for release at community level *continued*

Resources
Relevant resources from the compendium
Training Resource 2.22 Psychosocial Training Manual for Teachers I Support My Friends: A training for children and adolescents on how to support friends in distress **Models from the Evidence Review** KIDNET: A specific type of Narrative Exposure Therapy tested with CAAFAG Community-based participatory action research tool with CAAFAG Youth Forward Sugira Muryango (Strong Families, Thriving Children/Family Talk): Model tools and assessment tools Teaching Recovery Techniques Welcome to Therapy: TF CBT

MHPSS in reintegration

Reintegration can be a long and complex process, and the challenges to children's successful reintegration and mental health and psychosocial wellbeing are many. Both war experiences and post-release risk and protective factors affect the mental health and social reintegration of former CAAFAG (see Table 11).

Table 11 Protective/promotive and risk factors for mental health and psychosocial wellbeing among CAAFAG during reintegration

	Risk factors	Protective factors
Child/adolescent	Exposure to potentially traumatic events, displacement, stressors due to experiencing or witnessing violence, disability, learning difficulties, health conditions (including pregnancy), lack of education or practical job skills.[89]	Accessibility and availability of multisectoral services, emotional capacities and resilience, family support and stability, peer and community support, nurturing caregivers and parents, access to MHPSS services (emotional, informational and instrumental), access to safe spaces and educational and livelihood opportunities.[90]
Caregiver/family	Mental health and psychosocial problems among parents and caregivers due to family separation, family conflict, domestic violence, substance abuse, poverty and lack of livelihood opportunities, stigmatization of and discrimination against caregivers and family members.[91]	Accessibility and availability of multisectoral services, cross-sectoral sensitisation on the importance and integration of MHPSS in service delivery (e.g., in health care, youth clubs) religious support, social support and belonging, family cohesion, access to MHPSS services for caregiver wellbeing and parenting support, and programmes to prevent gender-based violence.[92]
Community	Stigma (e.g., around mental health armed group association, experiences), bullying, rejection, social isolation, discrimination, structural violence, physical and emotional violence (e.g., revenge violence) stereotyping, poverty, unemployment, economic hardship, ongoing and historical conflict, lack of services.[93]	School enrolment, mental health sensitization (teachers, community), peer support, recreational activities, enhanced safety inside and around school and other community social spaces, social support and belonging, community participation, faith and religious support, support and understanding from community leaders, vocational training opportunities, local stability with regards to conflict and peace, financial support, active engagement of NGOs and civil society.[94]

89 Rousseau, C. & Drapeau, A. (1998). 'The Impact of Culture on the Transmission of Trauma'. In Danieli, Y. (ed.) *The International Handbook of Multigenerational Legacies of Trauma*, New York: Plenum Press; Mohamed, S. & Thomas, M. (2017). 'The mental health and psychological wellbeing of refugee children and young people: An exploration of risk, resilience and protective factors'. *Educational Psychology in Practice*, 33(3), 249–263.

90 Karadzhov, D. (2015). 'Assessing resilience in war-affected children and adolescents: A critical review'. *Journal of European Psychology Students*, 6(3), 1–13.

91 Singh, J.P., Grann M. & Fazel S. (2011). 'A comparative study of violence risk assessment tools: a systematic review and metaregression analysis of 68 studies involving 25,980 participants'. *Clinical Psychology Review* 31(3): 499–513.

92 Tol, W. A., Stavrou, V., Greene, M. C., Mergenthaler, C., Van Ommeren, M. & Moreno, C. G. (2013). 'Sexual and gender-based violence in areas of armed conflict: a systematic review of mental health and psychosocial support interventions'. *Conflict and Health*, 7(1), 1–9.

93 Wessells, M. G. (2006). The importance of livelihood in Reintegrating Former Child soldiers. In Boothby, N., Strang, A., & Wessells, M. G. (Eds.). *A world turned upside down: social ecological approaches to children in war zones* (pp. 179–197). Kumarian Press; Denov, M. (2010). Coping with the trauma of war: Former child soldiers in post-conflict Sierra Leone. *International Social Work*, 53(6), 791–806; Denov, M. & Shevell, M. C. (2021). 'An arts-based approach with youth born of genocidal rape in Rwanda: The river of life as an autobiographical mapping tool'. *Global studies of childhood*, 11(1), 21–39; Mohamed, S. & Thomas, M. (2017). 'The mental health and psychological wellbeing of refugee children and young people: An exploration of risk, resilience and protective factors'. *Educational Psychology in Practice*, 33(3), 249–263.

94 Betancourt, T. S. & Ettien, A. (2010). Transitional justice and youth formerly associated with armed forces and armed groups: acceptance, marginalization and psychosocial adjustment. Innocenti Working Papers no. 2010-17; Denov & Shevelle (ibid); Betancourt, T. S., Borisova, I., Williams, T. P., Meyers-Ohki, S. E., Rubin-Smith, J. E., Annan, J., & Kohrt, B. A. (2013). Research Review: Psychosocial adjustment and mental health in former child soldiers – a systematic review of the literature and recommendations for future research. *Journal of Child Psychology and Psychiatry*, 54(1), 17–36.

Lost educational and economic opportunity

One of the most devastating outcomes for CAAFAG is the years of lost educational and economic opportunity. Many CAAFAG have had their education disrupted by conflict or their families have not been able to keep them in school.[95] This point was emphasized in the consultations with youth, who saw disruptions to their education and livelihoods as a key negative impact of the conflict. They may have very few skills other than those required for fighting and/or surviving in armed forces or armed groups. This can result in difficulties in attaining key lifecycle milestones. Many formerly associated children report these challenges to be more problematic than the actual experiences of the war. They are daily stressors that increase the risk of MHPSS difficulties.

- Many CAAFAG feel ill equipped to contribute to their family and local community economy upon return to civilian life, or to play their citizenship roles in the community.

- Attending school and training programmes is considered critical in helping CAAFAG attain a sense of normalcy and safety in their everyday lives while also increasing their future employment opportunities.[96] In a study from Uganda, former child soldiers who were given the opportunity to continue their education reported lower levels on assessments of depression, compared with those who directly entered vocational training.[97] In addition to educational opportunities, entry into the labour force is seen as enabling youth to redefine themselves and to shift their identity from soldier to civilian.

- Wessells (2006) found that former female soldiers in Sierra Leone suffered the greatest psychosocial stress as a result of poverty and limited livelihood opportunities. MHPSS approaches should also help to relieve economic stress for CAAFAG and their families, and bolster self-confidence and hope for female CAAFAG.[98]

Specific considerations regarding structural vulnerabilities

Pre-existing inequalities related to gender, disability and other factors tend to increase during humanitarian crises. MHPSS in CAAFAG programming brings awareness to structural and societal dynamics of inequity and the specific MHPSS needs of children, to avoid worsening stigma, discrimination and exclusion of risk groups in communities. Specific measures should be taken to ensure accessibility, inclusion and meaningful participation of children with disabilities, survivors of gender-based and other forms of violence, members of the LGBTQI community, and other at-risk groups.

Community acceptance is necessary for CAAFAG's psychosocial recovery and wellbeing. Community-based support mechanisms are crucial to facilitating the reintegration and inclusion of CAAFAG, both through reducing stigma and discrimination and promoting acceptance among community members, as well as through safe rituals and ceremonies that alleviate an individual sense of shame and guilt and promote forgiveness of returned CAAFAG. In this process, caregivers and families also play a critical role. Their acceptance or rejection of a child returning from association with armed forces or armed groups, how they welcome them back and whether they treat them as equal to their non-associated siblings affects how the community views the child. Acceptance by the family also has a significant impact on the recovery, mental health and psychosocial wellbeing of the returning child, and thus it is important to prepare caregivers and families before and during reintegration of children to promote the best possible outcome.

Gender

The effects of gendered norms are far reaching, touching every aspect of CAAFAG's mental health and psychosocial wellbeing during reintegration.[99] Gender plays a critical role in how children are treated and valued within families and communities. Societal gender norms influence girls' and boys' different experiences, potentials and risks. Gender also affects family dynamics and care arrangements for children.

95 Willis, A. S. & Nagel, M. C. (2015). 'The Role That Teachers Play in Overcoming the Effects of Stress and Trauma on Children's Social Psychological Development: Evidence from Northern Uganda'. *Social Psychology of Education: An International Journal* 18(1), 37–54.

96 Betancourt, T. S., & Khan, K. T. (2008). 'The mental health of children affected by armed conflict: Protective processes and pathways to resilience'. *International Review of Psychiatry*, 20(3), 317–328.

97 Ovuga, E., Oyok, T. O., & Moro, E. B. (2008). 'Post-traumatic stress disorder among former child soldiers attending a rehabilitative service and primary school education in northern Uganda'. *African Health Sciences*, 8(3), 136–141.

98 Wessells, M. G. (2006). *Child soldiers: From violence to protection*. Harvard University Press.

99 Samuels, F. (2019). *Gender norms and psychosocial wellbeing: The 'social' in 'psychosocial': how gendered norms drive distress*. ALIGN.

Experiences are different for boys and girls, with specific vulnerabilities for both. Girls may experience sexual abuse, unwanted pregnancy, unsafe and unwanted abortion, health problems during pregnancy and childbirth, and isolation from their families, all of which can be potentially traumatic events and conditions. Girls who were abducted and have had children with someone in the armed group may face isolation, lack of support and other stressors if their families refuse to accept the child.[100]

Female CAAFAG have been shown to have significantly lower levels of confidence and prosocial behaviours over time,[101] even after controlling for war experiences. A study in Sierra Leone with girls affected by war demonstrated higher rates of psychological distress compared to boys. Girls showed higher scores on anxiety scales (80% of girls and 52% of boys) and depression scales (72% of girls and 55% of boys). The study highlighted higher signs of hostility, and lower levels of confidence and pro-social attitudes among girls. A sense of shame and guilt can also affect the psychological wellbeing of female CAAFAG while, at the same time, girls may miss the sense of belonging to a group, an ideology and the sisterhood that has shaped their identity.

In some contexts, girls and women experience more freedom in armed forces or groups than they do in their communities, for example through enhanced decision-making power or through participation in combat. This can make it difficult for them to return to their communities, which might confine women and girls to low-value income-generating activities that offer little opportunity for self-sufficiency. This is particularly problematic for single mothers who have a child to support and women who seek out more remunerative forms of employment, who can be at greater risk of GBV for doing so.[102]

(For more information on specific experiences for girls, see UNICEF Technical Note on Girls Associated with Armed Forces and Armed Groups.)

Male CAAFAG may experience other unique risks to their safety, physical and mental health, psychosocial wellbeing and development. Male CAAFAG, particularly those who have crossed the threshold to adolescence, are more likely to be politically labelled as 'violent extremists' or 'terrorists' (rhetoric that can play on fear and anger and reinforce exclusion), separated from mothers and families, placed in detention with adult combatants, and criminalized for their association rather than seen as victims of recruitment and use by armed forces and armed groups (even among boys as young as 10 years).[103] According to the UN Special Rapporteur, "Extending the arm of counter-terrorism to children involved with non-state armed groups designated as 'terrorist' shifts the discourse from protection to punishment… In turn, this also changes the protection to which they are entitled… as well as their rights, away from a child rights perspective and the question of responsibility for violations of the rights of the child, including recruitment and use."[104]

Gender stereotypes around masculinity that become attached to young male children and adolescents associated with armed forces and armed groups play a part in both their experiences while associated, and in how they are viewed and treated upon their return. Male CAAFAG may spend all or part of their formative developmental years within a culture that promotes masculine expectations of violence, power and competitiveness, and that rejects weakness or expression of emotions, and deprives them of protection and nurture. Boys are more likely to have been directly engaged in hostilities – witnessing, experiencing and perpetrating violence, sometimes under force or threat – to have been physically injured during combat, and to be criminalized or feared by communities upon their return. Furthermore, boys may also be silent victims of sexual violence during their association with armed forces and armed groups, and struggle with shame for what they have experienced as well as acts they committed during their association. Girls may have experienced more freedom or power, while boys may have held positions of authority and may struggle with a loss of status in civilian life. Efforts to reintegrate boys into their families and communities must take account of masculine gender stereotypes and the specific experiences and expectations among returned boys and young men, and provide a pathway for positive engagement and identity within their families and communities.

