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# Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice

## November 2020

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## Contents:

# ACRONYMS

| | |
|---|---|
| ACF | Action Contre la Faim (Action Against Hunger) |
| AUD | Alcohol Use Disorder |
| CBI | Classroom/School-Based Intervention |
| CBT | Cognitive Behavior Therapy |
| CB MHPSS | Community-Based Approaches to Mental Health and Psychosocial Support |
| CFS | Child-Friendly Spaces |
| CP | Child Protection |
| CPRQ | Children's Participation Rights Questionnaire |
| AUDIT | Alcohol Use Disorders Identification Test |
| CPWG | Child Protection Working Group |
| CYP | Children and Young People |
| CYRM | Child and Youth Resilience Measure |
| EASE | Economic and Social Empowerment for Women |
| EBP | Evidence-Based Practice |
| ECD | Early Child Development |
| EPP | Employment Promotion Program |
| FGD(s) | Focus Group Discussion(s) |
| GBV | Gender-Based Violence |
| GFS | Girl Friendly Space |
| ODI | Overseas Development Institute |
| IASC | Inter-Agency Standing Committee |
| IICRD | International Institute for Child Rights and Development |
| IOM | International Organization for Migration |
| IPV | Intimate Partner Violence |
| IRC | International Rescue Committee |
| ISPCAN | International Society for the Prevention of Child Abuse and Neglect |
| KLT | Kids' Life and Times |
| LETs | Local Evaluation Teams |
| LGBTQI | Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex |
| LMIC | Low- and Middle-Income Countries |
| LSWAY | Longitudinal Survey of War-Affected Youth |
| MHPSS | Mental Health and Psychosocial Support |
| MNS | Mental, Neurological, and Substance Abuse |
| MoLSA | Ministry of Labor, Social Affairs, and Social Services |
| NET | Narrative Exposure Therapy |
| NGO | Non-Governmental Organizations |
| ODI | Overseas Development Institute |
| OSRSG | Office of the Special Representative of the Secretary-General |
| PAR | Participatory Action Research |
| PEPFAR | President's Emergency Plan For AIDS Relief |
| PM+ | Problem Management Plus |
| PTSD | Post-Traumatic Stress Disorder |
| PRA | Participatory Rural Appraisal |
| PSS | Psychosocial Support |
| RCT | Randomized Controlled Trial |
| RUL | Reach Up and Learn |
| SAM | Severe Acute Malnutrition |
| SF | Strong Families |
| SFP | Strengthening Families Program |

| | |
|---|---|
| TaT | Talking about Talking |
| TF-CBT | Trauma-Focused Cognitive Behavioral Therapy |
| TLC | Temporary Learning Centers |
| TRT | Teaching Recovery Techniques |
| UNGEI | United National Girls' Education Initiative |
| UNICEF | United Nations International Children's Fund |
| UNODC | United Nations Office on Drugs and Crime |
| VAC | Violence Against Children |
| VAW | Violence Against Women |
| YRI | Youth Readiness Intervention |
| VSLA | Village Savings and Loan Association |
| WHO | World Health Organization |
| YEP | Youth Empowerment Program |
| YRI | Youth Readiness Intervention |

# INTRODUCTION

## Why this Review?

The escalation of conflicts and conflict-related displacement around the world has significant impacts on the development and overall well-being of children. Disasters and infectious diseases also disrupt lives and negatively affect the mental health and well-being of children and their caregivers. Different forms of humanitarian crises have adverse impacts on children and adolescent's education, development, protection, and psychosocial well-being, while also negatively affecting the delivery of quality services and the social fabric of families and communities. The composite term mental health and psychosocial support (MHPSS) describes any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. (IASC, 2007). Despite acute challenges, MHPSS practitioners and other sectoral staff integrating MHPSS approaches endeavor to bring high-quality interventions to scale in unstable environments. With an emerging evidence base for MHPSS interventions for children and families in humanitarian settings, we are better informed about how to best support children in programming interventions (Bangpan et al., 2017; Kamali et al., 2020; ODI, 2018; Haroz et al., 2020; Promundo & Sonke, 2018). Interventions such as Child-Friendly Spaces (CFS), school-based interventions, and psychological first aid for children, for example, have demonstrated feasibility and acceptability for scale-up in some post-conflict settings (UNICEF, 2015a). However, huge gaps remain in knowledge and evidence. Increased efforts are required to ensure relevant, culturally appropriate interventions, as no "one size fits all" (Wessells, 2017).

The Interagency Standing Committee (IASC) MHPSS Guidelines in Emergency Settings guides humanitarian actors on how to reduce the risk of harm and respond appropriately to the different MHPSS needs that emerge in emergencies (IASC, 2007). One aspect of the Guidelines' principle on 'do no harm' is that practitioners must stay "updated on the evidence base regarding effective practices." This review provides practitioners with a review and update on effective practices and evidence in the field of MHPSS. It was first drafted in 2015, presenting evidence and practice specific to children in order to support the implementation of MHPSS activities in humanitarian settings. This updated 2020 Review includes recent evidence updates (2015-2020), and addressing an identified gap in the 2015 Review, includes additional evidence on child and community participation. It serves as a compilation of evidence and best practice around MHPSS for children in humanitarian settings and complements the UNICEF Guidelines on Community-Based Mental Health and Psychosocial Support in Humanitarian Settings: Three-tiered support for children and families (field test version) and Compendium of resources, a supporting document to UNICEF's operational guidance: Community-based child protection.

The following key messages and recommendations for MHPSS in humanitarian settings, identified in a review of the linkages between research and practice in the field, guide this report:

1) The field needs to focus on replication efforts of promising interventions, including better specification of what is done and when to build more conclusive evidence of whether these interventions work and how;
2) the over-representation of PSS interventions in health and protection sectors indicates a need to integrate and evaluate PSS interventions in other sectors of a humanitarian response;
3) as the majority of evaluations reported on person-focused interventions, there is a need to evaluate community-based PSS programming with theory-driven outcomes;
4) evaluation of community-based PSS will require development and dissemination of field-friendly study tools and approaches that are a better fit for these types of interventions;
5) almost no identified interventions were designed for and evaluated for outcomes specific to certain sub-groups– there should be an effort to include these in future studies.

***Source**: Haroz et al. (2020): What works in psychosocial programming in humanitarian contexts in low- and middle-income countries: a systematic review of the evidence. Intervention,18(1)3-17.*

## Framework & Approach

### Social-Ecological Model

This Review is structured within the overarching framework of the socio-ecological model, which recognizes that individuals are embedded within various social systems from families to social norms and that these multifaceted systems interact continually in the developmental process (Brofenbrenner, 1981). Bronfenbrenner's framework draws attention to important aspects of human development and well-being that are central to MHPSS for children in humanitarian contexts, with emphasis on the multiple levels at which risks and protective factors operate. Bronfenbrenner's social-ecological model identified the following structures:

i) the microsystem – the individual-level relationships and interactions experienced by an individual
ii) the mesosystem – the interaction between the microsystem and another setting, such as the school, family, or work
iii) the exosystem – settings that do not directly involve the individual but that affect and are affected by the developing person
iv) the macrosystem – comprised of cultural norms and ideologies that are consistent with the micro, meso, and exosystems.

The socio-ecological levels selected for this 2020 Review have been adapted from Bronfenbrenner's original framework to most accurately record available evidence. This report recognizes that risk and protective factors for children operate at the following levels: individual, family, and peers, education settings, and the community.

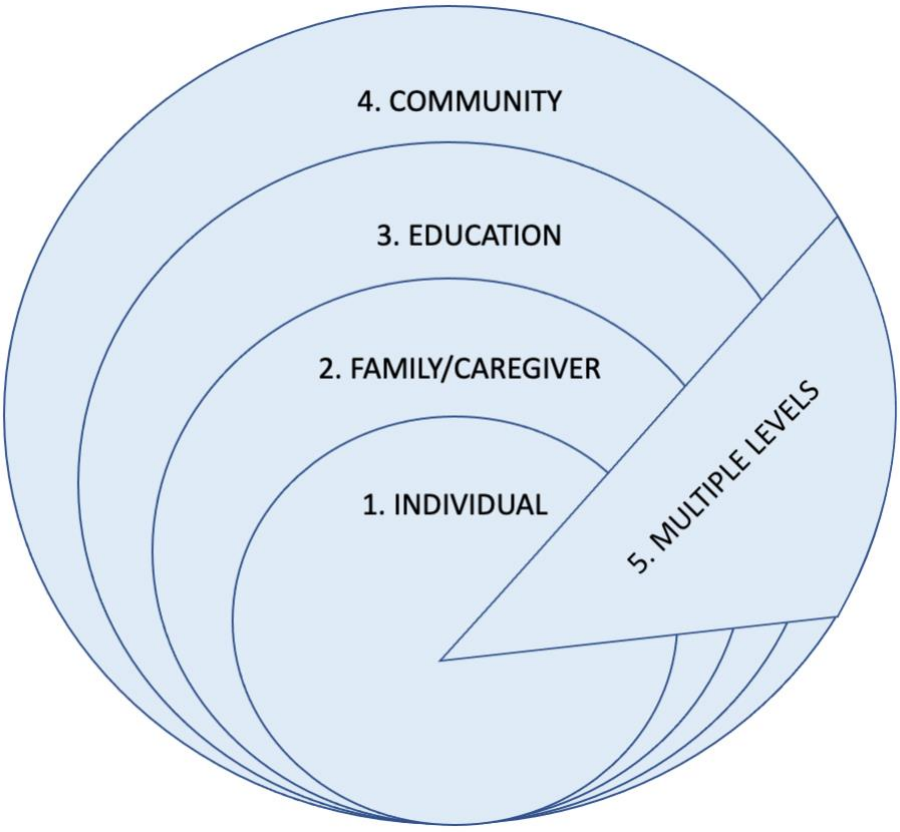



*Figure 1. Socio-ecological framework*

## Developmental Approach

This review recognizes that coping mechanisms, adaptive and maladaptive responses, and programming needs differ according to developmental stages. With some variations, these are often broken down as follows (UNICEF, 2018a):

- Early childhood: 0-5 years
- Middle childhood: 6-9 years
- Adolescence: 10-19 years

These age categories are used during the report; however, it is acknowledged that the age categories were not uniformly represented in all literature reviewed and presented in this report. Each area considered in this report is relevant to all children aged 0-18, significant gaps in evidence have been found relating to children at different development stages – the youngest children (0-5) are most frequently absent. Furthermore, research and intervention evidence is often not specific regarding the development stages it refers to or is relevant to.

Where available, this 2020 Review includes the developmental stages reported in the published research and reports. A summary of the strongest available evidence per age is listed at the top of each Area.

## Categorizing Evidence & Practice

This 2020 Review captures evidence and practices relevant to mental health and psychosocial support for children in humanitarian settings.

Three forms of **evidence** were considered:

1. Epidemiology - studies that explore associations between risk and protective factors and various MHPSS outcomes.
2. Evaluations – peer-reviewed studies of interventions.
3. Program Evaluations

***Process for search*:** A systematic review of epidemiological or evaluation literature was beyond the scope of this review. Instead, the authors identified systematic reviews of particular risk or protective factors or types of interventions as the preferred highest level of evidence and synthesis (see further below). Systematic reviews focused on research in humanitarian settings were prioritized. Where these were not available, relevant systematic reviews of research conducted in high-income settings were considered and included if findings were applicable. Systematic reviews were identified using the PubMed database, as well as through consultation with expert advisors. Where systematic reviews were not identified, authors selected a number of key resources to demonstrate some of the evidence present that has focused on that risk or protective factor.

Two forms of **practice** were considered:

1. Case Studies
2. Program Description

***Process for search*:** Calls for contribution through the MHPSS Reference Group and the Global Child Protection Working Group (CPWG), in addition to a thorough Internet search of MHPSS and other relevant databases, were used to identify reports of implemented MHPSS programs and activities targeting children, youth, and their families/communities.

**Key search terms used:** mental health, psychosocial, child protection, MHPSS, psychological, and "report" or "program." Our searches were restricted to reports in English.

## Evidence Hierarchy

The categorization of evidence within the report follows an evidence strength scale with systematic reviews and randomized controlled trials (RCTs), providing the strongest evidence for evidence-based practice (EBP).

| | |
|---|---|
| **A** | Systematic Reviews |
| **B** | Randomized Control Trials (RCTs) |
| **C** | Evaluations with control groups and or participatory processes |
| **D** | Evaluations with no control groups / Rich Program Description |
| **E** | Non-evaluated practice |

**A=** Systematic review refers to a summary of the clinical literature in a comprehensive manner. It is a critical assessment and evaluation of all available studies that address a particular issue.

**B=** RCTs are trials often used to test the efficacy or effectiveness of various types of interventions. They are considered a "gold standard" of evidence given they use randomization and control groups to assess the impact of a given intervention

**C=** Evaluations that utilize control groups to compare program outcomes. Plus, evaluations that explicitly use participatory processes and methods to actively engage children/caregivers/community members in the evaluation, even if a control group is not used.

**D=** Evaluations that do not utilize control groups for the evaluation of activity, such as focus group discussions or pre/post-tests, and that have limited participation of children, caregivers, and or community members in the evaluation.

**E=** Program Description of an activity that has not been evaluated. These descriptions may provide guidance around best practices, and serve as "primers" to lead to new research to generate an evidence-base for these practices.

*Figure 2. Evidence Hierarchy*

Assessment of the strength of evidence for each area was conducted using this evidence hierarchy. As noted above, evidence from non-humanitarian settings, including high-income settings, was included where relevant and applicable. The ranking of the "highest level of evidence available" for each area is based on evidence from humanitarian settings to ensure that this evidence ranking is as relevant as possible to field practitioners and provides a quick and accessible snapshot of the level of evidence for each factor, as it pertains specifically to children affected by conflict.

## Linking Evidence & Practice

The review links studies and evidence to good practice for each of the categories, using a matrix that specifies:

1. The following socio-ecological levels: individual, parents and caregivers, education, community, and multiple levels
2. Type of Factor:
    a. Protective factor: Any attribute, characteristic, or exposure that decreases levels of adverse symptoms or outcomes
    b. Promotive factor: Any attribute, characteristic, or exposure that increases levels of positive outcomes
    c. Risk factor: Any attribute, characteristic, or exposure that increases the risk of developing an adverse mental health outcome

Protective and promotive factors are often considered as interchangeable within the epidemiological literature; therefore, the areas described below considered factors as protective and or promotive.

## Analysis

The report analyzes evidence and practice linked to the following 13 areas of risk and protective/ promotive factors:

1. **Individual**
   - **Area 1.1: Exposure to severe distress/trauma** (risk)
   - **Area 1.2: Daily stressors and post-conflict hardships** (risk)
   - **Area 1.3: Resilience** (protective/promotive)

2. **Family/Caregivers**
   - **Area 2.1: Caregiver mental health & compounded stress** (risk)
   - **Area 2.2: Alcohol and substance-use within household** (risk)
   - **Area 2.3: Parent-child relationships** (protective/promotive)
   - **Area 2.4: Caring for caregivers** (protective/promotive)

3. **Education**
   - **Area 3.1: Access to safe and supportive schools** (protective/promotive)

4. **Community**
   - **Area 4.1: Stigma** (risk)
   - **Area 4.2: Social support** (protective/promotive)

5. **Multiple levels**
   - **Area 5.1: Violence against children and gender-based violence** (risk)
   - **Area 5.2: Children's participation** (protective/promotive)
   - **Area 5.3: Multi-layered approaches** (protective/promotive)

Each area presents updated epidemiological evidence and intervention evidence regarding risk and protective/promotive factors affecting the mental health and psychosocial well-being of children in humanitarian settings. A summary of identified evidence gaps is presented at the end of each area. The last section of the report summarizes cross-cutting issues that have been identified throughout this Review.

**2015 Review of Evidence and Practice**

The 2015 Review analyzed evidence and practice linked to the following 11 areas of risk and protective/ promotive factors:

| | |
|---|---|
| **Area 1**<br>Level: Family<br>Factor/Type: Parent-child relationships/ Protective/ Promotive<br>Developmental Stage: 0-5 | **Area 2**<br>Level: Family<br>Factor/Type: Caregiver Mental Health/ Risk<br>Developmental Stage: 6-12 years |
| **Area 3**<br>Level: Individual<br>Factor/Type: Trauma-Exposure/ Risk<br>Developmental Stage: 13-18 years | **Area 4**<br>Level: Community<br>Factor/Type: Stigma/ Risk<br>Developmental Stage: 13-18 years |
| **Area 5**<br>Level: Individual<br>Factor/Type: Post-conflict difficulties, hardships/ Risk<br>Developmental Stage: 13-18 | **Area 6**<br>Level: Individual<br>Factor/Type: Resilience/Protective/ Promotive<br>Developmental Stage: 6-12 |
| **Area 7**<br>Level: Family<br>Factor/Type: Alcohol and substance-use within household/ Risk<br>Developmental Stage: 6-12 | **Area 8**<br>Level: Community<br>Factor/Type: Social support/ Protective/ Promotive<br>Developmental Stage: 13-18 |
| **Area 9**<br>Level: School<br>Factor/Type: Access to safe and supportive schools/ Protective/ Promotive<br>Developmental Stage: 6-12/ 13-18 | **Area 10**<br>Level: Family<br>Factor/Type: Parental support and monitoring/ Protective/ Promotive<br>Developmental Stage: 6-12 |
| **Area 11**<br>Level: Multiple Levels<br>Factor/Type: Multiple risk and protective factors<br>Developmental Stage: 6-12 | |

## Symbol key:

| | | | |
|---|---|---|---|
|  | **Protective/promotive factor** |  | **Risk factor** |
|  | **X-X years** (*Strongest evidence available by age*) |  | **Evidence gap** |
|  | **Epidemiological Evidence** |  | **Intervention Evidence** |
|  | **Intervention example** |  | **Evaluation example** |
|  | **Conclusions** | | |

# Section 1: INDIVIDUAL


MHPSS programs focusing on the individual level aim to reduce risk factors and strengthen protective factors in order to enhance children's positive mental health and well-being, to reduce anxiety and the negative impacts of stress. This section shares evidence and interventions on two risk factors and one protective factor at the individual level:

**1.1 Exposure to severe distress/trauma** (risk)
**1.2 Daily stressors and post-conflict hardships** (risk)
**1.3 Resilience** (protective/promotive)

**RISK FACTOR:**

## 1.1 Exposure to severe distress/trauma

**Strongest evidence:**

**A – Systematic review(s)**

0-18 years

**Introduction:**

Children and adolescents living in conflict-affected settings, many of who are displaced internally or across borders, are at risk of experiencing various forms of trauma, including abduction into armed forces, witnessing family members being killed, and experiencing or witnessing sexual or gender-based violence (SGBV). Protection risks tend to increase in displacement settings, exposing children to continued forms of violence, including violence in schools and within households *[See Area 5.1].* Experiencing a disaster such as an earthquake, cyclone, infectious disease pandemic, or another disaster can also be traumatic. Posttraumatic stress disorder (PTSD) is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, or war/combat (American Psychiatric Association, 2020). People with PTSD have intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; they may feel sadness, fear, or anger; and they may feel detached or estranged from other people. People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch (Ibid).

**Epidemiological Evidence:**

Psychological distress is manifested in diverse ways in protracted and post-conflict settings, including anxiety (Devakumar et al., 2015), acute stress disorder, clinical depression (Borba et al., 2016), withdrawal and aggression (Mattingly, 2017), sleep problems, psychosomatic symptoms (Jordans et al., 2018), and PTSD (Fegert et al., 2018), which is the most widely studied (Devakumar et al., 2015). Emerging research also examines the impact of mental health on children's physical health outcomes in conflict contexts (Orrnert, 2019). For example, a study on the impact of war on emotional/behavioral problems and functional limitations of Liberians (aged 5–22 years) found that mental health issues in children aged 5-12 years often manifest as emotional and behavioral problems, which, in turn, had an impact on their physical health (Borba et al., 2016). This is because their functional limitations result in the inability to get enough food, as well as engage in self-care, personal hygiene, and other activities that normally promote good physical health (Borba et al., 2016, pp. 64-6).