100 Technical consultation

101 Betancourt, T.S., Borisova, I., de la Soudiere, M. & Williamson J. (2011) 'Sierra Leone's Child Soldiers: War exposures and mental health problems by gender'. *Journal of Adolescent Health* 49(1) 21–28.

102 Ward, J. & Stone, L. (2018). UNICEF Knowledge Product: CAAFAG and GBViE Programming. London: UNICEF GBViEHelpdesk

103 Ni Aoliain, F., Haynes, D.F. & Cahn, N. (2011) *On the Frontlines: Gender, war and the post-conflict process*. Oxford: Oxford University Press

104 United Nations Human Rights Special Procedures: Position of the United Nations Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism on the human rights of adolescents/ juveniles being detained in North-East Syria. May 2021.

Children recruited and exploited by groups engaged in terrorism or violent extremism

Children recruited and exploited by armed groups engaged in terrorism or violent extremism are often exposed to the most extreme forms of violence, deprivation and other potentially traumatic events.[105] Because of the nature and intensity of their exposure to violence, as well as the social consequences of their association with the groups, specific approaches to reintegration may be supportive, such as:

- Efforts to address and prevent secondary victimization of children alleged to have committed, accused of committing or recognized as having committed offences considered terrorism-related offences;

- MHPSS competency-based training for justice system staff.[106]

An immediate MHPSS goal is to equip CAAFAG with relevant prosocial skills to enable them to return to society, rather than to focus on 'deradicalization'. Basic competencies in prosocial skills may also include exploration of how children recruited and exploited by groups engaged in terrorism or violent extremism relate to and manifest empathy, and promotion of their experience of empathy in civilian life. Likewise, provision of empathy training for social workers and others who work with these children can enhance their own competencies in communication and other helping skills.[107] More fundamentally,

> *"…disengagement from violent extremism is a two-way street. If mobilization is the result of complex group dynamics that involve perceptions of social exclusion and consensualizing outgroup stereotypes, then the existence of an available, viable, and tangible alternative identity into which disengaging persons are welcome is not optional. Presenting such an opportunity is not straightforward – not only must the shames, fears, and behavioral health challenges of those who are disengaging be addressed to encourage help-seeking behavior and a willingness to interact prosocially among a broader community, but the broader community must also reduce its stigmas, fear, anger, and prejudice so that community members are willing to interact with those who are disengaging. Enabling such interaction is not enough, however, unless those interactions are routinized, social learning will not occur, relationships and bonds will not be built, and a sense of belonging will not be generated. Removing barriers to open spaces for prosocial interactions requires addressing the legitimate grievances or reforming political systems and social structures that contribute to divisions and violent extremism within a given social ecology."*[108]

Children returning from areas formerly under control of armed forces or armed groups engaged in terrorism or violent extremism

Not all children of foreign fighters and other children returning from areas formerly under the control of armed forces and armed groups match CAAFAG criteria. Some may have been involved in activities of groups designated as engaged in terrorism or violent extremism while others are family members who travelled with foreign fighters but have not been involved in any activity of groups designated as engaged in terrorism or violent extremism. Recent data suggest that half of deportees and returnees from areas formerly under the control of armed forces or armed groups are under 18 years of age, including toddlers [0–5 years, 48%], children [6–12 years, 42%] and adolescents [13–18 years, 10%]. Many of these child deportees and returnees have been exposed to potentially traumatic events, loss or separation from caregivers, detention and environments of severe deprivation that have potentially threatened their lives, health and mental health, safety and development, as well as family stability.[109] There are increasing numbers of these children who, along with their caregivers and families, are in need of repatriation and/or reintegration support. Many of these children have faced considerable suffering, including the potentially traumatic loss of family members, exposure to violence, including sexual violence and witnessing conflict. Many have never been in their country of origin before and can face stigma from family and community members on their return. Children who are returning and repatriating need MHPSS support and interventions

105 Jørgensen, N. H. (2019). 'Children associated with terrorist groups in the context of the legal framework for child soldiers'. *Questions of International Law*, 60, 5–23.

106 UNODC (2019). Roadmap on the treatment of children associated with terrorist and other violent extremist groups

107 https://international-review.icrc.org/sites/default/files/reviews-pdf/2020-05/irrc_101_911_reduced_.pdf

108 Bosley, C. (2020). *Violent Extremist Disengagement and Reconciliation: A peacebuilding approach*. Washington DC: US Institute of Peacebuilding

109 ICRC (2020). Interview with Mira Kusumarinai, Executive Director of the Coalition of Civil Society Against Violent Extremism (C-SAVE)

integrated within other services (e.g., social services, judicial, health, protection, legal) in a manner that is sustainable and of high quality across the course of development.[110]

Child and adolescent CAAFAG survivors of sexual violence

Sexual violence can have a significant long-term psychosocial impact on CAAFAG, frequently causing severe stigmatization that affects survivors' experience of reintegration. Both female and male CAAFAG who have suffered sexual violence may experience anxiety, difficulty with mood regulation, aggression, difficulty sleeping, nocturnal enuresis and post-traumatic stress disorder (PTSD) or other mental health conditions and psychosocial problems, as well as challenges in forming trusting and loving relationships with future partners.[111]

The gendered suffering of female CAAFAG not involved in combat may not always be acknowledged, and this can limit understanding of the unique challenges they have faced in performing support roles. CAAFAG survivors of sexual violence are not always recognized as victims of armed groups and armed forces, but their experiences may be common and may start at a young age. For example, female CAAFAG who were involved with ISIL (Islamic State in Iraq and the Levant) were likely to have reported experiencing GBV. Although the majority of documented cases were those of girls aged between 12 and 16 years, some girls were forcibly married and held as sexual slaves from as young as nine.[112,113]

MHPSS interventions should take into consideration the stigma, discrimination and isolation that CAAFAG who have survived sexual violence may face, recognizing that it affects both girls and boys, but in most cases rates are extremely high among females.[114] Peer support groups and recreational activities may be helpful to promote mental health and psychosocial wellbeing, and providers should refer to the *IRC Caring for Child Survivors (CCS) of Sexual Abuse Guidelines* for practical approaches to helping child survivors of sexual violence, and their families, recover and heal.

See Annex 5 for further information on case management for child survivors of sexual violence.

See UNICEF GBViE Helpdesk Children Associated with Armed Forces and Armed Groups and GBViE Programming

See UNICEF's Minimum GBViE Response Package

Birth and young childhood in an armed force or armed group

Children born from conflict-related sexual violence and associated with an armed force or group are at risk of social, economic and political exclusion that can make reintegration seem like an insurmountable challenge.[115,116]

- Children born into the Lord's Resistance Army in Uganda who transitioned out of the group continue to face traumatic memories, significant stigma and violent abuse from stepfathers, and employ strategies to conceal their true identities as a form of self-protection.[117]

- Children in Iraq born to Yezidi girls and ISIS members are not recognized as Yezidis, making it almost impossible for them to be reintegrated into the Yezidi community upon release.

Children born into armed forces and armed groups are likely to find the process of reimagining their identity very challenging, as life with the armed force or armed group is all they have known. In this sense, reintegration involves "a reconstruction of the child's place and role in the social world".[118]

110 Weine, S., Brahmbatt, Z. Cardeli, E. & Ellis, H. (2020). 'Rapid Review to Inform the Rehabilitation and Reintegration of Child Returnees from the Islamic State'. *Annals of global health*, 86(1), 64. https://doi.org/10.5334/aogh.2835

111 UNICEF (2019). *MHPSS & Children Affected by Armed Conflict*.

112 Human Rights Council (2018). "I lost my dignity": Sexual and gender-based violence in the Syrian Arab Republic: Conference room paper of the Independent International Commission of Inquiry on the Syrian Arab Republic. https://www.ohchr.org/Documents/HRBodies/HRCouncil/CoISyria/A-HRC-37-CRP-3.pdf; Quilliam (2015). *Women of the Islamic State: A Manifesto on Women by the Al-Khanssaa Brigade*. London: Quilliam.

113 Quilliam (2015) *Women of the Islamic State: A Manifesto on Women by the Al-Khanssaa Brigade*.

114 Betancourt (2020). 'Stigma and Acceptance of Sierra Leone's Child Soldiers', *Journal of the American Academy of Child & Adolescent Psychiatry*, 59(6), 715–726.

115 Amone-P Olak, K., Ovuga, E. & Jones, P. B. (2015). 'The effects of sexual violence on psychosocial outcomes in formerly abducted girls in Northern Uganda: the WAYS study'. *BMC Psychology*, 3:46. https://doi.org/10.1186/s40359-015-0103-2.

116 Amone-P Olak, K., Lekhutlile, T.M., Ovuga, E., et al. (2016). 'Sexual violence and general functioning among formerly abducted girls in Northern Uganda: The mediating roles of stigma and community relations – the WAYS Study'. *BMC Public Health*, 16:64. https://doi.org/10.1186/s12889-016-2735-4.

117 Stewart, B. (2018). *'I Feel Out of Place': Children Born into the Lord's Resistance Army and the Politics of Belonging*. Vancouver: University of British Columbia.

118 Wessells, M. G. (2006). *Child soldiers: From violence to protection*. Harvard University Press.

Additional structurally vulnerable groups of children

The following include other children who may experience structural vulnerability, and may require specific MHPSS attention and approaches:

- CAAFAG who experienced combat, killing and/or injuring other people, or domestic violence are at higher risk of mental health and psychosocial problems.[119]

- CAAFAG living with disabilities have complex and varying experiences and many CAAFAG have been injured and disabled by explosive ordnance. In many cases, their voices and lived experiences are not yet being heard. Although there is little evidence on the mental health and psychosocial wellbeing of CAAFAG with disabilities, research with conflict-affected children with disabilities in Darfur found that access to school was limited, they had poorer psychological wellbeing than other children in conflict settings, and school was not an effective protective mechanism against anxiety and distress.[120]

- Children who are not directly associated with armed groups themselves but belong to families with perceived ties to armed groups, also suffer from stigma and reduced access to basic services (education, health and social services), face the risk of revenge and retaliation, and suffer exclusion from social activities.

- The children of former CAAFAG may be affected by parental post-traumatic stress and depressive symptoms, as well as stigma.[121]

Key consideration: Recruitment and mental health/psychosocial wellbeing during reintegration

Armed groups use a variety of recruitment methods in different contexts, including physical abduction or kidnapping, face-to-face and online recruitment, and financial and protection incentives. The factors that influence child involvement with armed groups – including those characterized or listed as engaging in terrorism or violent extremism – are numerous, multidimensional and different for each child.

From a child rights perspective, children cannot give informed consent to their association because they cannot fully comprehend the severe implications and dangerous consequences of joining an armed force or armed group.[122] However, local understandings of children's choice in recruitment processes vary: for example, 'forced' recruitment may involve abductions while 'voluntary' recruitment may involve incentives of food, shelter and relationships, or family, community or online indoctrination.[123] For example, during times when ongoing conflict in the Democratic Republic of Congo (DRC) is considered low level, virtually all children who join an armed group in the Kivus do so 'voluntarily', locally understood to mean of one's free well without force or coercion, but done within the context of constrained life chances or limited options.[124] These dynamics are important because the relationships between different forms of recruitment and mental health and psychosocial wellbeing among CAAFAG varies by role, gender, mental health outcome and context.

continued on next page

119 Okraku, O.O. & Yohani, S. (2020). 'Resilience in the Face of Adversity: a Focused Ethnography of Former Girl Child Soldiers Living in Ghana'. *Journal of International Migration and Integration*, 1–22.

120 *ESRC, Education and disability in a conflict affected context: Are children with disabilities less likely to learn and be protected in Darfur?* St Louis: Washington University.

121 Song, S. J., Tol, W. & De Jong, J. (2014). 'Indero: Intergenerational trauma and resilience between Burundian former child soldiers and their children'. *Family Process*, 53(2), 239–251.

122 D'Alessandra, F. (2014) *The Psychological Consequences of Becoming a Child Soldiers: Post-Traumatic Stress Disorder, Major Depression, and Other Forms of Impairment*. Cambridge MA: Harvard Kennedy School.

123 Kohrt, B.A., Yang, M., Rai, S., Bhardwaj, A., Tol, W.A. & Jordans, M.J.D. (2016). 'Recruitment of child soldiers in Nepal: Mental health status and risk factors for voluntary participation of youth in armed groups'. *Peace and Conflict: Journal of Peace Psychology*, 22(3), 208.

124 WarChild (2018). *Tug-of-War: Children in Armed Conflict in DRC*. https://www.warchild.org.uk/sites/default/files/link-files/tug-of-war_children_in_armed_groups_in_drc_english.pdf

Key consideration: Recruitment and mental health/psychosocial wellbeing during reintegration *continued*

Recruitment history, gender, role in the armed force/group, specific mental health outcome, duration in captivity and context are all important considerations in the planning and implementation of MHPSS interventions in CAAFAG programming.

a) The general trend in the research suggests that recruitment practices understood as 'forced' may be associated with some negative mental health outcomes and that gender may make a difference.

b) In Nepal, boys who were forcibly recruited showed higher scores of post-traumatic stress disorder (PTSD) symptoms than those who 'voluntarily' joined the armed group. And 'voluntary' recruitment among girls was not related to levels of PTSD, depression symptoms, or functional impairment at all.[125]

c) For a child who has been forcibly abducted into an armed group and survived, despite severe constraints to their agency, a newfound sense of self-efficacy during reintegration may be incredibly meaningful to them and therefore deeply connected to their wellbeing.

d) In the DRC context, voluntary recruitment among CAAFAG in combatant roles has previously been shown to be related to appetitive aggression (that is, positive feelings associated with the perpetration of violence). However, it was not possible to determine if appetitive aggression was already elevated among children before their voluntary recruitment or if they became more aggressive over time after joining the armed group.[126]

During the process of reintegration, former CAAFAG undergo an important period of reimagining their identity from that of association with an armed force or armed group, to that of a civilian living within a family and community. A child's own understanding and rationalisation of what has happened is key to their mental health and psychosocial wellbeing.[127] Reintegration programmes should facilitate MHPSS for children as well as their family and community members, focusing on constructive ways to cope with change and identifying new roles, rather than attempting to reconstitute family life as it was before. Reintegration activities should balance different interests and needs in order to provide children with meaningful options for reconstructing their role in society, and involve long-term follow-up with children, families and communities.[128]

Illustrative MHPSS interventions in reintegration programming

The following tables describe illustrative interventions for reintegration programming that respond to the MHPSS needs of children, families and caregivers across the social-ecological model. They are linked to the three intermediary outcomes, as shown in Figure 6 on page 40.

Reminder: Children, adolescents, and caregivers are affected in different ways by children's association with armed forces and armed groups and require different kinds of support. All layers of the MHPSS pyramid are important and should ideally be implemented concurrently. Though specialized MHPSS services in layer 4 of the pyramid (color-coded in yellow) appear at the top of the intervention tables, they are not necessarily the services that most CAAFAG will need.

125 Kohrt, B. A. et al. (Op Cit.)

126 Hermenau, K., Hecker, T., Maedl, A., Schauer, M. & Elbert, T. (2013). 'Growing up in armed groups: trauma and aggression among child soldiers in DR Congo. *European Journal of Psychotraumatology*, 4, 10.3402/ejpt.v4i0.21408.

127 UNICEF. *Brief Guidance & Resource Summary – Addressing the MHPSS needs of foreign children returnees in humanitarian contexts*.

128 UNODC (2019). Roadmap on the treatment of children associated with terrorist and other violent extremist groups. https://international-review.icrc.org/sites/default/files/reviews-pdf/2020-05/irrc_101_911_reduced_.pdf

Figure 6 Illustrative interventions for reintegration at child and adolescent level

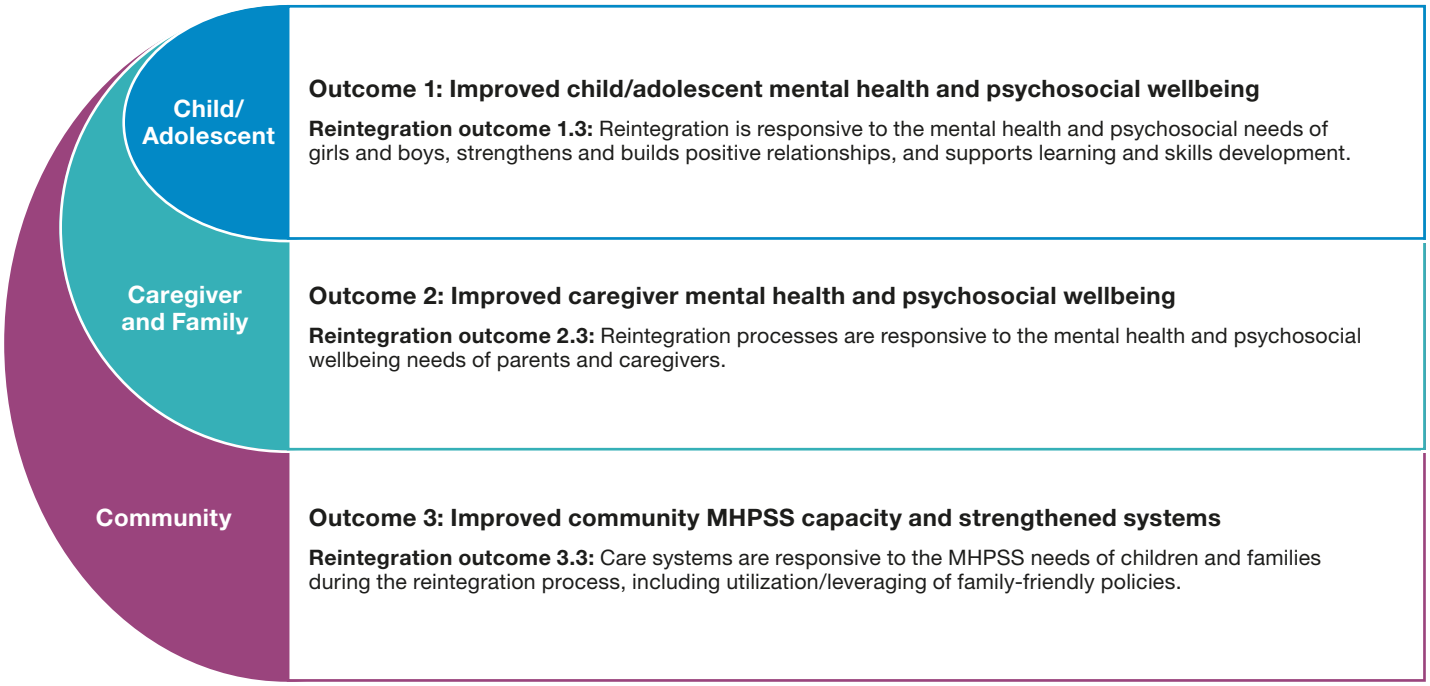

Table 12 Illustrative interventions for reintegration at child and adolescent level

Outcome 1	Improved child/adolescent mental health and psychosocial wellbeing
Intermediary outcome 1.3	Safe and supportive reintegration is responsive to the mental health and psychosocial needs of girls and boys, strengthens and builds positive relationships, and supports learning and skills development.
	CARE: Build capacity of specialized mental health service providers to identify and manage mental health and psychosocial conditions among reintegrating children and their caregivers.
MSP	**PREVENT**: Build and strengthen functional referral systems between specialized and community-based MHPSS services across sectors, including health, protection and education sectors.
MSP	**CARE**: Provide MHPSS to CAAFAG as part of clinical care for survivors of sexual violence and intimate partner violence.
MSP	**CARE**: Provide mental health care, psychosocial services and follow-up services to CAAFAG as part of general health services by primary health/general health practitioners trained in mhGAP and supervised.
MSP	**CARE**: Provide age- and gender-appropriate focused psychosocial interventions to CAAFAG experiencing distress, including focused individual and group support provided by trained and supervised non-specialized providers or by mental health clinicians.
MSP	**CARE**: Enable CAAFAG to safely access MHPSS through protection case management services.
MSP	**PROMOTE**: Provide early childhood development (ECD) activities to the children of CAAFAG.
MSP	**PROMOTE**: Provide group activities for CAAFAG to promote mental health and psychosocial wellbeing in schools and communities.

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Table 12 Illustrative interventions for reintegration at child and adolescent level *continued*

Outcome 1	Improved child/adolescent mental health and psychosocial wellbeing
Intermediary outcome 1.3	Safe and supportive reintegration is responsive to the mental health and psychosocial needs of girls and boys, strengthens and builds positive relationships, and supports learning and skills development.
	**PREVENT**: Provide community-level alternatives to detention that seek to restore children's safety and wellbeing.[129]
	**PROMOTE**: Include conflict-affected children in peacebuilding dialogues and processes at local, national and regional levels.
	**PROMOTE**: Promote inclusion and acceptance of CAAFAG, especially those doubly discriminated against based on specific experiences such as surviving sexual violence, living with disability, or being formerly associated with a group that attacked the community.
	**CARE**: Provide seamless appropriate psychosocial support to CAAFAG from prevention, to release and reintegration.
	**PREVENT**: Ensure MHPSS considerations are integrated throughout the reintegration process, across sectors.
	**PREVENT**: Provide CAAFAG with safe access to education and vocational skills training.
	**PREVENT**: Ensure the safety of CAAFAG at home, at school and in the community.
	**PREVENT**: Provide CAAFAG with safe access to livelihoods support as appropriate.