Increasing evidence suggests that mental health issues in childhood and adolescence can result in a number of other problems later in life, including in learning, behavior, and health (Orrnet, 2019): PTSD, if left untreated, can become chronic (Fegert et al., 2018). Trauma can also be further intensified by factors beyond the conflict, including poverty, health, and human resource constraints (Hassan et al., 2016), and increased presence of weapons and the normalization of violence within society (Devakumar et al., 2015). Systematic reviews also show that exposure to violence is a commonly measured and a highly prevalent risk factor for children who have experienced conflict *[See Area 5.1].*

A systematic review of mental disorders amongst conflict-affected children undertaken by Attanyakake et al. in 2009 identified 17 relevant studies, all of which include PTSD as an outcome measure, and assessed the relationship between exposure to trauma and PTSD. Overall, studies reviewed reported PTSD prevalence in more than 40% of children exposed to conflict (Attanayake et al., 2009). A systematic review of risk and protective factors for children affected by conflict found that exposure to violence has the highest risk of subsequent psychological disturbance, increasing the odds of negative mental health impacts (Reed et al., 2011). A systematic review of risk and protective factors for child soldiers identified several studies that explored the prevalence of exposure to violence, including being forced to kill, amongst child soldiers, and mental health and psychosocial problems (Betancourt et al., 2013). Exposure to bombardment and home demolition was identified as a significant risk factor for higher posttraumatic stress disorder scores and higher subscales of intrusion, avoidance, and arousal symptoms amongst children 9-18-years-old in war-affected regions of Palestine (Thabet, Abed, & Vostanis, 2002). A study conducted in Nepal compared the mental health status of former child soldiers (N=141) and children never conscripted by armed groups (N=141). The group of former child soldiers displayed worse mental health outcomes (i.e., symptoms of depression, PTSD, general psychological difficulties, and function impairment). Even after controlling for exposure to trauma, child soldier status was associated with poorer outcomes for depression and PTSD, indicating that non-trauma related factors may lead to higher rates of mental health problems (Kohrt et al., 2008). A longitudinal study conducted in Afghanistan focused on school-age and adolescent children and their caregivers (N=115 boys, 119 girls, 234 adults). One year after establishing baseline mental health data, analyses revealed four family-level exposures as notable risk factors for mental health outcomes: family-level violence, major family conflict, serious family illness, and witnessing/experiencing severe physical beatings at home, indicating the salience of non-conflict related traumatic events in the lives of children in this context (Panter-Brick et al., 2011).

Increasing evidence from individual studies confirms that cultural and societal norms, and the individual meaning ascribed to the "traumatic" event, ultimately shape individuals' reactions, whether or not they need, want, and seek help, and their expectations of recovery (Tay et al., 2019; Rabaia, Saleh, & Giacaman, 2014). Recent systematic literature research, considering children and adults, was conducted with reference to the contextual, social, economic, cultural, mental health, and health-related factors amongst Rohingya refugees living in the Asia-Pacific and other regions (Tay et al., 2019). This study found that the legacy of prolonged exposure to conflict and persecution compounded by protracted conditions of deprivations and displacement is likely to increase the refugees' vulnerability to a wide array of mental health problems, including posttraumatic stress disorder, anxiety, depression, and suicidal ideation. High rates of SGBV, lack of privacy and safe spaces, and limited access to integrated MHPSS support were identified as the most concerning issues within the emergency operation in Bangladesh. Eyüboglu et al. (2019) examined the PTSD-related symptoms, and difficulties of children, and general health levels of their parents in the conflict-affected district in the South-eastern Anatolia region of Turkey, in addition to investigating the relationship between direct and indirect effects of trauma on psychological outcomes and PTSD. Their research, which compared children exposed directly and indirectly to the armed conflicts after six months, found that the trauma symptoms were high in both groups. It was determined that being a female, the presence of both mother and child's psychosocial difficulties, and leaving home due to conflicts are among the factors that increase the risk of PTSD development. Contrary to expectations, trauma-related symptoms were not higher in the directly exposed children. The authors call for intervention programs to be developed for the detection, prevention, and treatment of PTSD symptoms to be applied to all children, regardless of exposure type, in areas affected by conflict (Eyüboglu et al., 2019).

Advances in neuroscience have identified that stressful events that trigger strong, frequent, or prolonged activation of the body's stress management system harm the brain architecture, resulting in substantial impacts on the well-being and mental health of children and adolescents (Harvard, 2014). Adolescents have been found to present an increased physiological response to stress compared to children and adults and are at higher risk of psychiatric problems during this period of development (Lupien, McEwen, et al., 2009; Angold et al., 2002). Early adolescence (10-14 years of age) has been identified as a particularly significant period of

brain development, with research demonstrating that population stressors, including war and famine, experienced at this age are more strongly associated with a decrease in total life span than stressors experienced at any other age of childhood (Balvin & Banati, 2017). These findings confirm the importance of appropriate types of MHPSS intervention for every age of childhood (Ibid.).

Recent research suggests that the variation of individual responses to early stressful experiences is related to differences in the expression of so-called "vulnerability genes," which make it more likely that early stressors will lead to subsequent problems in stress hormone regulation and behavioral difficulties (National Scientific Council on the Developing Child, 2005/2014). Positive early caregiving has been found to decrease the likelihood of these adverse outcomes, demonstrating that beneficial environmental influences can moderate the impact of genetic vulnerability (Ibid.).

The significant implications of not addressing MHPSS needs of children, youth, and adults in conflict settings are increasingly recognized (Orrnett, 2019). Mental health problems amongst children and adults have been found to persist a long time after a violent conflict ends, with negative consequences not only for their ongoing mental and physical health but for future generations (Ibid). Research into the intergenerational transmission of trauma is receiving increasing attention (Orrnert, 2019; Yehuda & Lehrmer, 2018). It is recently suggested that traumatic experiences are passed from one generation to the next through "non-genomic, possibly epigenetic mechanisms affecting DNA function or gene transcription" (Yehuda & Lehrmer, 2018, p. 243). Whilst aspects of intergenerational trauma effects are still contested, and there are warnings against conflating effects of parental behavior with directly "inherited" effects resulting from biological transmission, there is increasing recognition of their universality (Yehuda & Lehrmer, 2018). These developments are reflected in recent research on the mental health impacts of conflict (e.g. Betancourt et al., 2012).

### Intervention Evidence:

A systematic review conducted by Bangpan, Dickson, Felix, and Chiumento (2017) found strong evidence that MHPSS programs delivered to children are effective in reducing functional impairment but may have little or no impact on anxiety. The authors found moderate evidence that MHPSS programs slightly reduce symptoms of PTSD, psychological distress, and conduct problems, but they may have no impact on depression or prosocial behaviors. They found limited evidence that MHPSS programs delivered to children reduce emotional problems and increase hope. A recent systematic review on MHPSS programs for adults in humanitarian emergencies also finds that MHPSS programs show benefits in improved functioning and reducing post-traumatic stress disorder, identifying that cognitive-behavioral therapy and narrative exposure therapy may improve mental health conditions (Bangpan et al., 2019).

Other studies have found that focused MHPSS interventions can be effective in reducing PTSD and functional impairment and in increasing hope, coping, and social support (e.g. Purgato et al., 2018). In a recent systematic review of focused MHPSS interventions from 11 RCTs in low resource settings, Purgato et al. assessed the effectiveness of MHPSS interventions in children exposed to traumatic events in humanitarian settings in low-income and middle-income countries. Results from these studies were found to be inconsistent, showing variation by setting and subgroup (e.g. age or gender). However, overall, the authors found broad intervention benefits for symptoms of PTSD (both at immediate follow-up and mid-term follow-up), for multiple strengths (coping, hope, and social support), and for functional impairment. Intervention effects were stronger for older, non-displaced children and children living in smaller households. The authors recommend that future studies should focus on strengthening interventions for younger children, displaced children, and children living in larger households.

These findings build on earlier research of treatment approaches for children affected by conflict, identifying reductions in PTSD symptoms amongst participants (e.g. Jordans et al., 2009). Successful interventions have

included a psycho-dynamic support group, school-based interventions, including trauma/grief-focused psychotherapy groups (Layne et al., 2008) [*see Area 3*], mind-body skills groups for Palestinian adolescents (Staples et al., 2011), narrative exposure therapy and a meditation-relaxation intervention in Sri Lanka (Catani et al., 2009), and cognitive behavioral therapy in DRC (McMullen et al., 2013). The Common Elements Treatment Approach [*see Area 2*] has been tested with a trauma focus for PTSD symptoms among child soldiers and other war-affected children in Uganda and the Democratic Republic of the Congo (Ertl et al., 2011; McMullen et al., 2013, cited in Promundo & Sonke Gender Justice, 2018). The study conducted by Ertl et al. (2011) assessed the feasibility and efficacy of a community-based intervention targeting PTSD in formerly abducted boys (aged 13-17) in Uganda. Participants were randomized into three treatment groups – narrative exposure therapy (derived from CBT with a trauma focus), an academic catch-up program with elements of supportive counseling, and a waitlist- and were assessed for symptoms of PTSD, depression, and related mental health conditions. It was found that the narrative exposure/therapy group experienced a reduction in PTSD symptoms, lower rates/scores of depression, and reduced suicidal ideation and feelings of guilt, as well as decreased stigmatization, all essential to readjustment to society for former child soldiers (Ertl et al., 2011).

The literature increasingly confirms that yoga and mindfulness interventions have the potential for use with children and adolescents, particularly for stress, anxiety, and depressive symptoms (Kallapiran et al., 2015). Approaches that have demonstrated the most promising effects with youth include mindfulness-based stress reduction and acceptance and commitment therapy (Vujanovic et al., n.d.). Yoga is also increasingly recognized as an effective intervention for depression and PTSD among child or adolescent survivors of sexual assault and abuse (van der Kolk, 2014; La Schiava et al., 2016). It is argued that yoga may be a particularly relevant intervention with trauma survivors because it helps regain bodily awareness after the common PTSD symptom of physical dissociation (van der Kolk, 2014; La Schiava et al., 2016; Gordon et al., 2008, cited in Promundo & Sonke Gender Justice, 2018).

In response to Purgato et al.'s recommendation for more research with younger children, Hanratty et al. (2019) have recently published a research protocol for conducting a systematic review to assess the effectiveness of MHPSS interventions for preventing PTSD in young children aged 0–11 years old, living in war and conflict-affected societies. This study aims to shed light on when, if at all, an intervention should be offered after a potentially traumatizing event; how to decide who does and does not need intervention to reduce the risk that PTSD will develop; and whether at-risk children can be identified, screened, and offered appropriate interventions.

Limited understanding amongst MHPSS personnel of the local language, culture, and help-seeking behavior of the local population have been found to hamper the provision of culturally sensitive and contextually relevant MHPSS services (Tay et al., 2019). Tay et al. (2019) call for greater understanding and knowledge of the culture, context, migration history, idioms of distress, help-seeking behavior, and traditional healing methods, which can be obtained from diverse sources and applied in the design and delivery of culturally appropriate interventions.

**Evaluation example: Youth Readiness Intervention**

*Evaluation with control group (level C)*

The Youth Readiness Intervention (YRI) is a mental health intervention for war-affected youth implemented in Sierra Leone (Betancourt, 2018). The YRI builds on 15 years of research on the effects of war, violence, and other post-conflict adversity on the mental health of young people in Sierra Leone, starting immediately after the end of the brutal civil war in 2002 with the Longitudinal Survey of War-Affected Youth (LSWAY). While many programs focused on classic symptoms of PTSD, few focused on the anger and interpersonal difficulties young people were suffering (Betancourt, 2018). To address these issues, the team sought input from a range of local stakeholders. Interviews and focus groups with

community leaders, young people, professionals, and government officials highlighted the need for an intervention that could be delivered in communities by lay mental health workers. Informed by discussions with local stakeholders and evidence from other programs, the YRI incorporates two strategies: a common-elements approach, which adapts treatment strategies and techniques to fit new contexts and problems; and a trans-diagnostic approach, which applies treatment across the full range of mental illness, rather than targeting a specific diagnosis. The YRI's six components are delivered in three phases common in trauma-informed interventions: stabilization, integration, and connection (Betancourt, 2018). The intervention is divided into 12 sessions meant to be delivered over 12 weeks, with each phase building on the last. A group format encourages peer-to-peer learning and deepens social connections. The YRI can be delivered by lay counselors and does not require mental health professionals or specific educational requirements. The approach prioritizes intensive training, supportive supervision administered in individual and group formats, and fidelity monitoring via audio-taped intervention sessions and direct observation to bolster counselors' skills, reinforce key YRI components, and ensure the intervention is being delivered as intended. Following testing in a school, participants reported significant improvements in emotion regulation, social attitudes and behaviors, and social support compared to the control group. Eight months after the intervention, YRI participants were more likely to stay in school, had better attendance, and their classroom behavior had improved (Betancourt, 2018).

A current study will integrate the YRI within the youth Employment Promotion Programme (EPP) supported by the donor GIZ (Betancourt, 2018). The EPP responds to market demand to ensure that young people obtain the qualifications they need for employment or self-employment. It consists of three training modules intended to strengthen skills relevant to the labor market, increase income, and promote resilience to economic shocks. The research will look at a range of implementation factors, including feasibility, barriers, and facilitators, alongside a clinical effectiveness evaluation to measure changes in participants' mental health, notably emotion regulation. Thabet et al. (2005) describe a group crisis intervention delivered to children aged 9-15 in refugee camps in the Gaza strip. The intervention consisted of weekly sessions, encouraging children to communicate about their experiences of trauma, using drawing, games, and storytelling. However, compared to a control and educational-intervention group, the group crisis intervention was not effective at reducing PTSD symptoms or depression. The authors hypothesized that this was due to the nature of the context (ongoing conflict, resulting in children in the intervention group being re-exposed to trauma throughout the intervention) and the intervention (which was not designed to impart active coping skills). An RCT of the Youth Readiness Intervention, a ten-session cognitive behavioral therapy intervention implemented for war-affected youth in Sierra Leone, showed that the intervention significantly improved emotion regulation, increased prosocial behaviors, and decreased functional impairment and educational outcomes (school enrolment, school attendance, and classroom behavior). However, impacts on post-traumatic symptoms were not seen (Betancourt et al., 2014). These studies indicate the need to develop and implement specific interventions that address mental health and psychosocial symptoms related to trauma exposure. There are several systematic reviews of interventions to address the impact of trauma on children and adolescents in non-humanitarian contexts. For example, Gillies et al. (2013) identify a number of effective psychological therapies for the treatment of PTSD amongst children and adolescents, concluding that best evidence of effectiveness exists for cognitive behavioral therapy, while further research is needed to assess whether impacts of interventions are maintained beyond one-month.

**Evaluation example: IRC's Program Evaluation of Focused Psychosocial Activities for children affected by the Syrian Crisis in Lebanon (2013)** *[6-17 years]*

*Pre- and post-implementation survey (level D)*

Focused psychosocial activities are provided to smaller groups of children (10-12 children per group) and are tailored to meet the needs of children exhibiting signs of psychosocial distress. Over the course of eight sessions, these activities aim to not only boost children's cognitive, emotional, physical, and

social capacities but also to provide children with a safe space to acknowledge and express difficult emotions (in particular fear, sadness, anger, and guilt), explore different ways to deal with them (through external resources), and develop positive coping strategies (through internal resources). A pre- and post-implementation survey on children's psychological distress and resilience was conducted for children participating in "Focused PSS" activities at the beginning and end of the eight-sessions module. Data demonstrated a decrease in children's psychosocial distress level, leading to a hypothesis that with further follow-up and support that these children could go back to a pseudo normal distress level. However, an important finding is that in comparing these results with those of the children aged 6-11 that participated in the non-focused PSS activities only, we can see that the results are similar. This is a very key finding and an opportunity for researchers looking at evidence-based practices for this age group.

**Evaluation example: International Rescue Committee's Program Evaluation of Women's Protection and Empowerment / Child and Youth Protection and Development Program in Ethiopia (2014),** *[average age: 11 years]*

*Quantitative pre- and post-test and qualitative interviews (level D)*

The Caring for Child Survivors initiative included the design, implementation, and evaluation of a components-based mental health treatment for Somali refugee children in Ethiopia. The intervention applied the Common Elements Treatment Approach by trained counselors. The IRC and research partners from Johns Hopkins University and Duke University found that the intervention was feasible and acceptable in the refugee camp context, and children participating in the intervention experienced an average decrease of over 70% in traumatic stress and emotional and behavioral problems (Murray et al., 2018).

**Evaluation example: War Child Holland's Program Evaluation of Psychosocial Support Intervention I DEAL in Columbia and South Sudan (2013)** *[11-15 years]*

*Mixed method non-randomized pre- and post-test design (level D)*

War Child's psychosocial support intervention I DEAL supports children (11-15-years-old) to better cope with the aftermath of armed conflict by strengthening their social and emotional coping skills. The intervention addresses the themes of identity, dealing with emotions, relationships with peers and adults, conflict and peace, and the future. Participants actively contribute to the intervention by determining which of the issues the intervention will address, setting and monitoring their personal goals for the intervention, and providing regular feedback on the intervention's content, activities, and structure. The intervention consists of 19 sessions of 1.5 hours each, implemented over four to six months, depending on local circumstances and modules selected. Each session combines creative and participatory activities such as role-play, drawing, games, and group discussions to stimulate active learning. The groups consist of a maximum of 25 participants and are facilitated by community workers. Previously published and unpublished evaluations in other countries have shown that I DEAL has positive short-term outcomes for the children participating, particularly mitigating reactions to violence, such as aggression, and improving relations with adults and peers.

Key Findings:

• Objectives of the I DEAL intervention, and the themes it addresses, are consistent with children's local perceptions of well-being.

• Evaluations in both countries indicated positive results in children's achievement of their personal goals.

• Both evaluations indicate positive outcomes in the development of children's social coping skills, especially conflict resolution skills, and improved social relationships with peers and adults.

## Conclusion and Implications for Research and Field Practice

There is a strong evidence-base and a significant number of interventions and practices in the area of trauma-related measurement, although there are mixed findings concerning the impact of MHPSS interventions on increasing hope. Despite this, it is evident that some of the interventions with a strong evidence-base are not commonly implemented, and practices targeted at addressing mental distress amongst children commonly used in the field may not be adequately evaluated.

### Evidence Gaps:

Compared to some of the other factors included in this review, there is a strong evidence-base and a significant number of interventions and practices in the area of trauma-related measurement, intervention and practice. However, increased efforts are needed by practitioners and researchers to design, implement, and evaluate interventions that are grounded in an understanding of the local culture, with interventions contextualized, adapted, and findings disaggregated for gender, age, and other diversity factors. For example, there is currently a particular lack of evidence on children aged 0-11, children with disabilities, and other children in particularly marginalized situations, such as those on the move or in displaced settings. It is imperative to ensure that MHPSS evidence and practice takes into account the diversity of experiences faced by children in humanitarian settings.

While negative consequences of adverse childhood experiences have been well-researched, the evidence base on the longer-term consequences of unmet MHPSS needs, in the context of armed conflict and violence, is significantly weaker (Orrnert, 2019; Werner, 2012; Brown et al., 2016; Hijazi et al., 2018). Further longitudinal and multi-generational research into the intergenerational transmission of trauma as a result of conflict is needed to identify evidence (Yehuda & Lehrmer, 2018).

**RISK FACTOR:**

## 1.2 Daily stressors and post-conflict hardships

**Strongest evidence:**

**B – Randomized control trial(s)**

**6-18 years**

**Introduction:**

Research on children's mental health and psychosocial well-being in humanitarian settings has primarily focused on exposure to trauma and violence experienced as a result of conflict-related experiences and displacement. Stressful social and material conditions caused or worsened by armed conflict conditions, identified as "daily stressors" (Miller & Rasmussen, 2010), have increasingly been found to have a significant influence on children's mental health and psychosocial well-being. Daily stressors may include family violence, poverty, malnutrition, socioeconomic adversity, and social exclusion (Miller & Rasmussen, 2010). Stigma and violence are addressed in this review *[see Areas 4.1 and 5.1].* The high prevalence of (post-) conflict hardships and difficulties experienced by children is identified in the literature, exploring their association with mental health and psychosocial outcomes. Research indicates a need to examine and address these risk factors, alongside interventions and focus on trauma exposure. It broadens the focus from direct war-related traumatic events to account for a host of enduring, stressful conditions of daily life that may be generated or exacerbated by conflict, displacement, and ensuing living conditions (Fernando et al., 2010).

**Epidemiological Evidence:**

Although no systematic reviews have been identified that focus specifically on (post-) conflict difficulties and hardships, studies increasingly find that the mental health and well-being of children living in conflict-settings are affected, not only directly through exposure to war-related violence and loss but also indirectly through diverse daily stressors (e.g. Rees et al., 2015; Miller & Jordans, 2016; Jordans et al., 2018; Hijazi et al., 2018). This is a "paradigm shift" in research on the MHPSS needs of children and young people in conflict-settings – limited attention has previously been paid to the psychological impact of "daily stressors" on children in humanitarian settings (Miller & Jordans, 2016). Several reviews focused on factors influencing children's mental health and psychosocial well-being in humanitarian settings have addressed this set of risk factors, alongside others.