Resources
Relevant resources from the compendium
Strategies and Approaches Resource 2.25 Inspire to end violence against children: See Approaches, Counselling and therapeutic approaches, TF-CBT Helping Adolescents Thrive Toolkit: Strategy 4, Adolescent Psychosocial Interventions, including, group focused CBT & Trauma focused CBT **Guidelines** Resource 2.14 Guidelines for Child Friendly Spaces in Emergencies Resource 2.24 Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for teachers, parents, and children in conflict and post conflict areas. Resource 5.4 Mainstreaming psychosocial care and support through child participation Resource 6.7 Evaluation of Child Friendly Spaces: Tools and Guidance

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129 Alliance for Child Protection in Humanitarian Action (2019). Minimum Standards for Child Protection in Humanitarian Action. https://spherestandards.org/wp-content/uploads/CPMS-EN.pdf

Table 12 Illustrative interventions for reintegration at child and adolescent level *continued*

Resources
Relevant resources from the compendium
Programme Guidance Resource 1.7 REPSSI Mainstreaming Psychosocial Care and Support Services Resource 2.5 Move On & Engage Resource 2.6 Working with Children and Their Environment Resource 2.7 Children/Youth Resilience Programme Resource 2.10 A toolkit for Community-Based Psychosocial Support Children and Adolescents in South Sudan Resource 2.13 Toolkit for Child Friendly Spaces in Humanitarian Settings Resource 2.15 Safe Healing and Learning Spaces Resource 2.16 Psychosocial Support for Youth in Post-Conflict Situations Resource 2.20 IRC Parenting Skills Training Resource 2.29 Baby-Friendly Spaces (BFS): A Holistic Approach for Pregnant, Lactating Women Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.2 Broken Links: Psychosocial Support for People Separated from Family Members Resource 3.4 Psychological First Aid Training Manual for Child Practitioners Resource 3.6 Problem Management Plus (PM+): Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity mhGAP Humanitarian Intervention Guide mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings **Training** Resource 1.1 Six Orientation Seminars to Disseminate and Implement the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings Resource 2.12 Resource Training Package on Child-Friendly Spaces Resource 2.22 Psychosocial Training Manual for Teachers Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.3 Lay Counselling Trainer's Manual I Support My Friends: A training for children and adolescents on how to support friends in distress

Table 13 Illustrative interventions for reintegration at caregiver/family level

Outcome 2	Improved caregiver mental health and psychosocial wellbeing
Intermediary outcome 2.3	Reintegration processes are responsive to the mental health and wellbeing needs of parents and caregivers
	**CARE**: Ensure access to high-quality mental health care by trained mental health providers for caregivers and families of reintegrating CAAFAG (including CAAFAG who are themselves parents) and in need of specialized services (e.g., psychological or psychiatric treatment for mental health and psychosocial conditions).
	**CARE**: Provide MHPSS to caregivers of as part of clinical care for survivors of sexual violence and intimate partner violence.
	**CARE**: Provide MHPSS to caregivers of CAAFAG as part of general health services by primary health/general health practitioners trained in mhGAP and supervised.
	**CARE**: Initiate or strengthen the provision of psychological interventions for distressed caregivers of CAAFAG.
	**CARE**: Provide MHPSS to caregivers of CAAFAG in protection case management services.

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Table 13 Illustrative interventions for reintegration at caregiver/family level *continued*

Outcome 2	Improved caregiver mental health and psychosocial wellbeing
Intermediary outcome 2.3	Reintegration processes are responsive to the mental health and wellbeing needs of parents and caregivers
	**PROMOTE**: Support teachers of reintegrating CAAFAG to promote the mental health and psychosocial wellbeing of conflict-affected children, providing information about services, stress reactions and positive coping strategies.
	**PROMOTE**: Support caregivers of reintegrating CAAFAG to promote the mental health and psychosocial wellbeing of their children, with support groups and information about services, stress reactions and positive coping strategies.
	**PROMOTE**: Support caregivers of reintegrating CAAFAG with resilience-based parenting skills[130] and responsive infant caregiving skills through mother-baby interactions.
	**CARE**: Provide psychosocial support to caregivers/partners/families/friends before and during the reintegration of CAAFAG, including regular communal activities for parents/caregivers/family and children that include intergenerational supports for stressed parents.
	**PREVENT**: Alleviate stressors on families of reintegrating CAAFAG by enabling access to livelihoods opportunities, addressing stigma, and reducing food insecurity.[131]
	**PREVENT**: Ensure vulnerable children and families are included in provision of basic needs.
	**PROMOTE**: Promote family unity by avoiding separation of children and caregivers in all sectoral interventions.

Resources
Relevant resources from the compendium
Strategies and Approaches Resource 2.25 Inspire to end violence against children: Parent & Caregiver Support; Education and Life Skills Helping Adolescents Thrive Toolkit: Strategy 4, Adolescent Psychosocial Interventions, including, group focused CBT & Trauma focused CBT **Guidelines** Resource 2.24 Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for teachers, parents, and children in conflict and post conflict areas. Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children

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130 UNODC (2017). *Handbook on Children Recruited & Exploited by Terrorist & Violent Extremist Groups: The role of the justice system.*

131 CPMS (2019). *Minimum Standards for Child Protection in Humanitarian Action.*

Table 13 Illustrative interventions for reintegration at caregiver/family level *continued*

Resources
Relevant resources from the compendium
Programme Guidance Resource 1.7 REPSSI Mainstreaming Psychosocial Care and Support Services Resource 2.5 Working with Children and Their Environment Resource 2.7 Children/Youth Resilience Programme Resource 2.10 A toolkit for Community-Based Psychosocial Support Children and Adolescents in South Sudan Resource 2.15 Safe Healing and Learning Spaces Resource 2.16 Psychosocial Support for Youth in Post-Conflict Situations Resource 2.20 IRC Parenting Skills Training Resource 2.29 Baby Friendly Spaces (BFS): A Holistic Approach for Pregnant, Lactating Women Resource 2.35 Self-Help Booklet for Men Facing Crisis and Displacement Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.2 Broken Links: Psychosocial Support for People Separated from Family Members Resource 3.4 Psychological First Aid Training Manual for Child Practitioners Resource 3.6 Problem Management Plus (PM+): Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity mhGAP Humanitarian Intervention Guide mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings **Training** Resource 2.22 Psychosocial Training Manual for Teachers Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.3 Lay Counselling Trainer's Manual I Support My Friends: A training for children and adolescents on how to support friends in distress

Table 14 Illustrative interventions for reintegration at community level

Outcome 3	Improved community MHPSS capacity and strengthened system delivery for CAAFAG
Intermediary outcome 3.3	Care systems are responsive to the MHPSS needs of children and families during the reintegration process, including utilisation/leveraging of family-friendly policies
	**CARE**: Build capacity of specialized mental health service providers to identify and manage mental health and psychosocial conditions among reintegrating children and their caregivers.
	**PREVENT**: Build and strengthen functional referral systems between specialized and community-based MHPSS services across sectors, including health, protection and education.
	**CARE**: Support capacity building of clinical care providers for survivors of sexual violence and intimate partner violence to address MHPSS issues among CAAFAG and their families.
	**CARE**: Support capacity building of general health care system to provide safe, effective MHPSS services to CAAFAG and their families by primary health/general health practitioners trained in mhGAP and supervised.
	**CARE**: Support capacity building of community-based focused psychosocial intervention to provide safe, effective MHPSS services to CAAFAG.
	**CARE**: Support capacity building of case management systems to provide safe, effective basic psychosocial support services to CAAFAG and know how and when to refer.

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Table 14 Illustrative interventions for reintegration at community level *continued*

Outcome 3	Improved community MHPSS capacity and strengthened system delivery for CAAFAG
Intermediary outcome 3.3	Care systems are responsive to the MHPSS needs of children and families during the reintegration process, including utilisation/leveraging of family-friendly policies
	**PROMOTE**: Mobilize communities to disseminate key messages to promote mental health and psychosocial wellbeing among CAAFAG, such as information on children's stress reactions and coping strategies.
	**PROMOTE**: Support community-led MHPSS activities and social supports for caregivers of CAAFAG.
	**PROMOTE**: Support community-led activities and social supports to promote CAAFAG mental health, wellbeing and reintegration.
	**PROMOTE**: Support communities to engage female and male CAAFAG to safely participate in activities, such as mentoring and basic psychosocial support offered by former CAAFAG, to meet with peers and break social isolation.
	**PROMOTE**: Re-establish formal and non-formal education for reintegrating CAAFAG.
	**CARE**: Support to communities to re-establish safe rituals or cultural events (e.g., commemoration events to foster communal healing, cultural festivals or religious celebrations) along with traditional healers or leaders as appropriate.
	**PROMOTE**: Orient humanitarian actors and community members on MHPSS among CAAFAG and advocate for MHPSS considerations and actions to support CAAFAG reintegration.
	**CARE**: Orient frontline workers and community leaders in basic psychosocial support skills and knowledge of MHPSS issues among CAAFAG.
	**PROMOTE**: Engage communities in child rights-based awareness-raising and advocacy to support mental health and wellbeing among CAAFAG and mitigate stigma.
	**PREVENT**: Protect and care for CAAFAG in detention and other institutions.
	**PREVENT**: Mitigate risks of stigma or unintended psychosocial harm to CAAFAG in the delivery of material assistance.
	**PREVENT**: Ensure social considerations in basic needs are addressed and CAAFAG have access to adequate and appropriate basic services, education and livelihoods opportunities for successful reintegration and prevention/alleviation of mental and psychosocial distress.
	**PREVENT**: Establish MHPSS representation on multidisciplinary teams for responding to cases of child victims/witnesses of crime to ensure safe interviews and proceedings.

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Table 14 Illustrative interventions for reintegration at community level *continued*

Resources
Relevant resources from the compendium
Strategies and Approaches Resource 2.25 Inspire to end violence against children: *Parent & Caregiver Support; Education and Life Skills* HAT Toolkit **Guidelines** Resource 2.14 Guidelines for Child Friendly Spaces in Emergencies Resource 2.24 Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for teachers, parents, and children in conflict and post conflict areas. Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children Resource 5.1 MHPSS and Participation Guidance Resource 5.2 Engaged and Heard! Guidelines for Adolescent Participation and Civic Engagement Resource 5.4 Mainstreaming psychosocial care and support through child participation Resource 6.7 Evaluation of Child Friendly Spaces: Tools and Guidance **Programme Guidance** Resource 1.7 REPSSI Mainstreaming Psychosocial Care and Support Services Resource 2.5 Move On & Engage Resource 2.6 Working with Children and Their Environment Resource 2.7 Children/Youth Resilience Programme Resource 2.10 A toolkit for Community-Based Psychosocial Support Children and Adolescents in South Sudan Resource 2.13 Toolkit for Child Friendly Spaces in Humanitarian Settings Resource 2.15 Safe Healing and Learning Spaces Resource 2.16 Psychosocial Support for Youth in Post-Conflict Situations Resource 2.20 IRC Parenting Skills Training Resource 2.29 Baby Friendly Spaces (BFS): A Holistic Approach for Pregnant, Lactating Women Resource 2.35 Self-Help Booklet for Men Facing Crisis and Displacement Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.2 Broken Links: Psychosocial Support for People Separated from Family Members Resource 3.4 Psychological First Aid Training Manual for Child Practitioners Resource 3.6 Problem Management Plus (PM+): Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity mhGAP Humanitarian Intervention Guide mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings **Training** Resource 2.22 Psychosocial Training Manual for Teachers Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers Resource 3.3 Lay Counselling Trainer's Manual I Support My Friends: A training for children and adolescents on how to support friends in distress

Outcome and monitoring and evaluation guidance for MHPSS in CAAFAG programming

The outcomes for the *MHPSS in CAAFAG Operational Guidelines* link with programme design framework for the CAAFAG Programme Design Toolkit Guide. The three top-level MHPSS outcomes and nine intermediate outcomes all contribute to each corresponding CAAFAG programme objective – prevention of recruitment, and release or reintegration – reflecting the specific MHPSS changes expected by successful completion of each programme (see Table 15. Suggested outcomes for MHPSS for CAAFAG programming across social-ecological levels, and across prevention, release and reintegration programming). The log frame for the *MHPSS in CAAFAG Operational Guidelines* includes these outcomes along with corresponding indicators and suggested means of verification (MOV) (see Annex 1. Multi-agency Log frame for MHPSS for CAAFAG Operational Framework).

The outcomes of this multi-agency, multi-sector operational framework align with both the CAAFAG Programme Design Toolkit Guide and the *IASC Common Monitoring and Evaluation (M&E) Framework for MHPSS in Emergency Settings: With means of verification (Version 2.0)*, which provides a common goal and set of outcomes, indicators and guidance on means of verification for goal indicators as well as methods for data collection and contextualization.[132,133] The outcomes also align with UNICEF's Multisector MHPSS Log frame in the field demonstration version of the UNICEF Global Multi-sectoral Operational Framework for MHPSS of Children, Adolescents and Caregivers Across Settings.

This multi-agency MHPSS in CAAFAG programmes M&E guidance is organized in a simple way to allow individuals and organizations to use the IASC Common MHPSS M&E framework's overall goal and outcomes to complement their own CAAFAG M&E frameworks and project-specific designs.

Table 15 Suggested outcomes for MHPSS for CAAFAG programming across social-ecological levels, and across prevention, release and reintegration programming

Outcomes	1. Improved child/adolescent mental health and psychosocial wellbeing	2. Improved caregiver mental health and psychosocial wellbeing	3. Improved community MHPSS capacity and strengthened system delivery for CAAFAG
Prevention Intermediary outcomes	1.1 Children have access to safe and nurturing environments at home, at school and in the community and to high-quality services that improve their mental health and wellbeing, reducing their risk of recruitment by armed forces and armed groups	2.1 Parent and caregiver have access to mental health and coping that reinforces CAAFAG prevention efforts	3.1 Communities promote awareness of CAAFAG issues, the resulting mental health, wellbeing and protection needs of affected children, adolescents and their families that is rooted in a stigma-free environment
Release Intermediary Outcomes	1.2 Release processes are responsive to the mental health and psychosocial wellbeing needs of girls and boys	2.2 Release processes support CAAFAG caregiver mental health and psychosocial wellbeing and positive parenting	3.2 Release processes activate natural community supports and care systems to promote CAAFAG wellbeing
Reintegration Intermediary Outcomes	1.3 Reintegration processes are safe and responsive to the mental and psychosocial needs of girls and boys, they strengthen and build positive relationships, and support learning and skills development	2.3 Reintegration processes are responsive to the mental health and wellbeing needs of parents and caregivers	3.3 Communities are responsive to the MHPSS needs of children and families during the reintegration process, including utilisation/leveraging of family-friendly policies

132 IASC MHPSS RG (2021). *IASC Common Monitoring and Evaluation (M&E) Framework for MHPSS in Emergency Settings: With means of verification (Version 2.0).*

133 A current challenge for the MHPSS is the existing gap in metadata, including guidance on means of verification and data collection approaches, for outcome indicators in the common framework.

The common framework's overall goal is: Reduced suffering and improved mental health and psychosocial wellbeing. The common framework has identified five outcomes (see Figure 7, Summary of the Common Framework) that would likely contribute towards realization of the goal statement. These five outcomes can be further divided across the community-focused and person-focused levels at which MHPSS programmes are commonly implemented (see Figure 7, Summary of the Common Framework).

The common framework's six key goal impact indicators of reduced suffering and improved mental health and psychosocial wellbeing were selected through a rigorous inter-agency scoping and review process.[134] These key goal impact indicators are:

- **Functioning**: For example, the ability to carry out essential activities for daily living, which will differ according to factors such as culture, gender and age.
- **Subjective wellbeing**: Aspects of subjective wellbeing that could be measured include feeling calm, safe, strong, hopeful, capable, rested, interested or happy, and not feeling helpless, depressed, fearful or angry.
- Extent of prolonged **disabling distress and/or presence of mental, neurological or substance abuse (MNS) disorder** (or symptoms thereof).
- **Ability of people with mental health and psychosocial problems to cope** with problems (for example, through skills in communication, stress management, problem-solving, conflict management or vocational skills).
- **Social behaviour**: For example, helping others, aggressive behaviour, use of violence or discriminatory actions.
- **Social connectedness**: Referring to the quality and number of connections an individual has (or perceives themselves to have) with other people in their social circles of family, friends and acquaintances. Social connections may also go beyond one's immediate social circle and extend, for example, to other communities.

In addition, each of the five common framework outcomes is associated with multiple key outcome indicators presented on pages 20–22 of the *IASC Common Monitoring and Evaluation (M&E) Framework for MHPSS in Emergency Settings: With means of verification (Version 2.0)*.

The common framework is intended to be flexible. It is NOT expected that a CAAFAG programme will use every outcome or indicator from the MHPSS common framework. Nor is it expected that the recommended means of verification (MoV) will always be best suited for what needs to be measured in particular context.

Figure 7 Summary of the Common MHPSS M&E Framework

Goal: Reduced suffering and improved mental health and psychosocial well-being			
Outcomes:			
Community-focused	**1.** Emergency responses do not cause harm and are dignified, participatory, community-owned and socially and culturally acceptable	**2.** People are safe and protected, and human rights violations are addressed	**3.** Family, community and social structures promote the well-being and development of all their members
Person-focused	**4.** Communities and families support people with mental health and psychosocial problems	**5.** People with mental health and psychosocial problems use appropriate focused care	

134 Augustinavicius, J. L., Greene, M. C., Lakin, D. P., & Tol, W. A. (2018). Monitoring and evaluation of mental health and psychosocial support programs in humanitarian settings: a scoping review of terminology and focus. *Conflict and Health*, 12(1), 1–10.

Nonetheless, it is recommended that CAAFAG programmes include:

- at least ONE goal impact indicator from the MHPSS framework; plus,
- at least ONE recommended MoV related to that goal impact indicator; plus,
- at least ONE outcome indicator from the common framework.[135]

Ensure that all relevant monitoring and evaluation data is sex- and age-disaggregated with additional relevant gender-sensitive indicators that measure gender-related changes in society over time.[136]

Further detailed guidance on assessment, design, implementation, monitoring and evaluation, and research of MHPSS programmes applicable across emergency to development settings can be found in the *IASC Common M&E Framework for MHPSS in Emergency Settings: With means of verification (Version 2.0)*. The Alliance for Child Protection in Humanitarian Action (ACPHA) provides related guidance on contextualizing measurement tools for mental health and psychosocial wellbeing among children in the document, *Defining and Measuring Child Wellbeing in Humanitarian Action: A contextualization guide*.

Key competencies for MHPSS in CAAFAG programmes

Many people suffering from mental health conditions around the world do not receive adequate care, despite the high global prevalence of common mental disorders such as depression and anxiety. Studies among people living with major depression globally (across countries at all income levels) show that only one in five people in high-income countries and one in 27 in low- and lower-middle income countries receive minimally adequate treatment. This is partly due to a lack of trained mental health personnel, and social and case workers in mental health care. Further, given the existing stigma around seeking help for mental health issues and, in certain areas, lack of access to services or lack of trust in the formal health system, some people feel more comfortable seeking help from community members (leaders, traditional healers, other volunteers) that normalise their experience. Whereas this poses challenges to quality assurance in care, it has also proven to foster a wider service coverage where there is a lack of formal mental health professionals (e.g., many countries have only one or two psychiatrists per 100,000 people – or none, compared to a global average of 3.96). In these circumstances, task shifting and training non-specialists help to improve coverage of mental health services and broaden access to populations who previously were unable to access those resources, such as those in conflict areas. With adequate training and ongoing supervision of non-specialists on the knowledge, skills, attitudes and behaviours for a specific intervention, as well as regular assessment and follow-up, competencies can be developed, assessed and applied in effectively.

A competency is a measurable set of attributes, such as knowledge, skills, attitudes and behaviours that allow a person to adequately perform a given task within a specific field of work. Competencies can be assessed in different ways, through oral and written knowledge tests and assessments of attributes through exams or observation. This can include structured role plays that support non-specialists/helpers to demonstrate skills, while trainers and supervisors assess those skills using structured observation tools. Common competencies for the delivery of basic MHPSS prevention, promotion and care activities typically include skills that relate to developing warm, trustworthy relationships such as building rapport, using verbal and non-verbal communication skills, demonstrating empathy and genuineness, and effective multidisciplinary teamwork to improve outcomes.

The World Health Organization (WHO) and UNICEF have developed a project called Ensuring Quality in Psychological Support (EQUIP). It is a new online platform that provides a free, consensus-based workforce package to support stakeholders such as governments and humanitarian and development organizations in training and supervising their workforce to deliver effective MHPSS. EQUIP can be used with non-specialists and helpers across sectors (e.g., child protection, education, GBV and health). The workforce can comprise community workers, leaders, volunteers, traditional healers, lay personnel in health and care professions, case workers (including those working with children or at-risk groups in the legal realm), or other sectoral personnel that engage in MHPSS activities or protection work with adults, families and children. See the box on page 50 for brief FAQs on EQUIP.

135 Note that some of the six goal indicators can also serve as outcome indicators depending on the logic of the specific CAAFAG programme (theory of change).

136 UNICEF Regional Office for Europe and Central Asia (2019). *Gender Toolkit: Integrating Gender in Programming*.

Who, how, where and when EQUIP can be used[137]

- **Who can use EQUIP?** EQUIP is intended for trainers, supervisors and project managers implementing psychosocial support and psychological interventions.
- **How can EQUIP be used?** EQUIP can be used to improve implementation plans, competency assessments of trainees, and training and supervision curricula in common factors to accompany manualised interventions. Competency assessments may also be used to aid the selection of trainees and to guide institutional certification after achieving minimum skill targets.
- **Where can EQUIP be used?** EQUIP will be an online platform of resources with offline formats.
- **When can EQUIP be used?** To refine the platform and its materials, EQUIP is being developed using a human-centred design approach to enhance usability and engagement, and is being piloted in multiple countries. Materials are currently available in English, Arabic, French, Nepali and Spanish.

The EQUIP platform, with its easy-to-use training and assessment tools, aims to improve the competence of non-specialists, also called helpers, as well as the consistency and quality of training and service delivery. It has two main areas: an e-learning component and competency assessment tools.

EQUIP offers resources, tools and guidance to assess and improve essential MHPSS competences (e.g., foundational helping skills) as well as more specialized skills, to ensure that the helpers being trained achieve the skills to provide safe and effective care. It is not, however, a platform that provides knowledge tests for competencies or for formal psychological interventions. Rather, EQUIP supports trainers and supervisors to observe and assess trainee progress and suggest areas of improvement before they apply their skills and knowledge in real-world settings.

The EQUIP competency-based approach can help trainers and supervisors transform a typical training into an engaging and interactive learning experience where regular knowledge about a programme is enhanced with practical scenario simulation and practice. EQUIP users typically select the competency assessment tool of their choice and assess the respective competencies through brief role plays based on existing scripts. (Existing scripts are used for inter-rater reliability, providing the same scenario and interaction for all trainees.) The structured role plays resemble an interaction between a helper and a person using the service.

The EQUIP platform is easy to use and works online as well as offline, giving the option to visualize assessment results per trainee and per competency. This allows trainers and supervisors to give tailored feedback on trainee strengths, potentially harmful behaviours and ways to improve performance, as well as to adapt training and supervision plans to ensure that high-quality service is provided consistently.

EQUIP tools rate skill levels for each set of competencies assessed on the following scale:

Level 1 - Risk of Harm

Level 2 - Basic Helping Skills (Any or None)

Level 3 - Basic Helping Skills (All)

Level 4 - Advanced Helping Skills

EQUIP is evidence based (based on the review of 16 evidence-supported manuals for scalable psychological interventions delivered by non-specialists in low- and middle-income countries), is field tested and can be used across a range of cultural settings. See Table 16 on page 51 for specific sets of competency assessment tools and related skills.

137 Kohrt, B. A., Schafer, A., Willhoite, A., Van't Hof, E., Pedersen, G. A., Watts, S., Ottman, K., Carswell, K. & van Ommeren, M. (2020). 'Ensuring Quality in Psychological Support (WHO EQUIP): developing a competent global workforce'. *World Psychiatry*, 19 (1).