A recent qualitative needs assessment exploring priority mental health and psychosocial problems among displaced children in Kachin State, Myanmar, contributes to explanatory models of distress that include both direct trauma exposure and exacerbation of daily stressors (Lee et al., 2018). Lee et al. (2018) identified behavior problems, substance use, effects of war, and feeling sad/depressed/hopeless as priority problems, with identified interconnectedness between them. Overall, most problems were related to specific events, suggesting the symptoms themselves are responses to unusual situations; however, the problems were also linked to current psychosocial stressors such as poverty, poor nutrition, and discrimination. Effects of war were described primarily as a constellation of social and economic problems, rather than a list of mental health symptoms, although descriptions of these problems did include post-traumatic stress symptoms (Ibid.). This study supports Miller and Rasmussen's ecological model of refugee distress, which demonstrates that mental health among refugees and asylum seekers stems not only from prior war exposure but also from a host of ongoing stressors in their social ecology, or displacement-related stressors (Miller & Rasmussen, 2017). Hou

et al.'s (2020) recent meta-analysis, which evaluated the association between daily stressors and poor mental health among conflict-affected forced-migrants, also contributes to this evidence. This research found that for refugees, asylum seekers, or immigrants, everyday life experiences in the receiving context could have a stronger impact on their mental health relative to prior conflicted-related trauma. Significantly, stronger effect sizes were found for children and adolescents relative to adults (Hou et al., 2020). Based on this review, the authors propose that future strength-based interventions aimed at consolidating and enhancing basic, necessary daily routines (including personal and family hygiene, diet, and sleep), and improving living conditions, could have a significant positive impact on their mental health in the receiving countries (Hou et al., 2020).

The significance of gendered experiences and the importance of taking a gender perspective are emphasized by Samuels et al. (2017). Their study, drawing on qualitative fieldwork and group discussions in Gaza, Liberia, and Sri Lanka, highlights how the national context of a fragile or post-conflict state shapes how girls and their families recover from or continue to face violence, disruption, displacement, and loss of livelihoods. These experiences are often gendered, as social norms shape how families react to and cope with external shocks and stresses, often with negative outcomes for girls, including marrying them off early and pulling them out of school. Samuels et al. (2017) argue that: i) adaptive and adequately resourced health systems are necessary but not sufficient to ensure good health outcomes among adolescent girls in post-conflict settings; ii) integrating an understanding of the social determinants of health and well-being is critical in shaping health service uptake and ultimately outcomes for adolescent girls; iii) mental health and psychosocial outcomes are central to broader health and well-being and need urgent attention in post-conflict developing country settings in particular; and iv): tailored gender- and age-sensitive psychosocial service provisioning is vital in supporting the health and well-being of adolescent girls—a cohort often facing complex vulnerabilities in post-conflict settings.

Earlier studies also contribute to understanding this risk factor. Drawing on findings from standardized assessments (conducted with 363 Sierra Leonean youth [aged 10-17] six years post-war), Newnham et al. (2015) found that the extent of war exposures was associated significantly with post-traumatic stress symptoms, and a significant proportion was explained by indirect pathways through daily stressors. In contrast, there was little evidence for an association from war exposure to depression scores; rather, any association was explained via indirect pathways through daily stressors. The authors argue that clinical programs implemented in post-conflict settings have a significant opportunity to address these modifiable factors and should work to integrate with educational, vocational, and social support programs. Opportunities to engage with families and communities to embrace stability and healthy functioning, in addition to trauma-focused care, are vital for sustainable improvement. Expanding treatment approaches by incorporating a focus on daily stressors therefore reflects an important shift in addressing the needs of youth in post-conflict settings.

Studies focusing on post-conflict difficulties and hardships also include Betancourt's longitudinal study of former child soldiers in Sierra Leone, which found that post-conflict hardships (e.g., social stigma, lack of community acceptance, barriers to education) significantly contribute to youth's internalizing and externalizing problems and psychosocial adjustment (Betancourt et al., 2010). Specifically, high levels of daily hardship were associated with increased hostility, aggression, anxiety, and depression, as well as decreased adaptive/prosocial behaviors (Ibid). In Newnham's analysis, based on the same longitudinal study of Sierra Leonean youth, daily economic and interpersonal stressors (e.g., poverty, insecurity, and interpersonal relationships) played a mediating role in the psychological impairment of young people in the post-conflict setting six years following the war. Daily stressors were associated with increased symptoms of post-traumatic stress and depression (Newnham et al., 2015). Mels et al. (2010) found the psychological health of youth in Democratic Republic of Congo to be associated with contextual hardship (i.e., daily stressors including insufficient food and medical care, need to contribute to household income, social rejection, and family quarrels). When compared to returned and never-displaced peers, internally displaced youth of post-conflict

Democratic Republic of Congo experiencing higher rates of daily stressors exhibited more externalizing behavioral problems (males) and internalizing psychological problems (females) than their counterparts. The study of Afghan refugee parent-child dyads conducted by Panter-Brick et al. (2014) found everyday stressors of displacement, overcrowding, improper housing, insecure jobs, and family conflict negatively impacted family well-being and child-rated psychiatric difficulty scores. Reed et al. (2011) also identified household socioeconomic status as a risk factor for adverse mental health outcomes.

### Intervention Evidence:

Limited interventions have been found to focus specifically on reducing or addressing post-conflict hardships and stressors. However, interventions focused on reducing post-conflict hardships and difficulties include those that support adolescent livelihoods and income generation, as well as anti-poverty interventions with caregivers, and protection activities. For example, cash transfers have typically had positive effects on preventing child protection violations when provided to women or families in conjunction with another intervention, such as parenting training. However, specific types of cash transfers come with harm risks that need mitigation: cash transfers without any other complementary interventions can increase girls' risk of being subjected to sexual harassment (Butchard & Hillis, 2016). Several studies have shown that combined approaches, encompassing parenting training and cash transfers, have improved parental monitoring and reduced child maltreatment (Combaz, 2016). They have also increased the pro-social behavior of children – especially adolescent boys – resulting in more positive and helpful behavior, which also promotes "social acceptance and friendship among adolescent boys" (Butchard & Hillis, 2016, p. 56). Cash transfers in LMICs have also helped to keep girls and boys in school and have been shown to reduce intimate partner violence witnessed by children. This can, in turn, reduce children's likelihood of becoming victims or perpetrators of violence (Butchard & Hillis, 2016).

However, in many of these cases, the impacts on mental health and psychosocial outcomes are not measured, thus constraining opportunities for evidence-based interventions to improve children's mental health and well-being. For example, while the prevention of family separation and tracing of family members may be a key prevention intervention, addressing a host of post-conflict hardships and difficulties present for unaccompanied and separated children, these interventions are not assessed for psychological impacts (see Betancourt et al., 2013).

Family economic stability and empowerment reduce risk factors associated with violence and increase protective ones. Access to resources allows parents to invest in children's health and education and increases families' economic resilience and reduces financial stress. When carried out alongside gender-equity training, income-strengthening efforts may reduce risk factors for child maltreatment, witnessing intimate partner violence, exploitation, child labor, and early marriage (WHO, 2018). Interventions focused on family functioning, parenting, reduction of violence in the household, and access to and safety at school are addressed in more detail in other areas [*see, for example, Areas 2.1, 2.2, 3.1, 5.2, 5.3].*

### Community-based MHPSS support for children and families, Egypt, Plan International

*Program description with a rich description of the participatory process (level D)*

This case study, Community-Based Psychosocial Support for Syrian and Egyptian Children in Urban Areas, describes Plan International Egypt's community-based psychosocial program for over 4,000 Syrian refugee and vulnerable Egyptian children aged between 2-18-years-old in poor suburbs in Alexandria (Plan International, 2017). The intervention aimed to prevent and respond to high levels of psychosocial distress of Syrian refugee children and vulnerable Egyptian children. Key activities included center-based and mobile recreational activities, life skills sessions, and parenting circles to disseminate best parenting practices and provide support to parents. At-risk children and families were referred to child protection and more

specialized services when required. The program selected participants based on their involvement in a cash transfer program to attend MHPSS programs for children and parents. This allowed for a more holistic response. While the evaluation outlined that this selection criteria alone may have resulted in not all possible vulnerable families being reached or identified, the participants benefitted from an integrated approach. Achievements include the increased participation of Syrian children in community activities, as well as higher enrolment in education as a result of improved social integration. Awareness activities have led to increased reports of child protection concerns in the community and schools. Key lessons included the importance of having technical specialists to support the structured implementation of psychosocial support activities by non-specialized staff and the establishment of a functional referral system to respond to the concerns of Syrian refugee children and their families in a holistic way (Plan International, 2017).

**Evaluation example: International Medical Corps' Program Evaluation Youth Empowerment Program (YEP) for Vulnerable Iraqi and Jordanian Adolescents (2010)** *[13 – 18 years]*
*Pre-post test, no control group (level D)*
The Youth Empowerment Program (YEP) for Vulnerable Iraqi and Jordanian Adolescents seeks to improve adolescents' self-esteem, increase social support, decrease psychosocial stressors, and increase community connectedness. Through the 16-week curriculum, groups of same-sex adolescents meet in a group leader's home to learn about adolescence and to plan and execute a community service project within their Jordanian community. The YEP pilot program has preliminary support for being an efficacious intervention for vulnerable Iraqi and Jordanian youth. After completing the YEP program, adolescents scored lower on rates of depression, anxiety, parent relationship conflicts, and negative emotionality. Adolescents also scored higher on measures of self-esteem, social support, community connectedness, and positive emotionality.

**Conclusion and Implications for Research and Field Practice:**
While researchers and practitioners commonly understand the significant influence of post-conflict difficulties and hardships on children and family well-being in humanitarian settings, this factor has only recently been incorporated into studies. There are no systematic reviews that relate specifically to daily stressors and post-conflict difficulties and hardships, although some systematic reviews of children's mental health in conflict-affected settings have identified this risk factor as relevant to influencing children's outcomes.

Interventions designed to address these factors often do not include MHPSS outcome measures; interventions and practices described in other areas in this review may be relevant for this factor.

**Evidence Gaps: Implications for Research and Field Practice:**
Researchers are encouraged to explore the significant influence of daily stressors and post-conflict hardships on the mental health and well-being of children in humanitarian settings**.** The thin evidence base could be built upon in future assessments of children's mental health and psychosocial needs and factors influencing outcomes. Field practitioners may seek to work with colleagues in other areas of humanitarian support (e.g. child protection, livelihoods, food security, etc.) to incorporate MHPSS outcomes within these activities and build the evidence-base for interventions that both reduce and prevent post-conflict hardships and difficulties, and improve MHPSS outcomes for children. Measures relating to mental health and well-being could, for example, be integrated into outcome measures for social protection or income generation interventions. In recognition that poverty and unemployment are key sources of stress for parents, caregivers, and adolescents, it is especially important to increase research and evidence-based multi-sectoral interventions to reduce poverty and to support dignified livelihoods.

**PROTECTIVE/PROMOTIVE FACTOR**

## 1.3 Resilience

Strongest evidence:

A – Systematic review(s)  6-18

**Introduction:**

There is considerable variation in outcomes amongst children exposed to traumatic events and hardships, and researchers have sought to understand these variations through an improved understanding of resilience. This review defines resilience as "good mental health and developmental outcomes, despite exposure to significant adversity" (Tol et al., 2013). The motivating question guiding resilience research has been how individuals achieve positive functioning, whether in the realm of relationships, behaviors, emotional expression, or psychopathology, after exposure to adverse/ traumatic events and stressors. Focus on resilience is justified by the fact that in humanitarian contexts, the majority of individuals exposed to traumatic events do not develop psychiatric conditions, and symptoms of mental distress amongst children often reduce over time without clinical interventions. In particular, a focus on resilience in humanitarian crises can shift focus from a "deficits" model – assuming that children will experience mental health problems – towards focusing on the resources children, families, and communities draw on to address problems. Advances in neuroscience provide new explanations about why some children develop and foster resilience while others do not. These findings have significant implications for ensuring MHPSS programming is best able to support children living in humanitarian settings.

**Epidemiological Evidence:**

In a systematic review of methodologies from two quantitative and three qualitative studies of resilience and war-related trauma in children and adolescents in middle- or low-income countries, Karadzhov (2015) found that research on Post-Traumatic Stress Disorder (PTSD) is necessary but insufficient to account for the full range of responses to traumatic experiences such as war. Different aspects of resilience have been identified in individual studies of children and adolescent mental health and psychosocial well-being. Studies with Palestinian children, for example, indicate that children exhibit more resilience when they understand the conflict and their place in it (Rabaia, Saleh, & Giacaman, 2014). In a study of 240 Palestinian youth after war exposure, Punamaki and colleagues (2015) identified three groups exhibiting different trajectories of post-traumatic stress symptoms over time (*resistant*: relatively low number of symptoms that do not change significantly over time; *increasing*: relatively high number of symptoms increasing over time; and *recovering*: relatively high level of symptoms decreasing over time). These trajectories were found to be associated with cognitive-emotional regulation and attachment. Low levels of negative post-traumatic cognitions and more secure parental attachment were associated with belonging in the resistant trajectory (12% of sample); avoidant attachment relations and avoidance of cognitive processing were associated with belonging in the recovery trajectory (76% of sample); and high levels of negative post-traumatic cognitions was associated with belonging in the increasing trajectory (12% of sample) (Punamaki et al., 2015).

Resilience is a complex dynamic process driven by time- and context-dependent variables, rather than the balance between risk- and protective factors with known impacts on mental health (Tol et al., 2013). Resilience

amongst children and adolescents in conflict-affected settings has multiple sources, including individual factors such as hope, temperament, self-regulation, self-efficacy, and cognitive competence (e.g. Wessells, 2016; Karadzhov, 2015; Punamaki et al., 2015). Research in the neuroscience of resilience, which has been able to elucidate the brain structures that underlie resilience, confirms that resilience may derive from multiple factors, including early environment, social support, genetics, epigenetics, and coping strategies. (Hunter, Grey, & McEwen, 2018). It is suggested that the locus of resilience lies within nurturing relationships that can arise between many spheres of social connection and among groups of individuals, peoples, and institutions (Vindevogel, 2017). These findings add to the systematic review conducted by Tol et al. (2013) which identified qualitative, quantitative, and mixed methods studies focusing on resilience and found evidence for political and cultural beliefs, self-esteem, coping, parental support and parental monitoring, and quality of home environment and family life, as factors promoting resilience, while recording mixed findings on some factors such as school retention and peer social support.

Although quantitative studies of resilience have contributed to the understanding of resilience's complexity, it has been identified that studies tend to focus on isolated factors that increase the likelihood of a successful psychological recovery from trauma (Karadzhov, 2015; Vindevogel, 2017). This supports the development of interventions that target empirically-supported lifestyle risk factors such as domestic and community violence, yet might neglect contextual influences on the conceptualization, manifestation, and dimensions of resilience. These identified weaknesses are largely addressed in qualitative investigations, although these have their own identified practical challenges in conflict settings (Eggerman & Panter-Brick, 2010; Nguyen-Gillham et al., 2008, cited in Karadzhov, 2015). Karadzhov (2015) identifies that these methodological problems need to be overcome to further understand the heterogeneous concept of resilience.

Children who demonstrate the strongest resilience are identified as most frequently having a combination of biological resistance to adversity and strong relationships with the important adults in their family and community *[see Areas 2.3 and 4.2]* (Harvard Center on the Developing Child, 2020). Increased efforts are needed to focus on macro-structural aspects of the social environment that either enable or impede children's resilience. Interventions that best promote resilience include those that encourage positive relationships with caregivers and peers, consistent parenting, social frameworks that promote meaning, intelligence, high emotional self-regulation, and self-efficacy or mastery (Horn et al., 2016; Traub & Boynton-Jarrett, 2017).

**Intervention Evidence:**

Increased understanding of resilience is crucial to inform effective policies and programs that help more children in humanitarian settings. Advances in neuroscience demonstrate that while the brain and other biological systems are most adaptable early in life, the capabilities that underlie resilience can be strengthened at any age (Harvard, 2020). During adolescence, for example, structural remodeling and neuronal reconfiguring continue in the brain (Balvin & Banati, 2017). The adolescent brain can make new neural pathways, making it a critical stage for inducing neuroplasticity that supports building self-control of cognitive, affective, and social capacities in adolescents (Tang & Leve, 2016). This confirms that age-appropriate, health-promoting activities can significantly improve the abilities of children to cope with, adapt to, and even prevent adversity in their lives (Harvard, 2020). It also found that adults who strengthen these skills in themselves can better model healthy behaviors for their children, thereby improving the resilience of the next generation (Harvard, 2020).

No systematic reviews have been identified which focus specifically on resilience interventions with children in humanitarian settings. Given the vast cultural and contextual differences in resilience in non-humanitarian/ high-income settings, systematic reviews based in high-income settings were not included here. Some interventions designed to address resilience as an outcome measure, alongside other primary outcomes, have been evaluated, and some interventions have focused primarily or solely on resilience outcomes. It is increasingly found, however, that helping children and adolescents adapt and exercise their agency is likely to

strengthen their resilience and can help them develop a greater repertoire of choice in their lives. As they develop capacities to reflect on their experiences, as well as new problem-solving skills and means of expression, children and adolescents have the potential to become positive agents for change in their communities (UNICEF, 2015a) [*See Area 5.2].* This can be facilitated by the rapid development of digital communications and technologies that are providing increasing opportunities for some children affected by conflict to express themselves, connect with others, learn new skills, and strengthen resilience in this way. Research by New York University, the City University of New York, and Turkey's Bahcesehir University found that digital games can effectively teach refugee children aged 9-14 much-needed skills – including a new language, cognitive skills, and coding – while also improving their mental health (New York University, 2017). The Project Hope researchers created tasks to encourage children to imagine a better future for themselves using the popular commercial game Minecraft. These structured tasks asked children to create a dream house, a dream neighborhood, and a dream school. The researchers collected measures of children's hopelessness before and after Project Hope and found that the intervention significantly lowered children's sense of hopelessness.

Evidence shows that children's trauma is characterized by hopelessness and powerlessness, therefore as part of healing, programs need to give children back their power and sense of ownership and control (UNICEF, 2018b) *[see Area 5.2].* The importance of strengthening the population's social resilience instead of portraying children exposed to political violence as victims is emphasized by Rabaia, Saleh, and Giacaman (2014). They argue for an interdisciplinary approach focusing on the "population's collective experience in coping with international aggression and neglect, the availability of family and community support, children's own individual and collective coping mechanisms, and their resilience*"* (Rabaia, Saleh, & Giacaman 2014, p. 178). Interventions following this approach pay more attention to identifying and strengthening community-based resources, developing creativity, and enhancing life skills (Rabaia, Saleh, & Giacaman, 2014).

The importance of achieving a culturally grounded understanding of resilience is emphasized by Panter-Brick et al. (2018). Based on their research testing and validating an Arabic version of the Child and Youth Resilience Measure (CYRM) in Jordan, they identify the need for adapted tools and resources in non-Western settings. They piloted three approaches based on previous work in humanitarian settings: i) the Problems and Solutions Questionnaire, which asks youth to articulate top-of-the-mind concerns and responses to them (Eggerman & Panter-Brick, 2010); ii) the storytelling approach, which asks youth to describe someone they knew who was doing well versus doing poorly in the face of adversity (Miller et al., 2006); and iii) the CYRM, which involves a pre-implementation qualitative phase to understand local aspects of resilience, with prompts such as: "What do you need to grow up well here?" and "What do you do when you face difficulties in your life?" (Ungar & Liebenberg, 2013). The authors found that resilience scores were inversely associated with mental health symptoms, and for Syrian refugees were unrelated to lifetime trauma exposure. As a result, they argue that in assessing individual, family, and community-level dimensions of resilience, the CYRM is a useful measure for research and practice with refugee and host-community youth (Panter-Brick et al., 2018).

Studies that included hope as an outcome measure are included here, as it has been used in some contexts as an indicator of resilience. Group interventions (e.g., creative-expressive, recreational, and psychoeducational activities) for youth targeting cognitive-emotional processing have shown moderate effects including reduction of PTSD symptoms, depression, and grief, and increased hope, optimism, self-confidence, problem-solving, and communication skills (Werner, 2012). Some relevant evaluations are described in the published literature on interventions for children and adolescent mental health and psychosocial well-being in humanitarian settings.

### The Child and Youth Resilience Program, Save the Children

*Program description with a rich description of participatory process and methods (level D)*

This program is based on nonclinical, psychosocial, and protection methodologies, focusing on children's positive coping and resilience. The programs use psycho-educational and neuro-affective regulatory methods with elements of cognitive behavioral therapy approaches. Children's and young people's well-being is not an isolated individual issue but a dynamic interlink between individual functioning and the surrounding environment. Therefore, a critical component of the program design is that it works at multiple levels – with children/youth, their caregivers, and communities. Both the child and the youth resilience program include caregivers' meetings, which build their skills and understanding of child/youth well-being, protection, positive discipline, prevention of abuse, etc. Alongside this, activities are undertaken to reduce risks and strengthen protective factors within the community, including strengthening the community referral mechanisms. The programs are usually not implemented as stand-alone programs but are included as components of other programs and child protection systems strengthening approaches. This program is closely linked with the Parenting without Violence Parenting Common Approach, with the workshops for children closely following the methodology and content of the resilience programs. In contexts within which the Parenting without Violence Program is implemented, and more support is desired for children, additional Child/Youth Resilience Programming may be appropriate (either the full program model or parts of it based on the local context) (Save the Children, 2018a; Save the Children, 2016; Save the Children, 2010).

### Move on & Engage Youth Curriculum program, TdH

*Program description with a rich description of participatory process and methods (level D)*

TdH's Move on & Engage Youth Curriculum program engages adolescents and youth to strengthen their resilience and coping mechanisms through the identification of an issue that needs to be addressed. They then work together with the community to address the problem and the issues surrounding it. The participants explore/strengthen five key skills: Communication, Responsibility, Creative Thinking, Cooperation, and Emotional Management through participation in 20 structured sessions with trained facilitators. The participants select the issues to work on and use areas that are relevant to their own experiences and situations. The activities are participatory and creative in nature. The overall goal is to enable participants to acquire and confidently use the key Engage skills through experiential approaches that allow them to draw practical experience from the theory they have explored. In addition, these skills have been identified as crucial to support the meaningful participation of youth and can contribute to the reinforcement of the five pillars of well-being identified in the Tdh MHPSS Framework (Tdh, 2020).

### Classroom-based interventions, Burundi and Indonesia

*RCT (level B)*

Classroom-based interventions implemented in Burundi and Indonesia were assessed for their impact on children's hope, which may reflect aspects of resilience as a protective factor. These interventions – described in greater depth in Factor 9 (schools as a protective factor) – were evaluated through cluster-randomized trials, using standardized assessment measures of depression, anxiety, PTSD, hope, and functioning to assess the impact of the intervention on children receiving the intervention, compared to a wait-listed control group. Results in Indonesia indicate that children who received the intervention maintained hope compared to children in the control group (Tol et al., 2008). Whereas results in Burundi indicate that the intervention had no direct effect on hope; however, younger children and children with low levels of exposure to traumatic events in the intervention group showed improvements on hope (Tol et al., 2014).

**I DEAL in Northern Uganda, War Child** *[11-15-year-olds]*

*Participatory evaluation using participatory tools (level C)*

Claessens et al. (2012) present the process of developing and implementing a participatory evaluation of War Child's I DEAL intervention in Northern Uganda, a life skills training program aimed at 11-15-year-olds, including sessions designed to build "communication skills, interpersonal skills, self-awareness, and coping strategies," "using a combination of creative and participatory techniques, such as role play, drawing, games, and group discussions." The evaluation used four participatory tools – Personal Goals Exercises, Impact Mapping Questionnaires, Themed Quiz Exercises, and Module Evaluation Exercises – to assess the outcomes of the intervention. The discussion primarily focuses on the development of the tools used to evaluate the intervention, rather than outcomes or impacts of the intervention itself (though pilot data from a sample in Northern Uganda is included). Children reported that sessions improved their ability to relate to children of the opposite sex, that they better understood the roles and responsibilities of adults and children after the sessions, and that personal skills and relations with peers, caregivers, and teachers had improved. The study concluded that while the participatory evaluation suits the objectives of I DEAL better than standardized quantitative measures, "it is still difficult to draw strong conclusions about the process of I DEAL, e.g. how did the content of the intervention lead to changes in children's lives? The pilot illustrates that when using more-qualitative methods, the data becomes harder to interpret."

**Teaching Recovery Techniques (TRT)**

*RCT (level B)*

Diab et al.'s study of the intervention, Teaching Recovery Techniques (TRT), to increase resiliency amongst Palestinian children, assessed the impact of the TRT – a manualized intervention designed for children who have experienced trauma, using relaxation exercises, play, drawing, writing and narrating, psychoeducation, and techniques to deal with key symptoms of post-traumatic stress, including avoidance. The intervention was assessed for impact on resilience, "conceptualized as a presence of positive indications of mental health despite trauma exposure." Children aged 10-13 were randomly selected to be part of the intervention (n=242) or control group (n=240). Children were assessed at baseline and follow-up, with relevant outcome measures for psychosocial well-being and prosocial behaviors. Results showed that the intervention was not effective in maintaining or increasing resilience amongst children in the intervention group. The authors indicate that the intervention may not have been appropriate to address the level of trauma experienced by the children in the study, or that that intervention did not involve caregivers, who are an important source of protection for children in this context (Diab et al., 2015).

**Evaluation example: Advancing Adolescents program, Mercy Corps**

*RCT (level B)*

This is an adolescent-focused psychosocial intervention that has been implemented in Jordan, Lebanon, Iraq, and Syria, and the program has been evaluated in Jordan (Panter-Brick, Kurtz, & Dajani, 2018; Panter-brick et al., 2017). It is a psychosocial intervention of structured, group-based activities (technical, vocational, and art skills) targeting 8–15-year-olds. This brief, scalable intervention (16 sessions across eight weeks) is designed to alleviate profound stress, build resilience, strengthen social cohesion, and heal conflict. Key elements of the program are common to other psychosocial interventions, including group-based skills-building sessions (e.g. vocational skills, technical skills, fitness, and arts and crafts) run by trained local community volunteers. The program emphasizes stress management, relationships, and personal achievement (Panter-brick, Kurtz, & Dajani, 2018). Innovations in the research approach included: an experimental research design that enhanced both scientific rigor and cultural engagement, the use of

multiple methods to track mental health and psychosocial well-being over time, and it corroborated self-reports with biological measures of stress (Ibid.). Program impacts were assessed for adolescents participating in the intervention, over and above changes that may be observed for adolescents in the "control" group. The impact evaluation revealed both positive impacts as well as null findings, pointing to the need for improvements to programmatic approaches. There were moderate impacts across several dimensions of mental health and psychosocial well-being, as measured by international and regionally validated measures of Human Insecurity, Human Distress, Perceived Stress, Arab Youth Mental Health, and Strengths and Difficulties questionnaires. The Mercy Corps program evaluated was effective in regulating stress physiology and reducing the time that adolescents spent experiencing high levels of insecurity. Furthermore, impacts on levels of insecurity were sustained over time, lasting over 11 months of observation. Biological and cognitive outcomes: measuring stress in the body and brain were recorded, and the study found that hair cortisol concentrations declined by a third in response to the intervention. Participation in the program reduced chronically high cortisol levels, and it upregulated chronically low cortisol levels, showing improved regulation of cortisol production. However, there were no impacts on prosocial behavior or post-traumatic stress reactions, or on resilience levels during the period of study. Furthermore, there were no short-term improvements in some of the cognitive skills that underscore learning and social development (see Panter-Brick, Kurtz, & Dajani, 2018; Panter-brick et al., 2017).

### Conclusion and Implications for Research and Field Practice:

Individual studies of children and adolescent mental health and psychosocial well-being identify different aspects of resilience. One systematic review of resilience amongst children and adolescents in conflict-affected settings identified a range of aspects of resilience, emphasizing the need to view resilience as a "complex dynamic process," rooted in context. There are considerable variations in outcomes amongst children exposed to trauma and hardship, although advances in neuroscience provide new explanations about why some children develop resilience while others do not. A systematic review found that research on PTSD is necessary but insufficient to account for the full range of responses to traumatic experiences such as war.

No systematic reviews of interventions specifically designed to focus on resilience in humanitarian settings were identified. A limited number of rigorously evaluated interventions designed to promote resilience (amongst other intended outcomes) were identified. In particular, there are a number of RCTs evaluating Classroom-Based Interventions; however, findings of impacts on resilience outcomes are mixed.

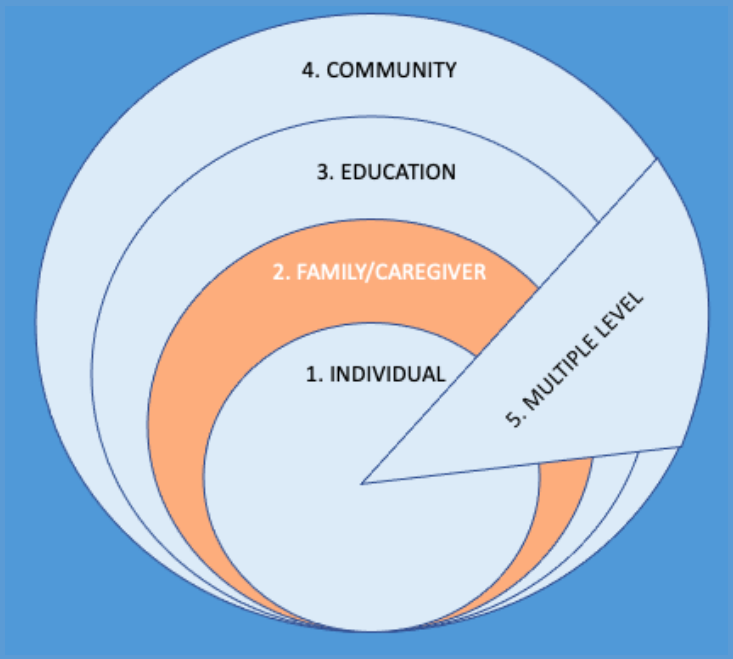
### Evidence Gaps:

Further exploration of appropriate research and evaluation designs are required to better understand the interplay between the resilience of children, families, and communities. Theoretically informed and rigorous assessment techniques are needed to conduct further research to better understand the complexity and dynamics of children's resilience in humanitarian settings, in situations of armed conflict, insecurity, disaster, and wider health pandemics. This would help better inform the areas of resilience that are most important to target and how other variables, such as gender, age, family support, and wider contextual factors, influence the development of individual resilience.

There is scope for longitudinal research to better understand how an individual's resilience may change over time. There is also a need for increased research and evidence-based interventions focusing on macro-

structural aspects (poverty, political agendas, etc.) that shape and influence personal, familial, and collective aspects of resilience. As emphasized by Vindevogel (2017), “political and institutional efforts shape the necessary preconditions and opportunities for social systems, services, groups and individual actors to mobilize resources and supports that promote resilience… Future theory, research, and interventions on resilience in war-affected children can more explicitly focus on the relational aspects of resilience, by, for example, linking indicators in children, collectives and systems on the one hand and macrosocial policies and service design on the other hand” (p. 81).

# Section 2: PARENTS/CAREGIVERS




The family constitutes the prime source of risk, as well as resilience for the well-being of children growing up in adverse conditions. This section shares evidence and interventions on the following risk and protective/promotive factors:

**2.1 Caregiver mental health and compounded stress** (risk)
**2.2 Alcohol and substance-use within household** (risk)
**2.3 Parent-child relationships** (protective/promotive)
**2.4 Caring for caregivers** (protective/promotive)

**RISK FACTOR**

## Area 2.1: Caregiver mental health and compounded stress

**Strongest evidence:**

**A** – Systematic review(s)

0-18 years

**Introduction:**

Caregiver mental health has been identified as a risk factor for children and adolescents in multiple contexts.[1] The impacts can be direct, for example, caregivers' poor mental health may directly impact children's mental health, or indirect, namely, caregivers experiencing high levels of distress may be more likely to engage in substance abuse, violent behavior, or harsh parenting and discipline that subsequently have negative impacts on children's well-being *[see Area 5.1]*. In humanitarian settings, caregivers' mental health may be particularly affected by exposure to direct trauma and conflict-related events, including changes in socioeconomic status, bereavement due to loss of family and community members, sexual and gender-based violence, and displacement, all of which are risk factors that can elevate symptoms of mental distress. This area shares increasing evidence that the household environment can increase exposure to risks for adverse mental health and psychosocial outcomes for children and result in longer-term consequences.

**Epidemiological Evidence:**

Multiple studies demonstrate that caregiver mental health, including trauma and psychosocial stress, can predict child mental health in conflict-affected and refugee settings through the proliferation of stressful social environments, as well as biological pathways (e.g., Eltanamly et al., 2019; Verdeli et al., 2016; Weissbecker et al., 2019; Slone & Mann, 2016; Devakumar et al., 2014). The study conducted by Bhatt et al. (2017), for example, found that in general, poor caregiver mental health acted as a risk factor for child psychiatric disorders, and specifically, psychological distress in parents was a main mechanism through which trauma caused poor psychological outcomes in children. A recent meta-analysis of 38 quantitative and ten qualitative studies found that more war-exposed parents, for example, exhibited less warmth and more harshness toward their children, which in turn mediated the association between war exposure and child mental health (Eltanamly et al., 2019). Eltanamly et al. (2019) found that it is both how much and what families have seen that shapes how adults care for children in times of war. More war-exposed caregivers showed less warmth and more harshness toward their children, which partly mediated the association between war exposure and child adjustment – that is, post-traumatic stress symptoms, depression and anxiety, social problems, externalizing behavior, and lower positive outcomes (e.g., quality of life) (Ibid).

Daily stressors including abuse or neglect, physical and mental health problems, marital conflict, substance use, domestic or community violence, and financial stressors, such as unemployment, financial insecurity, and homelessness, can place parents under considerable stress in any situation, yet are often exacerbated in adverse contexts (Ager et al., 2011; Miller & Jordans, 2016). It is widely understood that war increases parental stress (Conway et al., 2013). Exposure to traumatic events, in addition to multiple life stressors in humanitarian settings, significantly reduce a caregiver's capacity to cope effectively with the typical day-to-day stresses of

[1] In this Review, caregivers are defined as a mother, father, other family member, teachers, social workers, community volunteers, and any other frontline worker in a caregiver role for children.

raising children, including attending to their children's emotional needs (Department of Health & Human Services, 2018; Scharpf et al., 2019). Displacement as a result of conflict, for example, can lead to changes in family structures and roles played within it, in addition to reduced access to financial resources (Farhood et al., 1993; Farhood, 1999). Such financial burdens, induced by war exposure, can negatively impact parents' emotional state, leading to more conflicts, increased hostility, and reduced warmth in parent-child interactions (Eltanamly et al., 2019). In El-Khani et al.'s (2018) qualitative study carried out in refugee camps in Turkey, Syrian refugee mothers described how trauma, loss, and severe stress caused by poor living environments and uncertainty about the immediate and long-term future had made it difficult for them to maintain positive parenting strategies.

A study by Meyer et al. (2017) explored the relationship between caregiver depression and the mental health of adolescents aged 13 and 17 years in two refugee settlements in Uganda. They found a significant correlation between adolescent well-being and caregiver mental health in this refugee context. Research by Borba et al. (2016) with war-affected Liberians found that young adults often experienced challenges in parenting, relating to work, maintaining healthy relationships with their spouses, and forming intimate relationships. They suggest that disruptions in functioning may create a negative feedback loop, with "poor mental health promoting poor functioning, and poor functioning exacerbating poor mental health" (pp. 64-65). A study by Khamis (2014) on the impact of war trauma on behavioral and emotional disorders in children found that conflict-affected parents may face difficulties interacting with children, become less sensitive and responsive to their needs, and may be less effective at maintaining rules and setting boundaries. These findings are supported by a recent study by WHO that found that depressed women are likely to experience depressed mood, irritability, and pessimism, as well as difficulty expressing warmth, affection, and pleasure (WHO et al., 2018b).

The literature is reinforced by other research exploring evidence on the relationships between child-caregiver mental health in displaced populations (e.g., Scharpf et al., 2019; El-Khani et al., 2018). Scharpf et al.'s (2019) recent research with Burundian refugee children aged 7–15 years, living in Tanzanian refugee camps, examined the prevalence of PTSD and other mental health problems and identified patterns of comorbidity among children and their parents based on PTSD symptom levels and functional impairment. A representative sample of 230 children participated in the research in addition to both of their parents (n = 690). While a relatively low number of children needed support for trauma-related mental health problems, the authors found a correlation between children with high symptom levels and impairment living in families with two traumatized parents (Scharpf et al., 2019).

The relationship between child mental health and family bereavement or rape has also been explored in some studies. Eltanamly et al. (2019) found that experiencing sexual violence and bereavement in the context of war exposure affected families very differently, with opposing effects on parenting practices. Mothers who experienced sexual violence suffered a harmed self-image and were reminded of their trauma through their children's symptomatic behavior; they avoided engaging with their children and became overly withdrawn and insensitive (Almqvist & Broberg, 2003, cited in Eltanamly et al., 2019). By contrast, bereaved parents felt very close to and had a great sense of empathy toward their surviving children. They, therefore, spent more time together, tolerated children's misbehaviors, and became more lenient (Abbott, 2009, cited in Eltanamly et al., 2019). An earlier systematic review of risk and protective factors for children's psychological health in humanitarian settings also noted mixed findings on the relationship between family bereavement (for example, loss of a caregiver) and child mental health (Reed et al., 2011). This review notes that evidence from war-affected and non-refugee populations indicates that child-caregiver mental health associations in low-income and middle-income countries are likely to be a central factor in children's psychological health (Ibid.).

The effects of war have been found to persist for years after exposure (e.g. Bryant et al., 2018). Advances in neuroscience have identified that adversity has an impact on brain structure and function across the lifespan (Hackman & Farah, 2009; Teicher et al., 2016) *[see Area 1.3].* Intergenerational impacts of war and

displacement – how trauma experienced in one generation affects the health and well-being of descendants of future generations – are increasingly explored (e.g. Sim, Fazel, et al., 2018; Sangalang & Vang, 2017). Sim, Fazel, et al.'s recent study (2018) explores the effects of armed conflict on parenting behavior and subsequent impacts on child mental health and psychosocial outcomes. Cross-sectional data were collected in 2016–2017 from a sample of 291 Syrian refugee mothers in Lebanon. The authors found that exposure to war-related events was directly associated with maternal post-traumatic stress and general psychological distress, as well as indirectly via daily stressors. Mothers' general psychological distress, but not post-traumatic stress, was directly associated with negative parenting and child mental health and psychosocial difficulties. Negative parenting mediated the association between maternal general psychological distress and child mental health and psychosocial problems. The results suggest that the adverse effects of past war trauma and ongoing displacement on refugee mothers' general mental health can increase the risk of negative parenting behavior and, in turn, contribute to poorer mental health and psychosocial outcomes for children *[see Area 5.1].* Devakumar et al. (2014) find that while conflict's potentially long-lasting harms to health within an individual's lifetime is well-established, there is increasing awareness that its adverse effects may continue through intergenerational biological mechanisms (Devakumar et al., 2014). The systematic review conducted by Sangalang and Vang (2017) further contributes to this understanding by highlighting refugee trauma, the effects of parental trauma on children's health and well-being, and the mechanisms by which parental trauma transmits to others, and the underlying meanings attributed to parental trauma in refugee families.

The impact of the COVID-19 pandemic has also affected caregivers across the world. Recent evidence reviews concerning the impact of COVID-19 describe how caregivers are under increased levels of stress as a result of the pandemic and the confinement. Many parents demonstrate hypervigilance over the need to protect their children and themselves from infection (UNICEF, 2020c). Added pressures may include caring for sick or older family members, balancing work and homeschooling, and confronting new financial difficulties due to economic downturns (Ibid.). Physical distancing can limit parents' and caregivers' access to the social support that they need. Furthermore, caregivers' lived experience and stress relating to COVID-19 is compounded by the loss of livelihoods and future uncertainty for themselves and their children (Ibid.).

**Intervention Evidence:**

Miller and Jordans (2016) found that while calls for ecological approaches are widespread, most evidenced-based interventions continue to prioritize direct work with children, with limited attention to addressing ongoing stressors and resource deficits in their families and broader social environments (citing Jordans, Pigott, & Tol, 2016; Jordans et al., 2009). Miller and Jordans (2016) call for interventions in humanitarian contexts to address the prevention and treatment of caregivers' mental health in order to better support children's mental health outcomes is increasingly supported by others (e.g., Scharpf et al., 2019; Meyer et al., 2017; Sim et al., 2018).

Scharpf et al. (2019) argue that taking into account parental trauma could help identify at-risk children with elevated PTSD symptom levels and impairment even in the face of existing barriers to mental health care access for children in refugee camp settings (e.g. lack of targeted services, prioritization of managing daily stressors) (Scharpf et al., 2019). Sim et al. (2018) call for interventions to address the structural challenges that debilitate caregiver and child mental health.

Interventions designed to improve mothers' mental health, for example, have been found to have a positive impact on infants' health and development (WHO et al., 2018). There are effective interventions for reducing depression and promoting maternal mental health implemented by trained community health workers under professional supervision that have been tested in low- and middle-income countries (Rahman et al., 2013; WHO et al., 2018). Other promising practices identified by Bhatt et al. (2017) include:

- Mercy Corps Palestine implements group sessions using creative activities to help caregivers, mainly mothers of children already engaged in Mercy Corps programs. The sessions are designed to help the mothers better cope with their own stress, and children and caregivers participate in structured sessions together. There are also interventions at the family level to foster positive family interaction and learn about stress management.
- Save the Children Palestine implemented a program for ex-detainee children and their parents, which included MHPSS components involving MHPSS and counseling for parents and children.
- War Child implements a Caregivers Support Intervention (CSI) designed to reduce parental stress and distress through an increase in the provision of social support, psycho-education, and stress management techniques. The program also supports parents to learn about strategies to reduce harsh parenting and increase positive parenting.
- Action Against Huger implements Baby-Friendly Spaces in which the main objective is to take care of the mother/caregiver in order to support her to take care of the child/infant and prevent malnutrition of children. Staff in Baby-Friendly Spaces support parents with psychological distress and help women continue to breastfeed despite distress, and provide a safe space to connect with their babies.
- UNICEF developed a pilot program to integrate Nutrition Programming in West and Central Africa: one of two training modules focuses specifically on training Health workers to provide MHPSS support to caregivers, including strengthening coping mechanisms, developing support mechanisms, and identifying caregivers in need of more specialized support and referring for further support. The program is designed to strengthen the attachment between mother and baby.