Table 16 Competency assessment tools and skills

Competency assessment tool	Skills assessed
ENACT (foundational helping skills for working with adults)	Non-verbal communication Verbal communication Explain and promote confidentiality Rapport building and self-disclosure Exploration and normalization of feelings Demonstrate empathy, warmth & genuineness Assessment of harm and developing response plan Connect to social functioning and impact on life Explore client's explanation for problem Involvement of family and significant others Collaborative goal setting Promote realistic hope for change Incorporate coping mechanisms and prior solutions Psychoeducation with local terminology Eliciting of feedback
WeACT (foundational helping skills for working with children and adolescents)	Non-verbal communication Verbal communication (active listening) Rapport and (ongoing) relationship building Empathy, warmth and genuineness Supporting the reframing of the child's thoughts and feelings (puts a new positive frame) Manages and facilitates group work effectively (group management skills) Ensures children's meaningful participation Behaviour management – demonstrates behaviour management skills Problem solving – applies problem solving techniques for the child's problem Ability to identify and understand child's needs Safe identification of child abuse, exploitation, neglect, violence and self-harm Ability to be inclusive Giving, eliciting and receiving feedback
GroupACT (skills for facilitating groups)	Group guidelines and/or ground rules Group participation Fostering empathy among group members Collaborative problem solving Addressing logistical barriers to participation Group confidentiality Time management: appropriate breaks, energizers, and pacing
Treatment and intervention-specific skills (such as problem management, interpersonal, cognitive-behavioural and trauma-focused care techniques)	See EQUIP platform

Table 17 outlines key competency criteria recommended for MHPSS in CAAFAG programme staff and volunteers, in alignment with staffing considerations for each layer of the MHPSS Intervention Pyramid.

In addition,

- Any staff in 'helper' roles for delivering scalable interventions to CAAFAG and children at risk of (re-)recruitment or their caregivers should attain Level 3 for the corresponding competencies, and a Level 3 in ENACT, WeACT, or GroupACT as applicable;
- Any staff/volunteers in 'supervisor' roles for delivering scalable interventions to CAAFAG and children at risk of (re-)recruitment or their caregivers should attain Level 4 of the corresponding competencies, and a Level 4 in ENACT, WeACT or GroupACT as applicable.

The *CPHA Competency framework*, particularly the competencies on *Preventing and responding to psychosocial distress and promoting mental health*, can be optionally used as supplement to EQUIP for MHPSS in CAAFAG competency assessment.

Table 17 Suggested competency assessment tools for MHPSS in CAAFAG roles/activities

Pyramid layer	MHPSS staff and volunteer roles/activities	Competency assessment tool
4 3 2 1	Any staff in helping roles engaging directly with children	WeAct Level 4
	Any staff in helping roles engaging directly with adults	ENACT Level 3
	Any staff in helping roles engaging or facilitating groups	GroupACT Level 2
4	Providers of MHPSS to CAAFAG and children at risk of (re-)recruitment	WeACT Level 4
	Providers of MHPSS to caregivers of CAAFAG and children at risk of (re-)recruitment	ENACT Level 4
3	Providers of MHPSS to CAAFAG and children at risk of (re-)recruitment	WeACT Level 3-4 GroupACT Level 3 (as relevant)
	Providers of MHPSS to caregivers of CAAFAG and children at risk of (re-)recruitment	ENACT Level 4 GroupACT Level 3 (as relevant)
2	Providers, supporters and mobilizers of MHPSS, ECD, social cohesion and other activities that engage children	WeACT Level 4 GroupACT Level 2 (as relevant)
	Supporters and mobilizers of MHPSS and other activities that engage adults	ENACT Level 2 GroupACT Level 2 (as relevant)
1	Any staff in helping roles engaging directly with children	WeAct Level 4
	Any staff in helping roles engaging directly with adults	ENACT Level 2
	Any staff in helping roles engaging facilitating group.	GroupACT Level 2

MHPSS training and supervision

MHPSS service delivery carried out by CP, MHPSS, GBV, education and other cross-sectoral staff working collaboratively in MHPSS in CAAFAG programming should be accompanied by a strategy for capacity building and include systems for training and supervision.[138] An MHPSS capacity-building plan should include:

- Assessment of MHPSS competencies among multisectoral CAAFAG programme staff and local partners, including government staff, who will be on the frontlines of delivering prevention, promotion and care interventions and activities;
- An inventory of all the MHPSS interventions across all the domains of the CAAFAG programme in the specific context, along with a specification of the MHPSS competency sets and levels needed for staff to safely deliver them;
- Identification of existing curricula, training, and supervision materials and resources required for staff training for each MHPSS interventions, with an assessment of language translation needs;
- Identification of MHPSS trainers and supervisors with the appropriate competencies and skill in:
  - Competency-oriented training
  - Adult learning pedagogies
  - MHPSS interventions and activities, including mapping, assessment, monitoring and evaluation
  - Setting clear expectations about what trainees can do and also what they cannot do independently, including which activities should be done only under supervision and when referral needs to take place;
- A timeline for conducting the training, refresher sessions and supervision sessions that aligns with the timelines for delivering safe and high-quality MHPSS interventions;
- Coordination for functional integration with other CAAFAG programme training activities as well as relevant general curricula for health workers, teachers, social workers, police and peacebuilders.
- An MHPSS supervision plan that includes:
  - Attention to MHPSS skills and self-care/stress management (see Annex 7 Self-care and staff care resources)
  - Links to other supervision activities, or where possible, full integration of MHPSS supervision within existing supervision structures or schedules (e.g., child protection and GBV case management supervision, primary health care provider/nurse supervision, teacher mentoring)
  - Supervision of community outreach workers and helpers.

Resources

- UNICEF Mental Health and Psychosocial Support Virtual Training
- WHO EQUIP eLearning modules for Delivering Remote Services
- IOM (2021) Manual on Community-based Mental Health and Psychosocial Support in Emergencies and Displacement Chapter 15 Technical Supervision and Training
- Training resources at the Mental Health Innovation Network
- The Psychosocial Support Training Programme, SEED Foundation and Centre for MHPSS Services at Koya University, Kurdistan, Iraq

138 UNHCR (2013). *Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations*.

Annex 1. Multi-agency Log Frame for MHPSS for CAAFAG Operational Framework

This log frame includes the three outcomes of the MHPSS in CAAFAG Programmes framework, along with their intermediary outcomes, aligned with the CAAFAG Programme Design Toolkit Guide. The log frame also includes corresponding suggested goal impact indicators (**Gi**) and/or outcome indicators (**O**) aligned with the IASC Common M&E Framework for MHPSS in Emergency Settings: With means of verification (Version 2.0).

Description	Indicators	Means of Verification (MoV)
Outcome 1. Improved child/adolescent mental health and psychosocial wellbeing	Select at least one: • **Gi.1** Functioning • **Gi.2** Subjective well-being • **Gi.3** Disabling distress/symptoms • **Gi.4** Coping • **Gi.5** Social behaviour • **Gi.6** Social connectedness	See IASC M&E Framework for MoV & guidance specific to measuring changes in mental health and psychosocial wellbeing for ages 0–5 years, 6–11 years, and 12–17 years
Intermediary Outcome 1.1 Children have access to safe and nurturing environments at home, at school and in the community and to high-quality services that improve their mental health and wellbeing, reducing their risk of recruitment by armed forces and armed groups	Select at least one: • **O3.11**. Number of children with opportunities to engage in learning developmentally appropriate socio-emotional skills. • **O5.6**. Number of people per at-risk group (for example, unaccompanied or separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or clinical management of mental health conditions. • **O2.6**. Percentage of target group members (such as the general population or at-risk groups) who feel safe i) at home, ii) school, and iii) in the community. • **O3.9**. Number of affected people who use different formal and informal social structures (such as schools or informal education for children of all ages, health care, social services, early child development programmes, women's groups and youth clubs).	• See IASC M&E Framework for MoV & guidance specific to Table 2. Summary of Qualitative MOV Approaches and Example Methods including focus group discussions (FGDs) and key informant interviews (KIIs) with: i) children, ii) family/caregivers • Child, adolescent, parents, caregiver, and community KAP/ other surveys disaggregated for age, gender, diversity • Programme activity records

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Description	Indicators	Means of Verification (MoV)
Intermediary Outcome 1.2 Release processes are responsive to the mental health and psychosocial wellbeing needs of girls and boys	Select at least one: • **O1.1**. Percentage of affected people who report that emergency responses (i) fit with local values, (ii) are appropriate and (iii) are provided respectfully. • **O1.8**. Perceptions of needs addressed (that is, needs perceived as serious problems by affected people themselves, such as perceived problems with shelter or livelihoods). • **O2.6**. Percentage of target group members (such as the general population or at-risk groups) who feel safe. • **O2.8**. Number of people who have reported human rights violations and their perceptions about the responses of institutions addressing their case. • **O4.1**. Number of people with mental health and psychosocial problems who report receiving adequate support from family members.	• See IASC M&E Framework for MoV & guidance specific to Table 2. Summary of Qualitative MOV Approaches and Example Methods including focus group discussions (FGDs) and key informant interviews (KIIs) with: i) children, ii) family/caregivers • Child, adolescent, parents, caregiver, and community KAP/ other surveys disaggregated for age, gender, diversity • Programme activity records
Intermediary Outcome 1.3 Reintegration processes are safe and responsive to the mental and psychosocial needs of girls and boys, they strengthen and build positive relationships, and support learning and skills development	Select at least one: • **O1.1**. Percentage of affected people who report that emergency responses (i) fit with local values, (ii) are appropriate and (iii) are provided respectfully. • **O1.8**. Perceptions of needs addressed (that is, needs perceived as serious problems by affected people themselves, such as perceived problems with shelter or livelihoods). • **O2.6**. Percentage of target group members (such as the general population or at-risk groups) who feel safe i) at home, ii) school, and iii) in the community. • **O3.1**. Number of children reunified with family members or who are in other appropriate care arrangements according to their specific needs and best interests. • **O3.3**. Quality of caregiver–child interactions. • **O3.8**. Percentage of formal and informal social structures that include specific mental health and psychosocial activities or supports. • **O3.11**. Number of children with opportunities to engage in learning developmentally appropriate socio-emotional skills. • **O4.1**. Number of people with mental health and psychosocial problems who report receiving adequate support from family members. • **O3.9**. Number of affected people who use different formal and informal social structures (such as schools or informal education for children of all ages, health care, social services, early child development programmes, women's groups and youth clubs).	

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Description	Indicators	Means of Verification (MoV)
Outcome 2. Improved caregiver mental health and psychosocial wellbeing	Select at least one: • **Gi.1** Functioning • **Gi.2** Subjective well-being • **Gi.3** Disabling distress/symptoms • **Gi.4** Coping • **Gi.5** Social behaviour • **Gi.6** Social connectedness	See IASC M&E Framework for MoV & guidance specific to measuring changes in mental health and psychosocial wellbeing for relevant ages 12–17 years, 18–24 years, 25–59 years, 60+ years
Intermediary Outcome 2.1 Parent and caregiver have access to mental health and coping that reinforces CAAFAG prevention efforts	Select at least one: • **O3.2**. Extent of parenting and child development knowledge and skills among caregivers. • **O3.3**. Quality of caregiver–child interactions. • **O3.4**. Level of family connectedness or cohesion. • **O3.10**. Number of people in at-risk groups engaged in livelihood opportunities. • **4.2**. Abilities of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information and resources needed to access care). • **O5.6**. Number of people per at-risk group (for example, unaccompanied or separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or clinical management of mental health conditions. • Percentage of parents and caregivers participating in community or citizenship activities.	• See IASC M&E Framework for MoV & guidance specific to Table 2. Summary of Qualitative MOV Approaches and Example Methods including focus group discussions (FGDs) and key informant interviews (KIIs) with: i) children, ii) family/caregivers • Child, adolescent, parents, caregiver, and community KAP/ other surveys disaggregated for age, gender, diversity • Programme activity records
Intermediary Outcome 2.2 Release processes support CAAFAG caregiver mental health and psychosocial wellbeing and positive parenting	Select at least one: • **O3.2**. Extent of parenting and child development knowledge and skills among caregivers. • **O3.3**. Quality of caregiver–child interactions. • **O3.6**. Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development • **O3.10**. Number of people in at-risk groups engaged in livelihood opportunities. • **O4.2**. Abilities of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information and resources needed to access care).	

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Description	Indicators	Means of Verification (MoV)
Intermediary Outcome 2.3 Reintegration processes are responsive to the mental health and wellbeing needs of parents and caregivers	Select at least one: • **O3.6**. Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development. • **O3.10**. Number of people in at-risk groups engaged in livelihood opportunities • **O4.2**. Abilities of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information and resources needed to access care). • **O5.6**. Number of people per at-risk group (for example, unaccompanied or separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or clinical management of mental health conditions. • Percentage of parents and caregivers participating in community or citizenship activities.	• See IASC M&E Framework for MoV & guidance specific to Table 2. Summary of Qualitative MOV Approaches and Example Methods including focus group discussions (FGDs) and key informant interviews (KIIs) with: i) children, ii) family/caregivers • Child, adolescent, parents, caregiver, and community KAP/ other surveys disaggregated for age, gender, diversity • Programme activity records
Outcome 3. Improved community MHPSS capacity and strengthened system delivery for CAAFAG	Select at least one: • **O1.3**. Percentage of target communities where local people have been enabled to design, organise and implement emergency responses themselves. • **O1.6**. Number of affected people who know codes of conduct for humanitarian workers and how to raise concerns about violations. • **O5.1**. Percentages of medical facilities, social services facilities and community programmes that have staff trained to identify mental health conditions and to support people with mental health and psychosocial problems. • **O5.2**. Percentages of medical facilities, social services facilities and community programmes that have staff receiving supervision to identify mental health conditions and to support people with mental health and psychosocial problems. • **O5.3**. Percentages of medical facilities, social services facilities and community programmes that have and apply procedures for referral of people with mental health and psychosocial problems. • **O5.7**. Percentage of available focused MHPSS programmes that offer evidence-based care relevant to the culture, context and age of target group.	• See IASC M&E Framework for MoV & guidance specific to Table 2. Summary of Qualitative MOV Approaches and Example Methods including focus group discussions (FGDs) and key informant interviews (KIIs) with: i) children, ii) family/caregivers • Child, adolescent, parents, caregiver, and community KAP/ other surveys disaggregated for age, gender, diversity • Programme activity records

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Description	Indicators	Means of Verification (MoV)
Intermediary Outcome 3.1 Communities promote awareness of CAAFAG issues, the resulting mental health, wellbeing and protection needs of affected children, adolescents and their families that is rooted in a stigma-free environment	Select at least one: • **O1.1**. Percentage of affected people who report that emergency responses (i) fit with local values, (ii) are appropriate and (iii) are provided respectfully. • **O1.5**. Number of negative events perceived by beneficiaries to be caused by humanitarian and/or MHPSS interventions. • **O1.9**. Percentage of affected people who report receiving accessible information in a timely manner about (i) the emergency, (ii) the emergency response and (iii) self-help approaches for positive coping/ well-being. • **O2.1**. Number of reported human rights violations. • **O2.2**. Percentage of target communities (that is, villages, neighbourhoods or institutions, such as mental hospitals or orphanages) with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (for example, children, women, people with severe mental disorders. • **O2.3**. Percentage of target communities where representatives of target groups are included in decision-making processes on their safety. • **O4.4**. Perceptions, knowledge, attitudes (including stigma) and behaviours of community members, families and/or service providers towards people with mental health and psychosocial problems.	• See IASC M&E Framework for MoV & guidance specific to Table 2. Summary of Qualitative MOV Approaches and Example Methods including focus group discussions (FGDs) and key informant interviews (KIIs) with: i) children, ii) family/caregivers • Child, adolescent, parents, caregiver, and community KAP/ other surveys disaggregated for age, gender, diversity • Programme activity records
Intermediary Outcome 3.2 Release processes activate natural community supports and care systems to promote CAAFAG wellbeing	Select at least one: • **O2.5**. Number of members of at-risk groups (such as children or survivors of sexual violence) who use safe spaces. • **O3.5**. Level of social capital, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil or community groups). • **O3.6**. Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development. • **O3.8**. Percentage of formal and informal social structures that include specific mental health and psychosocial activities or support. • **O3.9**. Number of affected people who use different formal and informal social structures (such as schools or informal education for children of all ages, health care, social services, early child development programmes, women's groups and youth clubs.	

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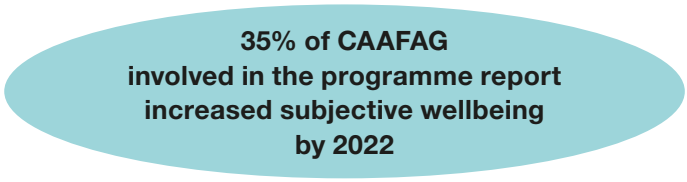
Description	Indicators	Means of Verification (MoV)
Intermediary Outcome 3.3 Communities are responsive to the MHPSS needs of children and families during the reintegration process, including utilisation/ leveraging of family-friendly policies	Select at least one: • **O1.7**. Programmatic changes made after comments were filed through feedback mechanisms. • **O1.8**. Perceptions of needs addressed (that is, needs perceived as serious problems by affected people themselves, such as perceived problems with shelter or livelihoods. • **O2.4**. Percentage of target group members who, after training, use new skills and knowledge for prevention of risks and referral. • **O2.6**. Percentage of target group members (such as the general population or at-risk groups) who feel safe. • **O3.1**. Number of children reunified with family members or who are in other appropriate care arrangements according to their specific needs and best interests. • **O3.4**. Level of family connectedness or cohesion. • **O3.6**. Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development • **O3.8**. Percentage of formal and informal social structures that include specific mental health and psychosocial activities or support • **O3.9**. Number of affected people who use different formal and informal social structures (such as schools or informal education for children of all ages, health care, social services, early child development programmes, women's groups and youth clubs • **O5.6**. Number of people per at-risk group (for example, unaccompanied or separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or clinical management of mental health conditions. • **O5.8**. Level of satisfaction of people with mental health and psychosocial problems and/or their families regarding the care they received.	• See IASC M&E Framework for MoV & guidance specific to Table 2. Summary of Qualitative MOV Approaches and Example Methods including focus group discussions (FGDs) and key informant interviews (KIIs) with: i) children, ii) family/caregivers • Child, adolescent, parents, caregiver, and community KAP/ other surveys disaggregated for age, gender, diversity • Programme activity records

SMART indicators that are Specific, Measurable, Achievable, Realistic, and Time-Phased can be further developed for outcomes specific to a particular programme context. Figure 8 shows an example of a SMART indicator using one selected from the IASC Common M&E Framework goal indicators to illustrate how they might be embedded into wider, organization-specific programme design.

Figure 8 Example of SMART MHPSS in CAAFAG programmes indicator



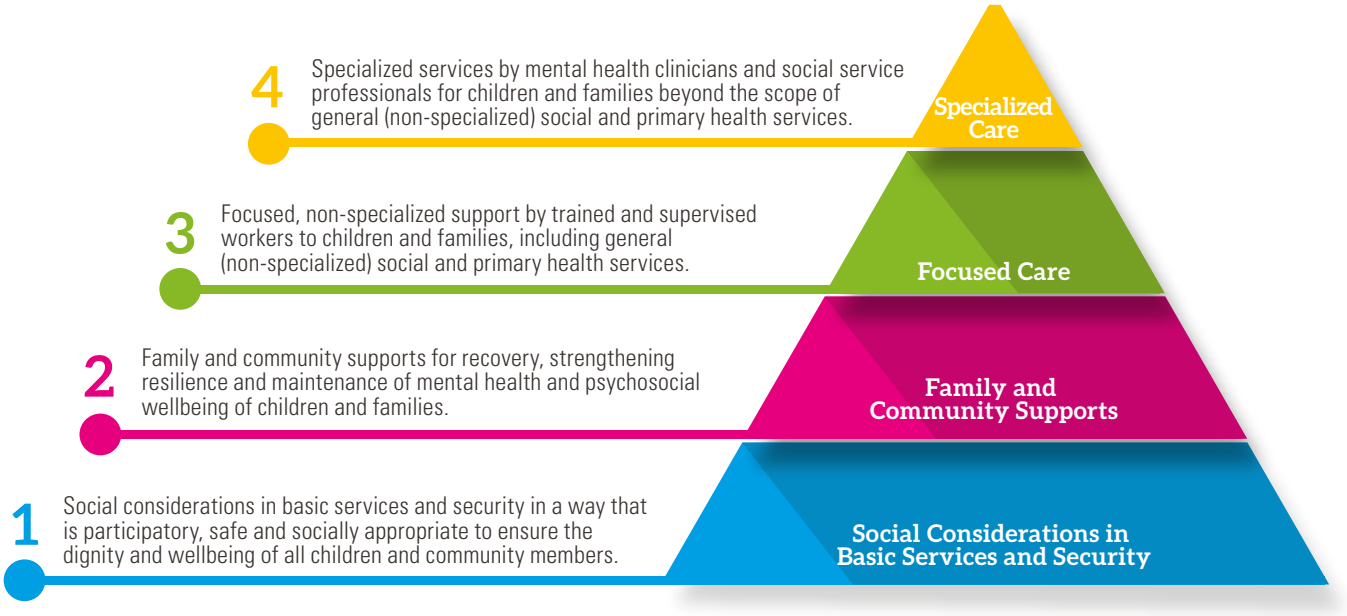
Annex 2. Core principles of the IASC Guidelines for MHPSS in emergencies[139]

Human rights and equity	Promote human rights of all affected persons and protect those at heightened risk of human rights violations; ensure equity and non-discrimination in the availability and accessibility of MHPSS supports.
Participation	Maximize the participation of local children, families and communities in assessment, design, implementation and monitoring and evaluation of humanitarian response.
Do no harm	Reduce the potential for MHPSS and other humanitarian interventions to cause harm, through, for example, effective coordination, adequate understanding of the local context and power relationships, cultural sensitivity and competence, and participatory approaches.
Build on local capacities and resources	Support self-help and identify, mobilize and strengthen existing resources, skills and capacities of children, families, the community, government and civil society.
Integrated support systems	Support activities integrated into wider systems (e.g., community supports, formal/non-formal school systems, health and social services) to advance the reach and sustainability of interventions and reduce the stigma of stand-alone interventions.
Multi-layer supports	Develop a multi-layer system of complementary supports to meet the needs of children and families affected in different ways

139 IASC (2007). *Guidelines for mental health and psychosocial support in emergency settings*. Geneva: Inter-Agency Standing Committee

Annex 3. IASC MHPSS Intervention Pyramid[140]

Figure 9 IASC Intervention Pyramid: from IASC Guidelines for MHPSS in Emergencies



The first layer, **social considerations**, is the broadest. It represents the foundations of wellbeing for all people affected by crisis events. It ensures that basic services and security are delivered in ways that are participatory, safe and culturally appropriate.

In the second layer, **family and community supports**, many people also benefit from strengthening supports and protective functions for family and community resilience.

The third layer, **focused care**, includes person-to-person support for distress, to address protection risks, or to maintain or enhance mental health and psychosocial wellbeing. It is provided by trained and supervised lay or non-specialized workers.

The fourth layer, **specialized services**, consists of professional care for people who have complex protection needs or for assessment and management of mental, neurologic and substance abuse (MNS) disorders. Delivered by mental health clinicians or social service professionals, specialized services are provided for children and families whose care and protection cannot be managed at lower layers of the pyramid.

Taken together, these multiple layers comprise **prevention** of mental health and psychosocial problems, **promotion** of mental and psychosocial wellbeing, and appropriate focused **care** for children, caregivers, families and communities experiencing mental health and psychosocial difficulties.