Systematic reviews of interventions outside of humanitarian settings shed light on some potential interventions to address caregiver mental health. A systematic review of group parenting programs designed to improve parental mental health and psychosocial well-being found that parenting interventions (behavioral programs, cognitive programs, and multi-modal programs) significantly improved several mental health and psychosocial outcomes amongst parents, including depression, anxiety, stress, anger, guilt, and confidence. However, these benefits were not retained at follow-up of one-year, suggesting that interventions have important short-term benefits, but that "further input may be needed to support parents to maintain these benefits" (Barlow et al., 2014). One review (focused specifically on studies of interventions to address parental depression that also assessed the impact on child psychopathology) found nine relevant studies, concluding that five out of the nine showed that treatment of parental depression reduced children's mental health problems, for example, reductions in symptoms of emotional and behavioral problems (Gunlicks & Weissman, 2007).

Studies focusing on adult survivors of torture and violence in humanitarian contexts have shown significant positive impacts of Cognitive Processing Therapy interventions on mental health and psychosocial outcomes (e.g. Bolton et al., 2014). An RCT of Common Elements Treatment Approach for Burmese refugees in Thailand also showed significant reductions of symptoms of depression, post-traumatic symptoms, anxiety, and increased functioning amongst participants receiving the intervention, compared to the wait-list control (Ibid). In addition, these studies describe interventions that went through cultural and contextual adaptation delivered by community mental-health workers who received approximately two weeks of in-person training, and thereafter, distance-support from supervisors. This model seeks to address constraints on the feasibility of delivering interventions in contexts with limited human resources (Murray et al., 2011).

**Common Elements Treatment Approach**

*RCT (level B)*

The Common Elements Treatment Approach is a transdiagnostic mental health intervention that was developed for trained non-professionals to deliver in low- and middle-income countries. The approach uses a modular and flexible approach to teach Cognitive Behavior Elements (CBT) to address trauma, anxiety, depression, and behavioral problems (Kane et al., 2017). As reported in Promundo and Sonke Gender Justice

(2018), the approach has demonstrated significant effects on a range of mental health symptoms among adults (Bolton et al., 2014; Weisz et al., 2012) (*see also intervention in Area 2.2 where the Common Elements Treatment Approach is adapted to address alcohol abuse*).

**Evaluation example: International Medical Corps' Home-Based Psychosocial Program for Iraqi families in Jordan**

*Mixed method evaluation with a waitlist control group (level C)*

Mobile psychosocial services supporting home-based activities were assessed to determine their impact on the emotional and behavioral health and functioning of Iraqi families displaced in and around Amman, Jordan. The program and evaluation process was conducted by the International Medical Corps, with technical assistance from faculty from the Applied Mental Health Research Group at Johns Hopkins Bloomberg School of Public Health. A controlled trial design was used to evaluate the effectiveness of mobile psychosocial services that brought isolated families together to engage in group activities. The design was chosen to 1) test the effectiveness of a home-based psychosocial program for reducing the isolation and increasing the social connectedness of Iraqi families displaced in the greater Amman-area, Jordan, and 2) to evaluate the impact of this intervention on the reduction of locally described mental health problems and improvement of functioning among the same Iraqi families. N=128 families were enrolled in the intervention, with 28 families forming a wait-list control group. Qualitative interviews with the intervention participants indicated that the participants enjoyed the program and improved social connection with other families and within their own families. Several participants, adolescents as well as adults (parents/caregivers), indicated that the program improved cooperation and communication within the family. Other respondents talked about meeting new people. Several of the adolescent participants indicated that through the program they made new friends. Participants also reported in qualitative interviews that they felt that program participation had improved their emotional well-being. Quantitative results, comparing adolescents and caregivers who received the intervention to those who did not, indicated that adolescents showed improvements in social support, while for male and female caregivers, none of the changes in social support indicators reached significance. On mental health and psychosocial outcomes, adolescents showed improvements and a decrease in functional impairment.

**Evaluation example: IRC, Reach Up and Learn (RUL)**

Reach Up and Learn (RUL) is a home-visiting program that was first introduced in Jamaica in 1975 and later adapted for Syrian refugees and host communities in the Middle East. Since 2017, the intervention was delivered in-person by Community Health Volunteers (CHVs). However, since June 2020, it has been adapted for phone delivery due to the spread of the coronavirus (COVID-19). The activities were adapted to be delivered on the phone to provide caregivers with developmentally appropriate play activities they can do with their children using basic household items (plastic bottles, bottle caps, plastic containers, etc.). Specifically, CHVs recruit caregivers from their social networks and register them in the program. They then call them three times a month to 1) check in on their well-being, 2) deliver community health messages, and 3) tell them about the play activities relevant to their child's age. The calls are scripted and available on a tablet that can be remotely updated as needed. The program aims to serve children from 6-36 months of age among Syrian and Jordanian households in Mafraq, Amman, Irbid, and Ramtha governorates in Jordan. Each age group is composed of two-month intervals (6-8 months, 9-11 months, etc.), resulting in ten age groups with each age group having eight scripts for a total of 80 scripts across all age groups. A randomized impact evaluation in partnership with NYU Global TIES is underway to evaluate the impact of the adapted version of RUL on the caregivers' well-being and children's development. In addition, a quality observation tool to determine the call quality will be developed and validated. This study is the first to be conducted in the Middle East that assesses the impact of a phone-based parenting intervention. More generally, few early childhood development (ECD) programs have been studied in the Middle East, especially for this age group. Relatedly, there is a dearth of measurement tools

to assess child development, parenting, or the quality of ECD services that have been validated in this context, especially in terms of phone-based parenting interventions.

**Conclusion and Implications for Research and Field Practice:**

Systematic reviews have been identified that focus on the association between caregiver mental health as a risk factor and mental health or psychosocial well-being amongst children or adolescents in humanitarian settings. Studies have identified significant impacts of interventions on mental health and psychosocial outcomes, showing reductions of symptoms (PTSD, depression, anxiety) and improvement in functioning levels. Systematic reviews of interventions outside of humanitarian settings shed light on some potential interventions to address caregiver mental health.

There is emerging evidence from humanitarian settings on the impact and effectiveness of interventions to improve adult mental health and well-being. Focusing on improving the well-being of caregivers and reducing family violence *[see Area 5.1]* provide important avenues to improve children's mental health and well-being.

**Evidence Gaps:**

Further evidence is needed on how trauma is transmitted across generations, as well as how transmission occurs in specific populations to inform appropriate supportive policies and programs, particularly for refugee families (Sangalang & Vang, 2017). Sangalang and Vang (2017) recommend greater inclusion of children and youth to identify potential developmental and psychological consequences of parental trauma, as well as protective factors early on, to inform appropriate interventions that can prevent negative outcomes in the future (Sangalang & Vang, 2017). Furthermore, greater efforts are needed to integrate the Nurturing Care Framework for Early Childhood Development into humanitarian policies, programs, services, and research (WHO et al., 2018).

**RISK FACTOR:**

## Area 2.2: Alcohol and substance use

**Strongest evidence:**

**A** – Systematic review(s)

0-18 years

**Introduction:**

Alcohol and substance use can be a direct and indirect risk factor for children and adolescents in conflict-affected settings. Children's mental health and psychosocial well-being may be affected if they engage in drinking alcohol or substance-use. Additionally, excessive drinking or substance use by caregivers in the child's household, or adults in the community, can increase risks of violence against children, risky sexual behaviors, and insecurity for children within households or in communal spaces. Recent evidence identifies that people affected by conflict, including refugees, and particularly men, face increased risks of using alcohol or other substances as a (negative) way of coping with exposure to trauma and ongoing stress (e.g., Weissbecker et al., 2019; Roberts & Ezard, 2015; de Jong et al., 2003). Adolescents and young adults have been found to be particularly vulnerable and susceptible, especially when their families are disrupted (Weissbecker et al., 2019).

One relevant systematic review on harmful alcohol use among conflict-affected populations has been identified, although in general, limited evidence has been found on alcohol and drug use patterns amongst children, adolescents, and women (refugees). Less is known about the connections between this risk factor and children's mental health and well-being in humanitarian settings.

**Epidemiological Evidence:**

Despite the identified risk of alcohol and substance use among populations affected by armed conflict, research and recognition of alcohol and substance use as both a cause and consequence of mental health problems are inadequate (Devakumar et al., 2014; Hassan et al., 2016; Roberts & Ezard, 2015; Lai, 2014; Horyniak, 2016). A recent review by Lo et al. (2017) systematically examined evidence on harmful alcohol use among conflict-affected populations in low- and middle-income countries. From a total of 22 quantitative studies, seven studies were found to examine the relationship between exposure to armed conflict and harmful alcohol use (Bosnar et al., 2004; Kozaric-Kovacic et al., 2000; Londono et al., 2012; Maksimovic et al., 2011; O'Donnell & Roberts, 2015; Roberts et al., 2011, 2014).

Although the direct impact of harmful alcohol use on or by children was not a primary objective of this review, several identified studies make associations between harmful alcohol drinking and violent behaviors, by adults or children, which may impact children's physical and mental well-being (Saile et al., 2013, 2014; Sibai et al., 2009). The predominant factors associated with harmful alcohol use were male gender, older age, cumulative trauma event exposure, and depression, although the authors found that the strength of evidence was limited by the moderate quality of the studies. The authors call for more evidence to understand the scale of conflict-associated harmful alcohol use, key risk factors, and the association of alcohol use with physical and mental disorders (Lo et al., 2017).

Hassan et al. (2016) report that unmet mental health needs may increase the likelihood of drug and alcohol abuse in adults in conflict-affected areas. In Syria, women dealing with loss have been found to be particularly prone to substance abuse – cases of addiction to prescription medications have been recorded in Syrian

refugee camps (Hassan et al., 2016, cited in Orrnert, 2019, p.131). An increase in substance use amongst displaced populations has also been identified, especially among combatants and former combatants, who may use substances as a way to cope with traumatic memories or stressful situations (Roberts & Ezard, 2015; Ezard, 2012; Devakumar et al., 2014). Refugee camps on the Thai–Burma border, for example, have become "a fertile breeding ground for drug and alcohol addiction in one manifestation of people's efforts to cope, however dysfunctionally, with the extreme stress of conflict-related displacement" (Lai, 2014, p. 183). Devakumar et al. (2014) record that in Afghanistan, increased intravenous opiate use has been observed as a result of conflict and related drug policy. In Somalia, the use of khat among ex-combatants was 60%, compared with 28% in civilian war survivors, and 18% in civilians without war exposure (Devakumar et al., 2014, p. 4, cited in Orrnet, 2019).

An earlier systematic review of evidence on alcohol and substance-use in humanitarian settings focusing on adult populations, found that while the incidence of substance use and abuse are complex and situation-specific, increased social, economic, and domestic problems are common consequences (Ezard, 2012). Ezard's review identified studies connecting alcohol and substance-use with gender-based violence and social and economic problems, including child abuse and family conflict. Ezard (2012) identifies the need to account for gender differences in alcohol and substance-use, noting that the complex relationship between use, harm, and gender and that it is situation-dependent. They found that dependence is more prevalent among men than women, and post-traumatic stress disorder is associated with alcohol dependence for men but not women *[See also Areas 2.2 and 5.1].*

A review of research on the intergenerational effects of war on children has identified that drug use may pass adverse effects from parents to their children (Devakumar et al., 2014). Drug use by pregnant women, for example, has been found to have transplacental effects or cause maternal ill-health or altered behavior. The manifestations of this may be acute (e.g., neonatal abstinence syndrome from opiate withdrawal) or lead to longer-term behavioral and cognitive changes (Orrnert, 2019). These, in turn, can have detrimental effects on parenting ability, which can have a direct impact on the child's mental health *[See Area 2.2, 2.3, and 5.1].* Given the potential adverse impacts on children's risk environments and mental health and psychosocial well-being, further research is needed to better understand alcohol and substance use associated with conflict, including potential intergenerational effects.

**Intervention Evidence:**

Despite the knowledge that conflict-affected populations are at higher risk of experiencing alcohol and drug misuse, very limited evidence is available on the effectiveness of interventions addressing this risk factor, particularly in connection with supporting children's mental health and well-being. For example, Lai's 2014 study was the only publication in Kamali et al.'s recent systematic review of MHPSS for conflict-affected women and children in LMICs that focused on interventions related to alcohol or substance abuse disorders (Kamali et al., 2020). Lai reports on an effective drug and alcohol rehabilitation program being carried out in the Thai-Burma camps by the Drug and Alcohol Recovery and Education (DARE) Network – a small, community-based organization with remarkable success in the treatment of addicts on both an in-patient and outpatient basis (DARE Network, 2011). DARE Network tries to address the social, political, and economic dimensions of addiction in order to achieve long-term recovery. Their treatment paradigm aims to support the recovery from drug and alcohol addiction in order to return people to their communities, making their communities more resilient to deal with political and economic upheavals: "Even though everything else has been taken from them, as long as they keep their minds they are free people" (DARE Network, 2011).

Further evidence from community-based mental health interventions is associated with reductions in the prevalence of substance use and contribute to the literature in this area. These include strengthening social networks, prosocial behavior, and community mobilization (Lund, Baron, & Breuer, 2018). Parenting

programs, for example, have been reported to have a positive impact on the relationship between parents, reducing conflict, and reported alcohol or substance misuse by fathers (Bacchus et al., 2017; WHO, 2018). Broader social protection schemes reducing stresses associated with family poverty have also shown promising evidence. For example, government's conditional cash transfers to families in Mexico have led to increases in school enrollment and decreases in school dropout and alcohol consumption (Bobonis & Castro, 2013, cited in Butchard & Hillis, 2016). However, Jordans et al. (2019) found that in low-income countries, especially in rural settings, targeted care for people with mental, neurological, and substance use disorders is largely absent. To increase treatment coverage, they argue that mental health services should be integrated into community and primary healthcare settings. Weissbecker et al. (2019) call for a collaborative system to address harmful practices and improve public health education with cross-referrals (e.g. via conveying messages regarding misuse of alcohol or drugs) and follow-up if required.

Systematic reviews of substance and alcohol-use prevention interventions in high-income settings indicate low to moderate effectiveness of various types of substance and alcohol-use interventions. For example, MHPSS interventions, defined as "contingency management (offering incentives for behavioral changes), relapse prevention, general cognitive behavior therapy, and treatments combining cognitive behavior therapy and contingency management," were found to have low-moderate to high-moderate effects on substance-use disorders (Dutra et al., 2008). A systematic review of mindfulness meditation interventions for substance-use disorders showed that several mindfulness interventions were effective in reducing substance-use disorders, while methodological limitations to studies prevent conclusive recommendations on these interventions (Zgierska et al., 2009).

Significant adaptation (including cultural adaptation) of interventions is required for humanitarian contexts, including type of substance use disorder (for example, taking into account commonly used substances), and implementation within low-resource settings. Given the dearth of substance and alcohol-use prevention and treatment interventions, and evidence concerning the burden of such conditions on individuals, households, and communities in humanitarian settings, adaptation, piloting, and evaluation of interventions would be worthwhile. Moreover, some interventions that are effective in high-income settings, such as legislation, banning alcohol advertising, and imposing alcohol taxes, are not feasible in low-income settings where alcohol is largely unregulated, as is the case in many displacement settings (Anderson et al., 2009).

**Common Elements Treatment Approach**

*RCT (level B)*

The Common Elements Treatment Approach, an ongoing transdiagnostic mental health intervention developed for trained non-professionals to deliver in low- and middle-income countries, has demonstrated significant effects on a range of mental health symptoms among adults (Bolton et al., 2014; and Weisz et al., 2015, cited in Promundo & Sonke Gender Justice 2018). An RCT conducted in Zambia evaluated an adapted version of the Common Elements Treatment Approach, which included a CBT-based substance use reduction component. The study considered the effectiveness of the approach with mothers, fathers, and children in terms of reducing violence against women and girls and decreasing alcohol abuse in families (Kane et al., 2017). Findings indicated that the intervention significantly reduced women's experience of sexual and non-sexual intimate partner violence over a sustained period, decreased both women and men's use of alcohol, and improved other mental health conditions (The Prevention Collaborative, 2019).

### Problem Management Plus (PM+) WHO

*RCT (level B)*

WHO has developed Problem Management Plus (PM+) as a non-specialist-delivered basic version of cognitive behavioral therapy (CBT) for adults in communities affected by adversity (WHO, 2016). It is designed to address psychological and social problems through problem-solving counseling and a range of complementary interventions such as stress management, behavioral activation, and strengthening of social support systems (Weissbecker et al., 2019). PM+ can be used with people experiencing a range of common mental health problems, including stress, anxiety, or depression. Initial research and RCTs have found that PM+ is a promising intervention for reducing depression and anxiety symptoms in conflict-affected populations, and there is potential for further developing and scaling up this intervention targeting refugee populations (Dawson et al., 2015; Rahman et al., 2016). Further research is required to determine the wider impact on family members, including children.

### Alcohol Use Disorders Identification Test [AUDIT],

*Pre-post test of health workers' attitudes and knowledge (level D)*

One intervention implemented in a humanitarian setting is described in Ezard et al. (2010). The study describes the design and piloting of an intervention in a refugee camp in Thailand using the Alcohol Use Disorders Identification Test [AUDIT] as a screening instrument within primary health care settings, and then a brief intervention, designed as a prevention intervention for risky drinkers. Screening and brief intervention were found to be feasible and acceptable (to health care workers), while acceptability and impact on community members were not assessed, with the study concluding that "more work is required to assess whether the intervention does indeed reduce alcohol-related harm in the target population."

### Harm reduction programs for injecting drug users

*Qualitative assessment (level D)*

Todd et al. (2009) presented a qualitative assessment of harm reduction programs for injecting drug users in Kabul, Afghanistan, using focus groups and free-list interviews to assess the program quality, utilization of needle exchange, and other harm reduction activities. The results show that while harm reduction programs are perceived positively, "inadequate geographic coverage and lack of programme resources to provide field-based outreach workers throughout the week indicate gaps that should be addressed quickly."

No program evaluations of alcohol and substance use prevention or treatment interventions relevant to children's MHPSS were identified in this review.

### Conclusion and Implications for Research and Field Practice:

A limited number of studies conducted in humanitarian settings focus on alcohol or substance use amongst conflict-affected populations. These studies focus on adults, which may be relevant to children's mental health

and psychosocial well-being, although the impacts on children are not directly measured. Epidemiological literature and evaluations of interventions focused on substance and alcohol use by caregivers and or by children in humanitarian settings is particularly lacking. One systematic review of evidence on substance use in humanitarian settings that was identified focused on adult populations in conflict-affected settings. The review, and the small number of studies outlined in addition above, focus on adults' alcohol and substance use in conflict-affected settings. While this may be a risk factor for children's mental health and psychosocial support, this relationship is poorly understood. No systematic reviews of interventions in humanitarian contexts were found. Systematic reviews of substance and alcohol use prevention and treatment interventions in high-income settings may shed some light on effective programming; however, many interventions identified as efficacious are not feasible or applicable in many conflict-affected settings.

**Evidence Gaps:**

More evidence is required to understand the scale of conflict-associated harmful alcohol use, key risk factors, the association of alcohol use with physical and mental disorders, and its impact on children (Lo et al., 2017). Potential intergenerational effects also warrant further investigation. Researchers are encouraged to identify opportunities to support and guide field practitioners in assessing prevalence and correlations of this risk factor for children, and field practitioners are encouraged to contribute to evidence on the effectiveness of interventions to address harmful alcohol use in conflict-affected populations.

**PROTECTIVE/PROMOTIVE FACTOR**

## Area 2.3: Positive Parent-Child Relationships

**Strongest evidence:**

**A** – Systematic review(s)

0-18 years

**Introduction:**

Positive parent-child relationships are essential for healthy child development. In fact, having at least one stable and committed relationship with a supportive parent, caregiver, or another adult, has been identified as the single most common factor for children who develop resilience (Harvard University, 2020) *[see Area 1.1].* These relationships buffer children from developmental disruption, build key capacities that enable children to respond adaptively to adversity, and thrive, providing the foundation of resilience (ibid). The majority of evidence and literature focused on this protective factor is based in high-income settings. However, there is growing evidence from studies and interventions in low-income and conflict-affected settings that emphasize the significance of parent-child relationships in supporting the mental health and well-being of children in humanitarian settings.

**Epidemiological Evidence:**

Growing evidence highlights that the availability of a responsive, loving caregiver is a key protective factor for children living in adversity, including poverty and conflict (e.g. Jones, 2019; Puffer et al., 2017; Betancourt, 2017, 2015; WHO, 2018; White et al., 2014; Fazel et al., 2012). Responsiveness is considered one of the key aspects of parental support and monitoring, defined by Eshel et al. as "parenting that is prompt, contingent on the child's behavior and appropriate to a child's needs and developmental state" (2006). Eshel et al. (2006) found that responsiveness has wide-ranging benefits for the child, from better cognitive and psychosocial development to protection from disease and mortality. Samuels et al. (2018), for example, found that family support, both nuclear and extended, was an important coping strategy for adolescent girls in Gaza. Aunts were frequently mentioned since they were often closer in age to adolescent girls and were better able to understand their issues and challenges. In humanitarian settings, caregivers may also struggle with their own response to their situation, potentially resulting in behaviors that pose a risk to their child's growth and development *[see Area 2.1, 2.2 and 5.1].*

No systematic reviews of evidence solely focused on the associations between the quality of the parent-child relationship, caregiver behaviors (stimulation and responsiveness), and child mental health and psychosocial outcomes in humanitarian settings have been identified. However, a number of systematic reviews include this factor as part of a wider analysis of children's health in conflict-settings. For example, Miller and Jordans (2016) find evidence in several studies of the significance of supportive relationships with parents, good parental mental health, and strong peer relationships that may help protect children from the adverse effects of exposure to poverty and armed conflict (e.g. Panter-Brick et al., 2014; Tol et al., 2013; Betancourt et al., 2011; Dubow et al., 2012; and Morley & Kohrt, 2013, in Miller & Jordans, 2016).

Individual studies in humanitarian settings contribute to the understanding of parent-child interactions as a protective or promotive factor for children's psychosocial well-being and mental health. A study of school-age children (N=240, between 10-13 years of age) assessed symptoms of post-traumatic stress symptoms at three,

five, and 11 months after the 2008/2009 war in Gaza (Punamäki et al., 2015). The findings show that parental attachment security (determined with a ten-item Security Scale) and child-identified avoidant attachment style (determined by the Coping Strategies Questionnaire and Security Scale) to be protective factors of psychosocial well-being and mental health following exposure to war (Punamäki et al., 2015). A longitudinal study of Afghan caregiver-child dyads (N=331, children between 11-16 years of age) used the Strengths and Difficulties Questionnaire (behavioral, emotional, and social problems) at baseline and in a follow-up study one year after to explore risk and protective factors for children's mental health, finding that "better home life/family unity" was a protective factor of children's mental health (Panter-Brick et al., 2014).

**Intervention Evidence:**

Some recent studies indicate that interventions that strengthen the capacity of parents and caregivers can provide the support and nurturing that children need to thrive (Healy et al., 2018; WHO, 2018; ISPCAN, 2016; Betancourt, 2015; Klasen & Crombag, 2013). It has also been found that programs that help caregivers teach their children skills, such as emotional regulation, problem-solving, and social skills, can help children build resilience (WHO, 2018). In their recent systematic review, Pederson et al. (2019) present evidence for family and parent-focused interventions on mental health outcomes for children and youth in LMICs and identify treatment components present in promising interventions. All studies in their systematic review included at least one parent/caregiver, the majority of which were mothers or grandmothers. The ages of children ranged from two weeks to 18 years. The authors argue that parent and family-focused interventions, such as psychoeducation, parent-and family-skills training, behavioral, psychosocial, and trauma-focused CBT may be beneficial to LMIC populations. They found that 88% of the studies they reviewed showed a significant positive effect in the intervention group on a myriad of outcomes, including child and youth mental health and well-being, as well as parenting behaviors and family functioning (Pederson et al., 2019). The authors identify that interventions conducted to date in LMICs have been specific in focus, including interventions for children with developmental disorders (although overall, evidence on interventions with children with physical and cognitive disabilities is sparse) (Hastings et al., 2012), interventions for improving parenting skills and addressing abusive parenting in LMICs (Knerr et al., 2013), and parenting programs focusing on early child development (ECD) (Britto et al., 2015). There is emerging evidence that group-based parenting interventions have worked well, including in humanitarian contexts (Butchard & Hillis, 2016), as have opportunities for parents to practice positive parenting skills (Wessels et al., 2013; WHO, 2018).

Evidence-based programs that support caregivers are identified as cost-effective ways to strengthen parent-child relationships, caregiving, and the health, safety, and resilience of children and families. Especially when the range of support available addresses different families' needs and children of different ages with specific and age-appropriate interventions (WHO, 2018). Furthermore, there is increasing recognition that MHPSS programs that support the meaningful participation of both caregivers and children result in improved child outcomes (Annan et al., 2016; Betancourt, 2015; Panter-Brick et al., 2014; Panter-Brick et al., 2014; Shonkoff & Fisher, 2013). For example, Betancourt (2015) argues that interventions, as well as wider mental health and social services, are particularly beneficial when all members of the family are considered in their development.

An ISPCAN (2016) study asks whether there are minimum conditions and capacities required for implementing positive parenting programs in countries and communities affected by armed conflict. While there is scope for further development and research in this area, increasing evidence suggests that parenting interventions aimed at improving parenting in low-resource, culturally diverse countries and in post-conflict settings may be both feasible and effective. Annan, Sim, et al. (2016) argue that in contexts where basic needs, stability, and safety are still concerns, parenting interventions are so important that they should be considered alongside other strategies to address the wide range of immediate needs. They argue that such programs are key because intervening with children and families as early as possible is the most promising strategy for

reducing the likelihood of mental health disorders later in adolescence and adulthood (Kieling et al., 2011, cited in Annan, Sim, et al., 2016).

For example, a recent study assessed the acceptability and preliminary outcomes of *Families Make the Difference*, an IRC parenting intervention to prevent child maltreatment and improve parental and child mental health among Syrian refugees in Lebanon (Sim et al., 2020). Structured assessment before and after a group-based parenting intervention showed significant reductions in harsh punishment and rejecting parenting behavior and significant improvements in measures of parental and child mental health from pre- to post-intervention.

**IRC's Families Make the Difference**

*RCT (level B)*

Sim et al. (2020, 2018) contribute to the limited literature on parenting interventions in conflict-affected settings by assessing the acceptability and preliminary outcomes of IRC's Families Make the Difference program, a group-based, ten-session parenting intervention specifically designed for caregivers affected by the Syrian conflict. The program was first implemented in Lebanon, Jordan, and Syria in 2014 as part of a broader response to the Syrian crisis but had not yet undergone an external evaluation (IRC, 2016). Content for the intervention was adapted by the IRC from a parenting program that had previously undergone a randomized evaluation in a post-conflict setting (Puffer et al., 2015). Qualitative methods were used to examine the mechanisms underlying the effects of war and displacement on parenting and child adjustment to inform intervention development. In April and November 2016, group and individual interviews were conducted with 39 Syrian parents and 15 children in partnership with IRC in Lebanon. Results identified three interrelated pathways linking daily displacement stressors to various dimensions of parenting: 1) **economic hardship prevents parents from meeting their children's basic needs** and forces adaptation strategies that impair positive parent-child interactions; 2) parental **psychological distress contributes to harsh parenting**; and 3) perceptions and experiences of insecurity in the community results in increased parental control (Sim et al., 2018). Preliminary results suggest that this parenting intervention showed potential in reducing child maltreatment and improving parental and child mental health in a humanitarian setting (Sim et al., 2020). Greater economic resources and social support emerged as potential protective factors for maintaining positive parenting, despite exposure to war and displacement-related adversity. The authors call for the implementation of policies and programs to remove structural barriers to refugees' physical and economic security which can have tangible impacts on parental mental health, parenting quality, and child psychosocial outcomes [*also see Area 2.3*]. Future research priorities include a stronger focus on the effects of war and displacement on family processes, taking into account interactions with the broader social, economic, and political context (Sim et al., 2018). In Parents Make the Difference, IRC offers three curricula aimed at different child age groups and combines small-group sessions (e.g., 10 – 12 weekly group sessions) with parent support groups and a limited number of home visits. The program uses behavioral skills training to teach content on positive parenting and child development. It has been implemented in Lebanon, Liberia, and on the Thai/ Myanmar Border. A randomized waitlist-controlled design trial of Parents Make in Difference in Liberia found that the intervention reduced harsh punishment and improved parenting practices and caregiver-child interactions, but had no impact on early childhood development outcomes (IRC, 2014). Important considerations for implementing parenting programs in conflict settings include attention to timeframe, children's safety, and content. An evaluation showed that the majority of parents demonstrated an improvement in their resilience, coping mechanisms, and daily family life. These results demonstrate the importance of programs that address parental well-being, among other things, fostering positive support networks between caregivers and strengthening their skills for coping with negative emotions and stress.

**Evaluation example: Singla, Kumbakumba and Aboud's community-based parenting programming intervention**

*A community-based cluster-randomized trial (level B)*

In 2018, Kohrt et al. evaluated Singla and Kumbakumba (2015) and Singla, Kumbakumba, and Aboud's (2015) community-based parenting programming to address maternal psychological well-being, child development, and growth in rural Uganda. The program was found to be effective in improving child development and preventing maternal depressive symptoms. The mothers' perceived support from spouses and psychosocial stimulation mediated the effects of the intervention on reduced maternal depressive symptoms and improved child development scores, respectively. Both stimulation and maternal mental health interventions have been effectively implemented by non-specialist providers (e.g., community health workers or volunteers) despite no formal training in mental health or child development. Embedding this universal program within a community platform and collaborating with community leaders helped to recruit participants, prevent stigma toward mental health, and encourage fathers to attend.

**Evaluation example: Strengthening Families Program (SFP)**

*RCT (level B)*

The Strengthening Families Program (SFP) is a family skills training program for children aged 6-11 years, developed in the USA for substance-abusing parents and their children. In the last two decades, SFP has been culturally-adapted and transported to over 30 countries (Ryzin et al., 2015). Annan et al.'s study (2016) examines the effectiveness of the SFP intervention on mental health outcomes among Burmese migrant and displaced children living in 20 communities in Thailand. Participants were primary caregivers and children aged 7-15 years (n = 479 families). Families were randomly assigned to receive an adapted version of the Strengthening Families Program or a wait-list control condition. One month after the program, children in the treatment condition showed significant reductions in externalizing problems and child attention problems compared with controls. There was no significant treatment effect on children's internalizing problems. Children reported a significant increase in prosocial protective factors relative to controls. The researchers also found a significant effect for gender on the caregiver-reported outcome of internalizing problems, with female children reporting more internalizing problems. No other outcomes showed significant gender differences. In open-ended questions about what they most liked about the interventions, both children and caregivers reported particularly liking the sessions on drugs and alcohol [*relevant to Area 2.4*]. Results suggest that an evidence-based parenting skills intervention adapted for a displaced and migrant Burmese population facing high levels of adversity can have positive effects on children's externalizing symptoms and is a protective psychosocial factor.

**Evaluation example: Psychoeducation intervention to improve parenting, Jordans et al., 2013**

*RCT (level B)*

Jordans, Tol, Ndayisaba, and Komproe's parenting psychoeducation intervention in Burundi was evaluated using a randomized controlled trial (Jordans et al., 2012). The intervention group, parents of school-age and adolescent children who screened positive for elevated levels of psychosocial distress, participated in two group sessions designed to increase parental awareness and understanding of psychosocial and mental health problems of children, as well as problem management strategies. Compared to a wait-listed control group, analyses revealed the intervention had a beneficial effect, reducing behavior problems, especially among boys.

**Evaluation example: Combined emergency feeding and psychosocial interventions in Northern Uganda**

*RCT (level B)*

Morris et al.'s study of combined emergency feeding and psychosocial interventions in Northern Uganda represents a rigorous evaluation of an intervention delivered in a humanitarian setting, providing data on the feasibility and effectiveness of this type of programming in the field (Morris et al., 2012). The intervention group (mothers who received home visits, as well as nutritional interventions for their infants and participated in a mother-baby group) was compared to a control group, which only received the nutritional intervention. Post-intervention measures showed that the intervention group showed greater involvement with their infants and greater emotional responsiveness. The intervention was also effective in reducing symptoms of worry and sadness amongst mothers.

**Evaluation example: International Medical Corps' Early Childhood Development (ECD) Program in and around Access Restricted Areas (ARA) in the Gaza Strip (2015)**

*Pre- and post-test evaluation (level D)*

The Early Childhood Development and Community Support program for pre-school children and mothers in and around ARA in the Gaza Strip seeks to improve caregivers' knowledge of child development (focusing from birth to five years) and to teach positive behavior modification techniques in order to improve parenting practices and parenting confidence. These goals are in line with two main objectives: Objective 1: Improved psychosocial well-being of children under the age of five in and around the ARAs, and Objective 2: Strengthened capacity of mothers and caregivers of children under the age of five living in and around the ARAs. The evaluation aims to assess performance, evaluate progress towards program objectives, and provide strategic direction for future implementation. Desk review of program data and the analysis of pre-posts test data show strong progress in reaching mothers and caregivers through community-based organizations to share ECD messages. Results indicate that mothers and caregivers report learning and practicing some key aspects of ECD. Certain components of this program were very strong, including its ability to target both mothers and fathers in one program, which was reported to strengthen the parental team in approaching child care and development support.

**Conclusion and Implications for Research and Field Practice:**

There is increasing evidence from studies and field interventions showing the importance of parent-child relationships and improvements in parental practices, parental well-being, and children's development in humanitarian settings. However, there is a need for stronger evidence of this protective factor, using rigorous measurement methods, including mixed methods approaches. Evaluations of parenting interventions should be refined to strengthen their focus on measuring children's mental health and psychosocial outcomes.

**Evidence Gaps:**

Researchers are encouraged to focus more strongly on the effects of war, displacement, and disaster on family processes, taking into account interactions with the broader social, economic, and political context and their impacts on children's physical and mental development. Furthermore, greater efforts are needed to disaggregate findings in relation to children's age, gender, disability, and other diversity factors.

**PROTECTIVE/PROMOTIVE FACTOR**

## Area 2.4: Caring for Caregivers

**Strongest evidence:**

**A** – Systematic review(s)

0-18 years

**Introduction:**

In recognition of the negative impact of compounded stress on caregivers during humanitarian crises and the crucial role of caregivers in strengthening children's well-being and mental health, it is essential to strengthen interventions that enhance the self-care and well-being of caregivers. Although there is a well-established evidence base on positive parenting interventions in high-income countries, there has been limited evidence on interventions focusing on strengthening the self-care and well-being of parents/caregivers and families in humanitarian contexts. Single studies have investigated interventions in this area. However, there is an urgent need to address this gap, with increased recognition of the crucial role that parents play to help protect the mental health of children and families affected and or displaced by conflict (El-Khani et al., 2018).

**Epidemiological Evidence:**

Eltanamly et al.'s (2019) systematic analysis of parenting in time of war reported on parents' cognitions, with most war-affected families identifying a reduction in their feelings of parental self-efficacy beliefs (e.g. El-Khani et al., 2016). Keeping their children alive and safe, and providing for their basic needs, were over-riding concerns. As mentioned earlier, the effects of war exposure on parenting practices depend on the specific nature of their exposure to war; for example, living in displacement or in highly dangerous settings affected families very differently than "merely" living under threat (Eltanamly et al., 2019). In displaced or highly dangerous settings, families had reduced access to financial means and feared that their children might be abducted or use drugs. Parents also had to work for long hours. This increased families' stress levels, made them less capable of offering warmth and support, and more likely to engage in harsh and inconsistent discipline *[see Area 2.2 and 5.1].*

With approximately 385 million children worldwide living in extreme poverty (World Bank, 2016), 230 million residing in countries torn apart by armed conflict, and 28 million forcibly displaced (UNICEF, 2017b), robust evidence on the impact of programs that target responsive caregiving and foster children's holistic development is urgently needed (e.g. Britto et al., 2017).

**Intervention Evidence:**

Given the potentially severe and long-term consequences for children's psychosocial development and well-being, interventions to reduce child maltreatment and promote positive parenting in humanitarian settings are urgently needed (Sim et al., 2020; Shonkoff et al., 2012). Interventions that increase parental coping skills should, in turn, increase the capacities of children to grow and flourish successfully (Hunter, Grey, & McEwan,

2018). Parenting programs that target parenting stress and psychological well-being, positive disciplinary practices, and parenting knowledge and skills are important in mitigating children's exposure to risk and harm in humanitarian settings (Ponguta, 2020; Murphy et al., 2017). Although there is a well-established evidence base on feasible and effective parenting interventions in high-income countries (e.g. Knerr et al., 2013; Pedersen, Smallegange, Coetzee et al., 2019), there has been limited evidence on interventions focusing on parents and families in humanitarian contexts (e.g. Ponguta et al., 2020; Haar et al., 2019; Weissbecker et al., 2019; Murphy et al., 2017; Jordans, Pigott, & Tol, 2016; Annan et al., 2016).

Recent studies, particularly in the Middle East, address the gap in evidence-based parenting interventions in humanitarian contexts (e.g. El-Khani et al., 2018, 2020; Sim et al., 2019, 2020; Ponguta et al., 2020). For example, RCT pilots of parenting interventions with war-affected care-givers in the West Bank found improvements in parenting, family functioning, and child mental health and psychosocial problems (El-Khani et al., 2020). RCT parenting pilots in Lebanon found positive impacts on parental stress and discipline practices (Ponguta et al., 2020). A small feasibility study with Syrian refugee families in Turkey found that an integrated mental health and parenting skills intervention showed promise in improving parenting efficacy and skills and child behavior problems and post-traumatic stress symptoms (El-Khani et al., 2018). In this study, parents living with the added stress of coping in a humanitarian context, both welcomed and benefitted from parenting support from trusted professionals (El-Khani et al., 2018). Parents felt that as a result of receiving parenting advice from someone they viewed as a professional, such as a camp doctor, their confidence grew, and there were positive impacts on their parenting behavior. Participants also identified barriers stopping them from seeking support. These included negative experiences such as aid workers visiting their refugee areas to deliver advice and practical difficulties, including leaving their children to go and seek support, or the limited time they have available after completing domestic chores as a result of living in a refugee camp (El-Khani et al., 2018). A further study contributed to the literature by assessing the acceptability and preliminary outcomes of a parenting intervention to prevent child maltreatment and improve parental and child mental health among Syrian refugees in Lebanon (Sim et al., 2020). Two hundred and ninety-two parents and 88 children (aged 2-12 years) participated in a structured assessment before and after a group-based parenting intervention implemented by an international nongovernmental organization serving refugee and vulnerable Lebanese communities. Preliminary results suggest that the parenting intervention was acceptable to refugee parents and may show promise in reducing child maltreatment and improving parental and child mental health in a humanitarian setting (Sim et al., 2020). Support-seeking is hampered by separation from extended family, mistrust of others in the community, and the perception that others were experiencing the same problems and thus unable to help (Sim et al., 2018). The same study also suggested that cultural norms may dissuade fathers, in particular, from seeking support from others outside the family (Sim et al., 2018).

An earlier systematic review by Tol et al. (2013) identified a small number of studies of interventions designed to address symptoms of mental distress amongst survivors of SGBV. This study found that although it was difficult to draw any robust conclusions from the identified evaluation studies because of methodological limitations, data tentatively suggested that the intervention has positive impacts. Counseling and community-support interventions may be beneficial in addressing the impacts of SGBV on mental health and psychosocial well-being

**Caregiver Support Intervention (CSI)**

*RCT (level B)*

Miller et al. (2020) identify that most parenting interventions emphasize the acquisition of knowledge and skills but overlook the deleterious effects of chronic stress on parenting. To address this, they have recently proposed a protocol for an RCT with The Caregiver Support Intervention (CSI), which aims to strengthen the quality of parenting skills by lowering stress and improving psychosocial well-being among refugee caregivers of children aged 3–12 years, while also increasing knowledge and skills related to positive parenting (Miller et al., 2020). The CSI is a nine-session psychosocial group intervention delivered by non-specialist providers. It is

intended for all adult primary caregivers of children in high-adversity communities, rather than specifically targeting caregivers already showing signs of elevated distress.

### Strong Families (SF) program, Afghanistan

*RCT (level B)*

Addressing the paucity of family skills programs developed for, or piloted in, low resource settings, Haar et al. (2019) designed a brief and light Strong Families (SF) program, culturally adapted to the Afghan context. The program consisted of five hours of contact time over three weeks. A pilot study was conducted with to test the feasibility of implementation, and a preliminary look at the effectiveness of SF, in improving child behavior and family functioning in families living in Afghanistan. Female caregivers and children aged 8–12 years were recruited through schools and drug treatment centers in Afghanistan and enrolled in the SF program. A total of 72 families were enrolled with a 93.1% retention rate (n = 67) for data collection six weeks post-intervention. Week one explores parents' challenges and ways to better deal with stress. In week two, caregivers discuss the means of showing love while at the same time having and enforcing limits and listening to children, while the children learn how to deal with stress. During the family session, they practice positive communication and are encouraged to practice stress relief techniques together. In week three, parents learn to encourage good behavior and discourage misbehavior, while children explore rules and responsibilities and think about future goals in addition to the important roles their caregivers play in their lives. In the final family session, caregivers and children learn about family values and practice sharing appreciation for each other. The authors concluded that the implementation of a brief family skills program was seemingly effective and feasible in a resource-limited setting and positively improved child mental health, parenting practices, and family adjustment skills. These results suggest the value of such a program and call for further validation through other methods of impact assessment and outcome evaluation (Haar et al., 2019).