140 IASC (2007). *Guidelines for mental health and psychosocial support in emergency settings*. Geneva: Inter-Agency Standing Committee

Annex 4. Psychosocial aspects in Paris Principles and Guidelines on CAAFAG

The Paris Principles and Guidelines on Children Associated with Armed Forces and Armed Groups (2007) are a set of voluntary political commitments on international minimum standards for effective, credible national human rights institutions that over 100 governments worldwide have signed onto.[141] The Paris Principles lay out detailed guidelines for protecting children from recruitment and for providing assistance to those already involved with armed groups or forces. These guidelines include a section on psychosocial aspects:

7.73 Psychosocial support should be incorporated into the release process at the earliest stages and into all stages of reintegration programming to assist children, families and communities in developing and building their strengths and resilience and involving them actively in their own recovery. Encouraging and facilitating children's active participation in developing responsive and sensitive activities and programmes is central to reducing their vulnerability and increasing their resilience.

7.74 Psychosocial support should focus on identifying and addressing any obstacles to the ability to develop an appropriate social role and engage in culturally expected social relationships.

7.75 Agencies and donors concerned with programming for the release and reintegration of children associated with armed forces or armed groups should make use of the Inter-Agency Standing Committee's Guidance on Psychosocial Support. The following principles should inform approaches to psychosocial support:

- 7.75.0 The development of strong networks of peer support through youth groups or other community-based programmes such as girls' clubs can allow young people to work together to solve problems, develop social competencies appropriate to civilian life and define their roles and responsibilities in their community;
- 7.75.1 Culturally appropriate approaches to assisting children with emotional and behavioural problems should be identified and assessed. Programmes should include recreational activities in order to promote development and wellbeing, enable recovery, and replace the military mentality with the community spirit needed to rebuild communities and support reconciliation;
- 7.75.2 It should not be assumed that all children associated with an armed force or armed group are traumatised – practical concerns such as identifying education or livelihood opportunities may be the priority for many children;
- 7.75.3 Referral support should be available for children who have been severely affected. Actors should avoid assumptions about which children may be most affected and which sets of violations will result in children becoming severely affected;
- 7.75.4 The provision of a safe and supportive environment where children are kept fully informed about what is going to happen and where health and other basic needs can be met is fundamental to psychosocial wellbeing;
- 7.75.5 Children should be allowed the opportunity to talk individually or in a group about their future or about past experiences, if they wish to do so. There should not be an expectation that children have to 'open up' and counselling should not be forced on them. Most children benefit from a sensitive combination of traditional approaches and opportunities for supportive conversations;
- 7.75.6 Programmes should acknowledge that girls' and boys' experiences may be very different and that their psychosocial needs will reflect their differential experiences;
- 7.75.7 Programmes should acknowledge that children's experiences will vary according to their age and level of responsibilities within the armed force or armed group and that this will have an impact on their psychosocial needs.

7.76 Trained staff members should be available to provide psychosocial assistance to children who have been subjected to sexual violence. Such violations are likely to have a profound and long-lasting impact on their capacities for social relations and reintegration into the community.

141 The Paris Principles and Guidelines on Children Associated with Armed Forces and Armed Groups, 2.8, February 2007, https://www.unicef.org/emerg/files/ParisPrinciples310107_English.pdf

Annex 5. Case management to support child survivors of sexual violence[142]

Both GBV and child protection services can support child survivors of sexual violence if they have the necessary competencies and appropriate organizational procedures are in place. It is good practice to establish inter-agency standard operating procedures (SOPs) that lay out roles and responsibilities for providing case management to child survivors based on capacities and expertise.

A child should have only one case worker at any one time, and the case worker should coordinate with other providers as needed to ensure that the child does not have to endure duplicative assessments or assessment questions. A range of factors should be considered when determining the most appropriate service provider for any given child, including the child's wishes; the availability, training, and competencies of staff; existing referral pathways and local agreements; and the service to which the child/adolescent was first referred. Caseworkers and others working with survivors should seek further support from technical experts and supervisors with relevant expertise.

Children should have a choice about what services they receive and from whom, recognizing that child survivors are not a homogeneous group. For example, adolescent girls may feel more comfortable accessing services through women- and girl-focused GBV services and spaces, while adolescent boys may prefer to access support through protection or health services. For operational guidance on how child protection and GBV actors can collaborate to support child survivors, see UNHCR (2021) UNHCR Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child. p. 98.

142 The Mental Health and Psychosocial Support Minimum Services Package https://mhpssmsp.org/en

Annex 6. Example MHPSS approaches

The following presents examples of MHPSS approaches that can be used in programming across the CAAFAG MHPSS framework, based on evidence where available.

Approaches	Description
Collective, peer-to-peer approaches	The power of collective and peer-to-peer approaches can be significant for improving a sense of belonging and support among CAAFAG, and has been highlighted in multiple studies as a promising practice for psychosocial recovery among girls.[143] Those studies highlight the following (although framed for girls in this study, consider also implementing such approaches for boys): • Encouraging girls to meet other girls with similar experiences and form a support network in their community; • Setting up collective support mechanisms where girls can bond with each other to enhance their sense of belonging and collective identity; • Peer-to-peer support and mentoring from older girls or ex-CAAFAG; • Organizing activities for other girls.
Approaches to build caregiver capacity and skills	Interventions that strengthen the capacity of parents and caregivers can provide the support and nurturing children need to thrive.[144] It has also been found that programmes that help caregivers teach their children skills, such as emotional regulation, problem solving and social skills, can help children build resilience.[145] Parenting skills programmes, adapted to the needs of CAAFAG, can improve family acceptance. One programme designed for girls advises inclusion of sessions such as communication skills, empathy, psychoeducation on adolescent brain development and psychosocial needs of girls, how to positively support adolescent girls' decision making and an understanding of their experience of association with armed forces and armed groups.
MHPSS training and supervision for case management	A case management approach can contribute to the coordination of MHPSS services by one focal point (the caseworker) for the child, the family and the service providers, increase confidentiality and reduce the risk of the girl or boy experiencing potentially traumatic events from the way the service is provided. Caseworkers can support the wellbeing and resilience of girls and boys, building on strengths, including any skills they gained before and during the period of association, their individual and collective agency, and the coping skills they developed. MHPSS training and supervision must be in place for any staff member providing full child protection or GBV case management services to CAAFAG. Caseworkers should have a supervision mechanism to support their work with CAAFAG, including the handling of emotionally and ethically challenging issues. A comprehensive long-term (but flexible) reintegration plan should be developed for each child that includes clear objectives and sound indicators of progress, and should identify the different MHPSS services that best respond to the needs and specific circumstances of the child. Case managers must be trained in MHPSS skills such as psychological first aid, active listening, problem solving, basic psychological support, advocacy on behalf of their clients, referrals, strength-based approaches, and accompaniment of at-risk persons.

143 Child Protection Alliance in Humanitarian Action (2020). Technical Note on Girls Associated with Armed Forces and Armed Groups.

144 Healy, S., Borowiak, C., Pavlovskaya, M. & Safri, M. (2018). 'Commoning and the politics of solidarity: Transformational responses to poverty'. Geoforum.

145 WHO (2018). *INSPIRE handbook: Action for implementing the seven strategies for ending violence against children*. Geneva: World Health Organization.

Approaches	Description
Approaches to education, vocational training and school safety	Education and vocational training opportunities should be provided, as they facilitate access to future economic opportunities and may strengthen critical thought, dialogue and exchanges with peers.[146] Formal and non-formal education contributes to mitigating the negative psychological impact of conflict, especially girls, associated with armed forces and armed groups.[147] Teachers can be trained in the mental health and psychosocial needs of girls and boys affected by conflict and how to provide a safe and conducive learning environment at school for girls and boys affected by conflict. Their training can include positive teaching techniques, enabling emotional and social support, inclusion of children with disabilities, an understanding of the psychological needs of children affected by conflict, GBV, and how to reduce gender inequalities at school.
Life skills sessions through community organizations	Programmes that build girls' self-confidence through empowerment and life-skills sessions such as girls' clubs or youth clubs, or local women's organizations, have contributed to improvements in their psychosocial wellbeing. This strategy is not limited to girls because both male and female children need skill-building. Gender-sensitive cultural, sport, artistic or any other recreational activities for girls helps to boost their self-confidence, their sense of belonging and their sense of self-worth. It is also a way to promote the skills they learned during their association, such as leadership, communication and logistic skills.
Engaging community and faith leaders	Establishing trusting, safe community networks and relationships is essential for community-level MHPSS during reintegration. Establishing multi-disciplinary community advisory groups through relationship building with and among community and faith leaders can be a slow but powerful way to support responsiveness among natural care systems for CAAFAG and their families.
Conflict-sensitive MHPSS, social cohesion and peacebuilding	Peacebuilding activities and MHPSS among CAAFAG can have a very strong impact on community building,[148] and MHPSS can contribute to children's, their peers', families' and communities' social cohesion.[149] Ensure that former CAAFAG and children at risk of recruitment are included in peacebuilding dialogues and processes at local, national and regional levels. Conduct a conflict analysis to inform the use of MHPSS activities, such as creative activities, counselling, psychoeducation, and social and recreational activities, in social cohesion elements of CAAFAG reintegration programmes. Where needed, introduce conflict mediation into MHPSS components of CAAFAG programmes to monitor conflict dynamics and ensure conflict sensitivity.[150]
Resilience promotion	Through a resilience-focused approach, rehabilitation and reintegration programmes seek to cultivate positive coping skills among CAAFAG through activities at multiple levels (individual, family, community). The resilience approach pays close consideration to gender and age differences among CAAFAG, as well as other threats, risks and resources identified in the community, including protective processes across a child's social ecology.[151] Individual-community resilience relations has been identified as a possible transformative space in psychosocial programming for social reintegration among young CAAFAG mothers.[152]

146 UNODC (2019). *Roadmap on the treatment of children associated with terrorist and other violent extremist groups*.

147 UNICEF (2020). *Technical note on girls associated with armed conflict and armed groups*.

148 Sevenants (2019). *Evaluation Community-based Reintegration Programme for Children Released from Armed Forces and Armed Groups in Boma State (former Greater Pibor Administrative Area) 2015–2018*

149 War Child (2019). *Rethink Child Soldiers: A New Approach to the Reintegration of all Children Associated with Armed Forces and Groups*. London: War Child UK

150 IOM (2021). *Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement*. IOM: Geneva.

151 Shakya, A. (2011). 'Experiences of children in armed conflict in Nepal'. *Children and Youth Services Review*, 33(4), 557–563; Williams, R. & Drury, J. (2011). 'Personal and collective psychosocial resilience: Implications for children, young people and their families involved in war and disasters'. In *Children and armed conflict* (pp. 57–75). London: Palgrave Macmillan.

152 Veale, A., Worthen, M. & McKay, S. (2017). 'Transformative spaces in the social reintegration of former child soldier young mothers in Sierra Leone, Liberia, and Northern Uganda'. *Peace and Conflict: Journal of Peace Psychology*, 23(1), 58–66.

Annex 7. Self-care and staff care resources

Self-care resources for staff and community members and volunteers providing MHPSS in CAAFAG programmes:

- WHO WV WTF Psychological First Aid: Guide for Field Workers.
  Chapter 4. Caring for yourself & your colleagues.
- WHO (2020). Doing what matters in times of stress: an illustrated guide. Geneva: World Health Organization.
- WHO (2019). mhGAP Community Toolkit: Field Test Version.
  Section 2.6 Self-Care for community Providers
- Hong Kong Red Cross, 2020, 14-day Wellbeing Diary
- WHO, 2020, Coping with stress during the 2019-nCoV outbreak
- IASC MHPSS RG (2020). Basic Psychosocial Skills: A Guide for COVID-19 Responders.
  Module 1. Your Wellbeing.
- MHPSS MSP Activity 2.3 Care for staff and volunteers providing MHPSS.