### Evaluation example: Mother-Child Education Program (MOCEP)

*RCT (level B)*

Ponguata et al. (2020) tested the effects of a group-based intervention, the Mother-Child Education Program (MOCEP), on parenting stress and practices among two refugee communities and one other marginalized community in Beirut, Lebanon. A pilot wait-list RCT was conducted to assess the impact on maternal, child (average 4-years of age), and dyadic outcomes. One hundred and six mother-child dyads were randomly assigned to either the intervention group (n = 53) or the wait-list control group (n = 53). Forty families (38%) withdrew early from the study. The authors found that mothers in the intervention group who completed the study showed a reduction in their harsh parenting and their level of parenting stress. However, the study did not identify any positive impact on the behavioral and emotional status of the children. The authors suggest that broader effects on maternal and child outcomes may be dependent on program attendance and the availability of other services.

### Evaluation example: Child and Youth Resilience Measure – Arabic version

*RCT (level B)*

The importance of the family as a protective factor for children in humanitarian settings is demonstrated in a report by Panter-Brick et al. (2018). This study tested and validated an Arabic version of the Child and Youth Resilience Measure (CYRM) in Jordan with 11- to 18-year-old Syrian refugees and Jordanian youth in the host community. For both groups, family relations were paramount to accessing and negotiating social, economic, and political resources—and were more salient than peer or school-based relationships. The authors draw attention to how this reflects a local reality: in the Arab world, the family is fundamental to leveraging

resources, as it works to constrain or enable the younger generation in matters of school, marriage, or employment.

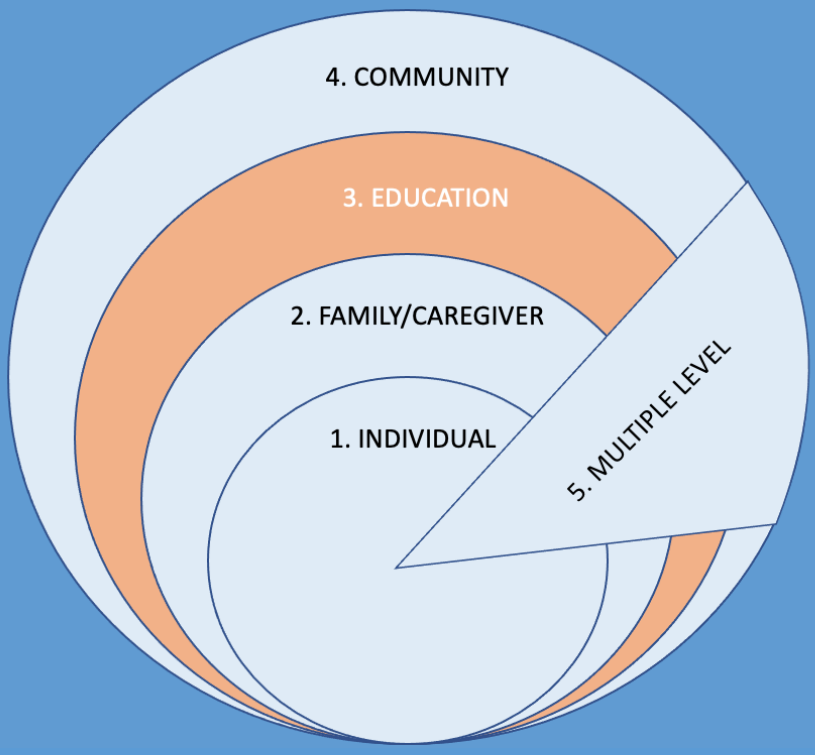
**Conclusion and Implications for Research and Field Practice:**

There has been limited evidence of interventions that strengthen the self-care and well-being of caregivers and families in humanitarian contexts, although single studies demonstrate the importance of this protective/promotive factor. Increased efforts are required to work with families, supporting positive relationships and non-violent communication among caregivers and children irrespective of their gender, age, disability, or other factors. Studies conducted in non-humanitarian settings have identified various possible relationships and mechanisms through which parenting factors may act as a protective factor. Emerging evidence, and some promising findings from rigorous evaluations of parenting programs, indicate that this is an area in which findings and interventions from other contexts are being adapted, piloted, and evaluated in humanitarian settings.

**Evidence Gaps**:

Further research is needed in humanitarian settings to inform effective interventions to improve caregiving support and monitoring and improve children's mental health and psychosocial support.

# Section 3: EDUCATION




The importance of education for individuals, families, and communities affected by emergencies is emphasized in the IASC Guidelines on MHPSS in Emergencies, which states that *"in emergencies, education is a key psychosocial intervention: it provides a safe and stable environment for learners and restores a sense of normalcy, dignity, and hope by offering structured, appropriate, and supportive activities."* This section presents evidence of education as a protective/ promotive factor and incorporates the risks of experiencing violence in schools, which CAN negatively impact children's mental health and well-being.

### 3.1 Education

**PROTECTIVE/PROMOTIVE FACTOR**

## 3.1: Access to Safe and Supportive Learning Environments

**Strongest evidence:**

**A** – Systematic review(s)

6-18 years

**Introduction:**

Increasing evidence demonstrates the importance of education and attendance in school (both formal and non-formal) in humanitarian settings (Mattingly, 2017). Schools provide the stability, structure, and routine that children need when coping with loss, fear, stress, and violence, which can improve mental health and resilience and can help recovery for the majority of children and youth affected by conflict or disaster (Miller & Jordans, 2016; UNICEF, 2016b, 2016c; Burde et al., 2015). For these reasons, schools have been identified as potentially protective locations for MHPSS interventions in humanitarian settings (Kamali et al., 2020; Kohrt et al., 2018).

**Epidemiological Evidence:**

Safe and supportive schools, including positive relationships with teachers, the presence of a protected space for children, and educational outcomes (including learning key life skills), contribute to safe and supportive learning environments that can be a crucial protective factor for children in humanitarian settings. A psychosocially supportive school environment contributes to the well-being of children and supports a return to normalcy in emergency contexts.

Systematic reviews by Tol et al. (2013) and Betancourt et al. (2012) identified evidence that education access was associated with reduced mental health symptoms, although school retention was not necessarily associated with reduced symptoms of depression, anxiety, or hostility (Tol et al., 2013). Other earlier studies also support the role of school as a protective factor. In assessing the mental health and psychosocial well-being of former Nepalese child soldiers, Kohrt et al. (2010) found greater levels of education before affiliation with armed groups is associated with better outcomes. Being older and having received more education was predictive of accessing/receiving greater reintegration support and exhibiting lower depression scores. Betancourt's study exploring the benefits of emergency education interventions in post-war Chechnya indicated that adolescents benefited from the safe space and increased social support fostered by informal programs and opportunities to engage in activities that contributed to the restoration of self-confidence and sense of agency (Betancourt, 2005). Reed et al.'s (2011) systematic review of risk and protective factors for the mental health of displaced and refugee children only identified one study that explored the role of peer and school relationships.

Schools have been found to provide a protective location for interventions when other safe spaces are not available. In studies conducted in Uganda and the Democratic Republic of Congo, for example, primary care services were found to be either non-functional or controlled by threatening political groups (Bolton et al., 2014, 2003). By enhancing the capacity of schools to meet the mental health and psychosocial needs of their

students, school-based interventions were found to enhance the role of schools as supportive and sustainable community resources (versus one-off interventions that do not develop local capacity) (Miller & Jordans, 2016). By training teachers or other local community members as implementation agents, such methods also broaden children's access to supportive adults (Miller & Jordans, 2016). Mattingly (2017) cites a study conducted by UNICEF (2009) that found high levels of community and family participation were positively associated with students feeling safe and included in their child-friendly school program, especially among girls (Mattingly, 2017). While there was no emphasis on participation specifically, there is a significant focus on the benefits of integrating MHPSS in school settings. Inclusive education environments and school-based MHPSS intervention services can also provide care in locations accessible to all students, addressing the needs of the most marginalized and potentially reducing the stigma associated with conflict (e.g., Fazel et al., 2014; Burde et al., 2015) *[See Area 4.1].*

The literature confirms the significance of schools as a location for MHPSS interventions in humanitarian settings, although evidence on the role of schools in promoting good mental health outcomes is mixed (e.g., Kamali et al., 2020; Kohrt et al., 2018). In the recent meta-review conducted by Kohrt et al. (2018), it was found that for children and adolescents of school-going age, the most successful interventions were delivered in schools (n = 19), compared to other community spaces (n = 6) or homes (n = 3). In a review of MHPSS interventions for children affected by armed conflict, most MHPSS interventions were school-based, with seven interventions reported to utilize the school platform, one in the home, and six within the community (Jordans, Pigott, & Tol, 2016). This study demonstrated mixed results, with smaller effect size impacts on symptom reduction of primary outcomes, and more positive effects on secondary outcomes which were mostly not disorder-specific, for example, behavioral problems, or factors such as hope and social support (Jordans, Pigott, & Tol, 2016).

MHPSS results from studies evaluating the effectiveness of focused MHPSS interventions in children exposed to traumatic events in humanitarian settings in low-income and middle-income countries have been inconsistent across settings, with different results for specific subgroups (e.g., by gender, age, or previous trauma exposure) or outcomes (Jordans et al., 2016; Tol et al., 2013; Purgato et al., 2018). Purgato et al. (2018) suggest that this inconsistency might partly be due to the lack of power in subgroup analyses of single RCTs.

In reality, many children in conflict-affected settings lack access to safe and stable educational opportunities. Students and teachers at all levels of education have been deliberately or indiscriminately killed, assaulted, or threatened, and schools and universities have been destroyed or damaged. Nearly 50 million children and young people in conflict zones face barriers to accessing education every day, keeping them out of school and preventing them from reaching their true potential (Save the Children, 2013). Attacks on education, defined as the intentional threat or use of force directed against students, teachers, education personnel, and or education institutions, are increasing. Between 2015 and 2019, more than 11,000 attacks on education were reported, harming more than 22,000 students and educators in at least 93 countries (Global Coalition to Protect Education from Attack, 2020). More than half of all school-aged children with disabilities do not go to school, with their right to education further compromised during emergencies (UNICEF/Handicap International, 2017). Existing facilities for the education of children and adolescents with disabilities, such as resource rooms, accessible and inclusive mainstream schools, and specialized equipment and learning materials, may be destroyed during an emergency, and children and adolescents' ability to participate in education activities can be reduced if they lose their assistive devices and disruption in health services prevents or delays their replacement. Studies find that on average, refugees miss three to four years of schooling because of forced displacement (UNHCR, 2016), and in refugee camps, girls with disabilities are less likely to attend school than boys with disabilities (WRC, 2008). Furthermore, in the first four months of 2020, the COVID-19 pandemic resulted in school closures in more than 190 countries (UNESCO, April 2020). School closures have been linked to increased risks of psychological distress, socialization, and vulnerability to abuse and exploitation (The Alliance for Child Protection in Humanitarian Action, 2020). Furthermore, children

affected by poverty, especially adolescent girls and children with disabilities, face increased risks of not returning to school (Ibid.).

Very young children are particularly vulnerable in humanitarian settings. The earliest years from birth to age eight (particularly the 0-2-year age group) are vital in the formation of intelligence, personality, and social behavior (UNICEF, 2016a). During this formative period, children encounter some of life's most significant learning experiences and they develop competencies that form the foundations of all later learning. However, in humanitarian settings, there is very limited attention and support provided to children of early/pre-school age and their parents compared to school-aged children (UNICEF, 2017a). Researchers and practitioners are encouraged to explore the impact of ECD interventions on mental health outcomes of pre-school aged children.

### Intervention Evidence:

Several reviews and recent evaluations of school-based interventions have identified rigorous evidence for interventions implemented in school settings in humanitarian contexts. Findings include some promising improvements in child mental health, indicated by reduced PTSD and distress symptoms and by increased protective factors such as peer and family support (Purgato et al., 2018). However, the impact of school-based interventions on mental health outcomes remain mixed in some studies (Tol et al., 2008).

In a systematic review of reviews, Kohrt et al. (2018), for example, found that the Classroom-Based Intervention – a community program with a school-based component implemented in five conflict-affected countries: Sri Lanka, Burundi, South Sudan, Indonesia, and Nepal – increased access to school for children and reduced risks of stigmatization (Jordans, Tol, et al., 2010; Jordans et al., 2010; Tol, Komproe, et al., 2014; Tol, Komproe, et al., 2012). There were some small-scale initiatives within this program where children were involved in facilitating activities within the intervention. For example, in Burundi, children were involved in a "child-to-child" initiative where children identified other children in their communities that needed social or financial support, which was subsequently organized by the children. Overall, the school-based approach increased community and parental acceptance and buy-in. However, it was found that the main barrier to using the school as the primary platform for implementation was that it was hard to include non-school going children.

A review of preventive and treatment interventions for children affected by war noted a number of school-based interventions. The review identified interventions that have had positive impacts on children's mental health and psychosocial well-being, both through universal school-based programs (programs implemented for all children, regardless of identified mental health status) and selected or indicated programs (activities for children selected to participate due to current mental health problems) (Betancourt et al., 2013). In addition, the review outlines several different treatment interventions, describing interventions such as classroom-based cognitive behavioral therapy. A systematic review of evidence and treatment approaches for MHPSS support in conflict identified three studies (Stichick-Betancourt, 2005; Kos & Huzejrovic, 2003; Arafat & Musleh, 2006) that focused on education, with interventions seeking to improve support for children and achieve the normalization of day-to-day life through education, relationships with teachers, and school environment, as well as activities that use the school as a site through which to deliver recreational and non-formal activities (Jordans et al., 2009).

A series of rigorous evaluations of school-based cluster-randomized controlled trials of Classroom-Based Intervention [CBI] in Nepal, Indonesia, Burundi, and Sri Lanka indicate mixed findings on the impact of the intervention on mental health outcomes. The intervention is a 15-session manualized intervention, delivered by trained community workers and delivered in school-based sessions, with sessions including "trauma-processing activities, cooperative play, and creative expressive elements" (Tol et al., 2008). Children were

screened for participation in the intervention based on prior exposure to traumatic events and current levels of PTSD and anxiety. Children were also assessed before and after participating in the intervention for levels of PTSD, anxiety, depression, hope, aggression, and functioning. They found a significant reduction of PTSD levels and improved functioning levels amongst girls, as well as retained levels of hope amongst girls and boys, compared to children in the control group (Tol et al., 2008). Further analysis of the same intervention found that girls showed larger treatment benefits in PTSD symptoms than boys and that girls, children in smaller households, and children receiving social support had larger treatment effects on functioning (Tol et al., 2010).

Recent evidence from predominantly high-income contexts contributes to the understanding that school environments can encourage the promotion of protective factors for the mental health of children and adolescents, such as social-emotional competencies and skills (e.g., García-Carrión et al., 2019; Bennouna et al., 2019). From an in-depth analysis of over 300 articles published between 2007 and 2017, García-Carrión et al. found that the effects of the interventions carried out in schools and communities with an emphasis on fostering supportive interactions benefited children and adolescents in four distinct ways. These included:

- positive effects on the treatment and prevention of affective disorders such as depression and anxiety (e.g. Connell & Dishion, 2008; Ohl et al., 2013; McWhirter & McWhirter, 2010)
- improved aspects related to aggression and behavioral issues (Ohl et al., 2013; McWhirter & McWhirter, 2010; Bradshaw et al., 2009; Cappella et al., 2012)
- positive effects on strengthening psychological-related aspects to well-being, including self-concept, self-esteem, self-efficacy, and empowerment, among others (Cappella et al., 2012; Atkins et al., 2015; Ohl et al., 2013; Houlston et al., 2011; Bloemraad & Terriquez, 2016; and McWhirter & McWhirter, 2010)
- improvements in the classroom climate and teacher-student and peer interactions (Cappella et al., 2012; McWhirter & McWhirter, 2010; Puffer et al., 2016; Bloemraad & Terriquez, 2016).

**SEHER (“Dawn”) Whole school approach**

*RCT (level B)*

SEHER (meaning “dawn” in Hindi) is a multi-component, whole-school health promotion intervention implemented in government-run secondary schools in Bihar state, India (Shinde et at., 2018). The intervention is delivered either by a lay counselor or an existing teacher and has whole school-, class-, and individual-focused components (Shinde et al., 2020). It includes information-sharing on hygiene, bullying, mental health, substance use, reproductive and sexual health, gender and violence, rights and responsibilities, and study skills. Whole-school activities include a School Health Promotion Committee, peer groups, workshops, awareness-raising through drama and discussions, a letterbox platform for children to share their concerns, a wall magazine to build and share their knowledge on selected themes, and referral for individual counseling for self- or teacher-referred students if required (Shinde et al., 2018). A clustered, randomized trial conducted in 75 schools in the Nalanda district of the state of Bihar found that the lay counselor-delivered intervention, compared with the control group, reported improvements in school climate, depression, bullying, attitude towards gender equity, violence victimization, and violence perpetration (Shinde et al., 2020). The effect sizes for these outcomes at end of year two were larger than at the end of year one. There was no evidence of an intervention effect on the teacher-delivered intervention at either follow-up (Shinde et al., 2020).

**Smartphone applications**

*Program description (level E)*

Open-source smartphone applications have recently been designed to build foundational literacy skills in Arabic and improve the mental health and psychosocial well-being of out-of-school Syrian refugee children

aged 5-10 in Syria and neighboring countries (Norad, 2017, cited in Mattingly, 2017). The games have been found to develop literacy and social-emotional learning (SEL) skills by helping children to process information without becoming distracted, use their working memory, control their impulses and emotions, persevere, solve problems, and get along with others.

**Community-based education and MHPSS in Sudanese Refugee camps in Western Ethiopia, Save the Children (2012)**

*Program description (level D)*

Community-based education and MHPSS support for children was a key part of the program with an emphasis on child and community participation. The community was engaged through mobilization activities to engage parents and community members in sending their pre-school and school-aged children to school. Parents were trained and supported to run PTAs, while schools were provided with material provision and school management support. The community was responsible for building and maintaining the schools. Groups of girls and boys were established to promote and discuss the benefits of education and encourage others to participate, including disability awareness clubs. The groups were responsible for advocacy and encouraging a change in attitudes and practice relating to harmful traditional practices. Children with disabilities were integrated into sports, mainstream schools, etc. For example, between 1996 and 2000, the participation of children with disabilities in schools increased from 52% to 80% (Save the Children, 2012).

**Save the Children's B-SAFE program, Haiti and Solomon Islands**

*Pre-post survey, no control group (level D)*

Madfis et al. (2010) describe the implementation of Save the Children's B-SAFE program in Haiti and the Solomon Islands. B-SAFE targets several strategies (i.e., "build relationships, cooperation, and respect among peers; screen for high-risk children and youth; active, structured learning and life-saving information; facilitate children's resilience and return to normalcy; establish a sense of security self-esteem") to enable children to engage their innate resilience. Program-specific measurement tools (developed to measure improvements in emotional, social, and psychological well-being) indicated that the rapid implementation of B-SAFE Safe Spaces in both contexts aided children in managing post-incident hardships and regaining a sense of normalcy and security.

**Psychosocial Structured Activities program (PSSA),**

*RCT (level B)*

This program, implemented in two schools in war-affected Northern Uganda by Ager and colleagues in 2007 and 2008, is a two-week, 15-session program "designed to progressively increase children's resilience through structured activities involving drama, movement, music and art" (Ager et al., 2011). A free-listing exercise conducted with children, parents, and teachers generated an 18-item list of indicators of child well-being that then served as measures for the study. At the 12-month follow-up, both intervention and control groups showed significant improvement in well-being, suggesting trends for recovery over time; however, the intervention group exhibited significantly greater gains than the control.

**School-based intervention for trauma symptoms**

*Quasi RCT (level C)*

Berger and Gelkopf's (2009) quasi-randomized control trial evaluated the efficacy of a school-based intervention for tsunami-exposed school-age children and youth in Sri Lanka showed significant improvement

of symptoms across all outcome variables measured (i.e., post-traumatic symptomology, depression, somatic problems, and functional problems). Twelve 90-minute sessions provided the intervention group with "psychoeducational material, cognitive-behavioral skills [training], meditative practices [training] and bio-energetic exercises as well as processing traumatic experiences by utilizing art therapy and narrative techniques" (Berger & Gelkopf, 2009).

**School-Based Psychosocial Program (SBPSP)**

*RCT (level B)*

This program provided MHPSS support to high-risk school-age children in the occupied Palestinian territories to address the needs of those exposed to violent environments through strengthening caregiver, peer, and teacher interactions (Constantinides et al., 2011). The intervention included 20 in-school workshops provided to children over the course of one school year, combined with ten community workshops, educator and school counselor capacity-building trainings, and guided sessions for parents. The evaluation demonstrated the positive effects of the intervention across measured indicators of psychosocial well-being (i.e., relationships, trust, problem-solving, violence, tolerance, hope, and stress management).

**Mind-body skills group**

*RCT (level B)*

Gordon and colleagues conducted a randomized controlled trial of a mind-body skills group (Gordon et al., 2008), using an intervention that had previously been tested in a pilot study (Gordon et al., 2004). The intervention aimed to reduce symptoms of PTSD among postwar Kosovar adolescents. Although the protocol had been adapted from the pilot study version for the RCT, both studies included training in meditation, relaxation, and biofeedback, as well as autogenic training. The RCT, using the Harvard Trauma Questionnaire as a primary outcome measure, demonstrated significant improvement in PTSD symptoms at post-test and sustained outcomes at follow-up.

**Evaluation example: Youth Readiness Intervention (YRI), Sierra Leone**

*RCT (level B)*

Betancourt et al. (2014) examined the impact of Youth Readiness Intervention (YRI) – a randomized control study focused on a cognitive behavioral therapy intervention on school functioning for multi-symptomatic war-affected youth (aged 15–24 years). The authors highlighted that war-attributed mental health consequences on children – including internalized psychological distress (such as depression and anxiety and post-traumatic stress reactions), which may also manifest as (externalized) anger problems, difficulties with anger/emotional regulation, interpersonal deficits, and impairments in daily functioning – generate the risk of poor psychological, social, and educational outcomes. Their study found that YRI participants had significantly better school attendance compared to controls and that, among youth in school, YRI participants also demonstrated significantly better classroom behavior.

**Evaluation example: School Project of Humanitarian Association of "Prijatelice"**

*Quasi RCT (level C)*

Hasanović and colleagues' (2009) evaluation of the MHPSS activities implemented as part of the *School Project of Humanitarian Association of "Prijatelice"* sought to assess the effectiveness of the provision of MHPSS services in reducing symptoms of PTSD among postwar primary and secondary school children in Bosnia and Herzegovina. The program included 20 lessons for students on diverse issues including "emotions, non-violent communication, peer mediation, cooperation and tolerance, stereotypes and prejudices, children's rights, and humanization of inter-gender relations" (Hasanović et al., 2009) and also offered training for parents and individuals in school leadership, coordination, and management to create environments that will foster greater mental health, psychosocial well-being, and development. Utilizing the Impact of Events Scale as the instrument of measure, PTSD symptom severity, especially cluster symptoms of re-experiencing and avoidance, were significantly reduced as a result of the intervention.

**Evaluation example: Save the Children's Classroom/Community/Camp-Based Intervention (CBI) Program in WB and Gaza (2004)** *[6-16 years]*

*Evaluation using a waitlist control group (level B)*

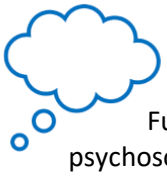
The Classroom-Based Intervention (CBI) Program was implemented in the West Bank and Gaza. The CBI program, designed and developed by the Boston Center for Trauma Psychology, is a psychosocial integration and recovery program for children, adolescents, and their adult caregivers who are exposed to psychological trauma. Through highly structured expressive-behavioral group activities, CBI is designed to 1) reduce potentially harmful traumatic stress reactions, such as fear and depressed moods, and 2) to increase children's ability to solve problems, maintain pro-social attitudes, and sustain self-esteem, as well as hope for the future. Regarding the young group (children aged 6-11 years), there were highly significant positive changes in five of the eight assessment scales employed for this age group. A different picture appears when studying CBI intervention amongst Palestinian adolescents. CBI does not yield the same highly significant positive changes with the 12- to 16-year-old group as it did with the younger age group.

**Conclusion and Implications for Research and Field Practice:**

The literature increasingly identifies that learning spaces can provide a safe and protective setting, which can support the mental health and psychosocial well-being of children in humanitarian settings, although some mixed findings identify that further research in this area is needed. School-related factors, such as school attendance and school retention, have been explored as factors hypothesized to impact children's mental health and psychosocial well-being, while some interventions and program evaluations have focused on activities implemented in school settings.

Systematic reviews provide evidence of the significance of schools as a location for MHPSS interventions in humanitarian settings, and they enable wider access for children. However, evidence as to the protective nature of schooling, including school retention and relationships with peers and teachers in school, is lacking. Some findings from systematic reviews of the role of school-based mental health programming for children in non-humanitarian settings may also be relevant. Findings identify that programs using indicated approaches (targeting youth with early or mild symptoms of mental distress) are more effective than universal interventions. Furthermore, Miller and Jordans (2016) caution about the primary emphasis of MHPSS interventions in school settings being able to change variables within the child without addressing the critical

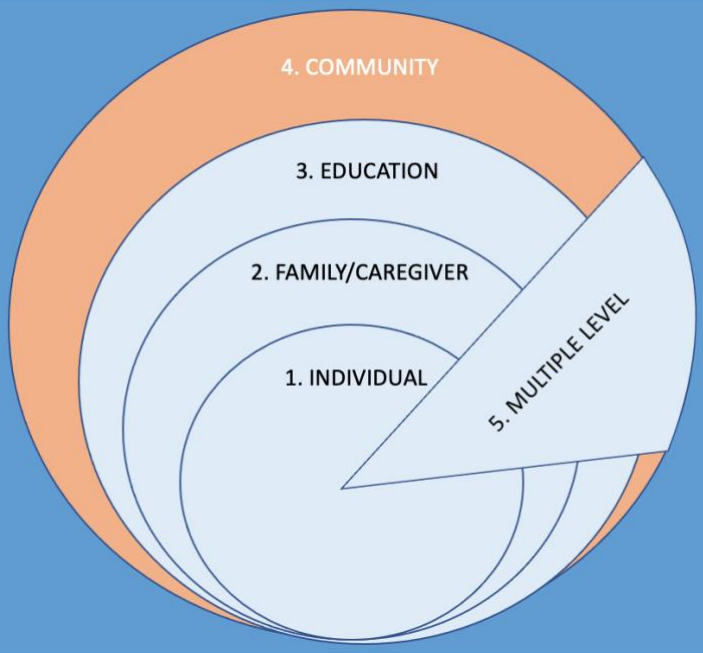
sources of ongoing risk in the environment that threaten children's well-being. There is limited evidence showing the effect of MHPSS interventions on education outcomes (Gallagher, 2018; Mattingly, 2017).



**Evidence Gaps:**

Further analysis of the interconnections between schooling and improved mental health and psychosocial well-being is warranted. More research is needed to understand the importance of contextual factors in promoting or inhibiting resilience both in and through education systems, with a particular focus on the inclusion of vulnerable groups and on any outcome differences based on gender, disability, race, ethnicity, family income, or other forms of diversity. Researchers and practitioners are encouraged to prioritize the impact of school-based interventions on pre-school children in ECD-environments, particularly marginalized children, such as children with disabilities. Further research is also required into the impacts of not accessing education on the mental health and psychosocial well-being of children in humanitarian settings, particularly for adolescent girls and children with disabilities.

# Section 4: COMMUNITY




The role of the community in supporting children's mental health and psychosocial well-being in humanitarian settings is increasingly recognized. MHPSS community-based approaches contribute to restoring and or strengthening the collective structures and systems essential to the daily life and well-being of children and adolescents. However, harmful stereotypes (including gender stereotypes) and stigmatization at the community-level have been found to undermine healthy relationships, dismantling the supportive and inclusive environments that are required for the good mental health and well-being of everyone. This section includes the following factors:

**4.1 Stigma** (risk factor)
**4.2 Community participation and social support** (protective/promotive) factor)

**RISK FACTOR**

## 4.1 Stigma

**Strongest evidence:**

**B** – Randomized control trial(s)

13-18 years

**Introduction:**

Stigmatization – the social process of exclusion and discrimination arising from local norms – can have complex social and economic consequences and can be devastating for children in humanitarian settings. Individuals in humanitarian settings may experience stigmatization, rejection, and isolation from families and communities for a range of reasons. For example, children have been stigmatized due to experiencing mental distress, sexual violence (Kohli et al., 2013; Kohli et al., 2014), association with an armed group (Hake, 2020; Betancourt et al., 2013), disability (Smythe et al., 2020), being a child born out of wedlock, and being a child from an ethnic or minority group (War Child, 2019).

Reducing inequalities is a precondition for promoting mental health and for reducing key risk factors, such as violence, disempowerment, and social exclusion (UN Human Rights Council, 2019), yet this risk factor has not been widely addressed within studies of child and adolescent mental health and psychosocial well-being in humanitarian settings. Given the specificities of this risk factor, literature from high-income, developed settings may not be directly relevant or applicable.

**Epidemiological Evidence:**

Stigma reduces opportunities for participation in the community, access to vital services, and can have a significant negative impact on an individual's physical and psychosocial well-being (War Child, 2019). Children experiencing stigmatization risk being made scapegoats, may be exposed to further violence, or may even face exclusion from their communities or families.

There are no available systematic reviews that focus specifically on the evidence of stigma's impact as a risk factor for adverse mental health or psychosocial outcomes for children and adolescents in humanitarian settings. A recent systematic review of 24 multi-level stigma interventions from LMIC and HIC settings included one study on orphaned and vulnerable children (Smith Fawzi et al., 2012, cited in Rao et al., 2019). A limited single number of studies provide evidence of stigma's impact on children and adolescents' mental health and psychosocial well-being in humanitarian settings. In a series of studies of the reintegration of child soldiers in Sierra Leone, Betancourt and colleagues have investigated the role of stigma (due to involvement in armed forces during the conflict) and mental health and psychosocial outcomes. A study exploring the impact of changes in caregiver mental health on adolescents' mental health outcomes identified community stigma as being significantly associated with increased internalizing symptoms amongst adolescents (Betancourt et al., 2015). Experience of post-conflict stigma was associated with an increase in PTSD symptoms amongst ex-combatants in Sierra Leone (Betancourt et al., 2013b). A recent study on the stigma faced by female ex-abductees in Northern Uganda found that stigma and its consequences can become intergenerational: "female ex-abductees, as well as their children, are found to be facing name-

calling, labelling, stereotyping, emotional and physical as well as sexual abuse in their respective communities. This leads to decreased social, economic, and educational opportunities" (Hake, 2020, p.5).

A study focused on adolescent girls in the DRC found that experiencing rape was significantly associated experiencing stigmatization. It also found that stigmatization explained part of the relationship between the experience of rape and mental health outcomes, including symptoms of depression and post-traumatic stress (Verelst et al., 2014). The literature on stigma against children in low-income settings whose parents have died of HIV/AIDS, or who themselves have HIV/AIDS, may shed light on the possible impacts of stigma on mental health and psychosocial outcomes for children and adolescents in other vulnerable situations (Cluver et al., 2008).

Evidence on the mental health impact of equity contributes to a richer metric of what matters to well-being and the importance of the non-material dimensions of poverty, discrimination, and deprivation (UN Human Rights Council, 2019, A/HRC/41/34). The outcomes of structural inequality not only have a negative individual impact but are also detrimental to societal health, as they break down key protective factors, such as trust, social inclusion, and the healthy development of young people (Ibid.). A focus on relationships and social connection is important when conceptualizing the determinants of mental health.

To reduce mental ill-health and the associated stigma in accessing mental health services, participants in the Mind the Mind Now conference (Ran, 2019) highlight the importance of opportunities for the inclusive participation of marginalized groups in response and recovery activities, with increased efforts to address stigma and social exclusion. Ran (2019) also emphasized the need for a greater focus on policy and practice developments to address political, economic, and social efforts to improve security, justice, poverty, unemployment, and exposure to violence.

**Intervention Evidence:**

A recent systematic review synthesized child-focused stigma reduction strategies in LMIC and compared them to adult-focused interventions (Hartog et al., 2020). The review compared studies, interventions, and strategies focusing on children (and adolescents) as either a target group alone or with adults, or as an impact group focused on adults. Of 61 studies published between 2002 and 2018, only 14 (23%) had a child focus, either as a direct target group in isolation (29%), together with adults (64%), or as an indirect target group (7%). Positive outcomes were reported on all child-focused interventions, and promising interventions were identified, with education-based approaches combined with contact strategies identified as the most promising approaches tackling stigma, particularly public stigma (Birbeck, 2006; Cross, 2006). Burde et al. (2015) found that inclusive education environments address the needs of the most marginalized and reduce the stigma associated with conflict.

Integration within and across sectors has been found to address the stigmatization and discrimination often experienced by those with mental health and psychosocial needs (Ran, 2019) *[see Area 5.3]*. Therefore, integrated and coordinated service provision that reduces stigma, exclusion, and discrimination is required to improve mental health and psychosocial well-being outcomes in humanitarian settings. However, current approaches to address stigmatization typically overlook the specific experiences of children, with limited evidence on (the impact of) interventions for low- and middle-income countries (LMIC) (Hartog et al., 2020). An earlier review found that children and adolescents were represented in only 3.7% of 109

stigma studies (Link et al., 2004), and limited evidence has been found on interventions addressing the stigma of children in humanitarian settings. This is alarming given the need to protect children from prejudice and raise them without perpetuating harmful stereotypes on others. Stigma can impact opportunities for a lifetime. Studies focusing on child and adult interventions outside of humanitarian settings may contribute some understanding in this area, but a lack of attention is paid to sources of stigmatization related to non-medicalized issues. Child-focused interventions were found to mainly address HIV/AIDS and mental illness (as in adult-focused interventions). Hartog et al. (2020) found child-focused interventions were shorter and more often community-based.

The literature increasingly reports that addressing stigma at multiple socio-ecological levels can improve outcomes, recognizing that stigmatization is ingrained within the community at individual, interpersonal, organizational, social, and institutional levels (Richman & Hatzenbuehler, 2014). However, most stigma interventions are implemented only at one socio-ecological level, with very little difference between child- and adult-focused interventions (Hartog et al., 2020; Rao et al., 2019). There is scope for more evidence-based stigma-reduction interventions consisting of strategies at multiple socio-ecological levels (Hartog et al., 2020). Recognizing stigmatization as a dynamic social process, Hartog et al. (2020) argue that stigma reduction interventions should also anticipate potential positive or negative effects in the wider community. They assess the anticipated effects of the stigma reduction interventions among groups beyond the intervention target groups, such as children and adolescents, when the intervention might impact them through interaction with the direct target groups, such as service providers (Hartog et al., 2020). Hartog et al. (2020) recommend that interventions directly target children in combination with adults, as well as understanding children and adolescents as an indirect target group, acknowledging that interventions could make an impact beyond the direct target group. This is supported by Mukolo et al. (2010) who argued that stigma reduction interventions should take the differences between adults and children into account.

While not focusing exclusively on children, Semrau et al.'s (2015) overview of evidence from low- and middle-income countries addressing the nature of stigma and discrimination, and relevant context-specific factors, found that few intervention studies were identified related to stigma re-education in low- and middle-income countries. The authors found that none of the studies addressed behavior change/discrimination and that no long-term follow-up studies were conducted. Findings from a recent systematic review of studies of interventions that aim to reduce stigma experienced by children with disabilities and their families in low- and middle-income settings highlighted the lack of quality evidence on effective stigma-reduction strategies for children with disabilities. The authors call for validation and consistent use of contextually relevant scales to measure stigma to advance this field of research (Smythe et al., 2020).

Despite gaps in relevant epidemiological evidence, the literature increasingly emphasizes the importance of addressing the stigma against boys and girls living in humanitarian contexts. This includes integrating MHPSS services into existing community-based structures and government services (education, health, nutrition, protection, etc.) to reduce the associated stigma of accessing mental health services, and increasing coverage and sustainability (Kamali et al., 2020; Ran, 2019). Importantly, few reviews have synthesized stigma reduction interventions from the viewpoint of children and adolescents (Clement et al., 2013; Nayar et al., 2014). To address the stigma of girls and boys affected by armed conflict, War Child (2018) emphasizes the need to "*commit to listening to children, youth, their families, and communities to understand their needs, resources, and vulnerabilities."* The Human Rights Council also calls on

States to support user- and peer-led movements, which help to demonstrate that human experiences that are considered unconventional represent just another form of human diversity and contribute to more tolerant, peaceful, and just societies (UN Human Rights Council, 2019). There is increasing evidence suggesting that children and young people's participation in peacebuilding helps reduce discrimination and increases social cohesion and access to support (McGill et al., 2015; UNICEF, 2015a; United Nations General Assembly Security Council, 2018). These findings highlight the need for more evidence-based stigma reduction interventions that work with children and adolescents and their support networks in multiple spaces and through the delivery of complementary interventions at multiple socio-ecological levels.

**Stigma Reduction Approach, War Child (2019)**

*Program description (level D) – pilot test is planned*

Addressing the gap in evidence of interventions aiming to reduce stigma experienced by children in humanitarian settings, War Child (2019) is in the process of developing and rigorously evaluating an intervention aiming to reduce the stigmatization of children. The Stigma Reduction Approach (STRETCH) aims for applicability to any stigma in any conflict-affected context. Its development is informed by evidence and research to increase the understanding of stigmatization inside communities and to identify the potential resources needed to bring about change. A socio-ecological approach is adopted to help reduce harmful beliefs and practices ingrained within communities. Research has already been undertaken in DR Congo and Lebanon, and through literature – lessons learned from this research will serve to further inform the approach. A pilot test of the intervention is planned for 2020-2021.

**Manual for engaging young men and boys in emergencies, CARE, Belgrade, (2018)**

*Program description with a rich description of the participatory process (level D)*

A significant focus of this program involved reducing the stigma associated with being a Syrian refugee in Serbia. The program also encourages young male members of the Syrian community to work together and look for similarities instead of what separates them. Through a series of workshops and PRA activities, participants are invited to establish the issues that affect them. Workshops include sessions on "labeling" and "similarities and differences between home and various backgrounds." Following initial PRA activities and participatory introductory workshops, participants participate in structured workshops selected on the basis of their specific needs and requests.

**Participatory Action Research and Activities to address stigma and improve integration**

*Participatory study with a rich description of the process and tools including FGDs, interviews, post-intervention survey (level C)*

McKay, Veale, Worthen, and Wessells' (2011) evaluation of intervention in Liberia, northern Uganda, and Sierra Leone focused on the challenges of reintegration faced by stigmatized and vulnerable women. To create meaningful participation for women experiencing social isolation and marginalization, McKay et al. (2011) implemented a participatory action research program where women communally identified problems they face as a result of stigma and marginalization and then developed plans for social action to address and change their

situation. The PAR project enrolled young mothers, many of whom had been associated with fighting forces, in Liberia, Sierra Leone, and Uganda to plan and implement activities to improve and increase the reintegration of young mothers, and particularly, to work with communities to increase their acceptance. The PAR project "encouraged the active involvement of the young mothers in planning, implementing, and evaluating project processes and impacts, within the context of their communities." As such, the interventions varied across communities and locations, but all involved developing health, livelihoods, and social programs to improve social support for young mothers to facilitate and support their reintegration. Group-based processes for young mothers enabled girls to "talk with, and listen to, each other in respectful ways, manage conflict, engage in collective problem solving (such as ways to reduce stigmatization and improve community acceptance), and give support." The outcomes of the intervention were assessed using ethnographic methods (focus groups, interviews, and analysis and synthesis of field notes), as well as using a post-intervention survey of women's perceptions of the outcomes of their participation in the intervention. Key findings of the study include an increased sense of agency and self-esteem, increased positive coping skills, and increased access to livelihood different from sex work (McKay et al., 2011). Furthermore, results reported in another analysis of the same project indicated that 89.1% of participants reported feeling more supported and respected by community members than before the PAR, 58.2% reported feeling able to help the community after participating in the program, and 86.5% of respondents reported that "involvement in the PAR has made my children and me more liked or loved by my family" (Ibid.). [*also of relevance to Area 4.2]*

**Sealing the Past, Facing the Future**

*Post-intervention survey; control group generated with matched non-intervention villages (level C)*

This intervention focuses on supporting the reintegration of women formerly associated with armed groups in the Koinadugu District of Sierra Leone. It is related to social support as a protective factor in that it included a specific focus on efforts to "help community members understand that the girls themselves had suffered, since communities tended to view as perpetrators anyone who had been part of the groups that had attacked villages," thus seeking to facilitate reintegration through activating community supports. Supportive services offered to the girls and women participating in the intervention included traditional cleansing ceremonies, financial assistance for medical treatment of sexually transmitted infections, skills training, and micro-credit loans. The intervention also carried out awareness-raising activities in communities to aid community members in understanding the situation for returning girls and women. The evaluation sought to compare outcomes for girls who participated in the program to those who had not, thus conducting surveys in communities where the program has been implemented and matched communities (as similar as possible to the intervention communities) where the program had not been implemented, specifically addressing the question of whether the program had accelerated reintegration of girls into their communities. The in-depth structured interviews focused on indicators of reintegration – including both community acceptance and attainment of locally defined good mental health. Analysis of integration outcomes, comparing girls who had participated in the program vs. those who had not, showed that mental health outcomes were significantly associated with participation in the program. Participation in this intervention was associated with improved outcomes for mental health and improved quality of marriages for many participants and appeared to support greater community acceptance and inclusion in traditional cultural practices (Ager, 2010).

*Features of key program evaluations*

No field program evaluations addressing stigma were identified in this review.

**Conclusion and Implications for Research and Field Practice:**

There are no available systematic reviews that focus specifically on the evidence of the impact of stigma as a risk factor for adverse mental health or psychosocial outcomes for adolescents in humanitarian settings, although a limited number of single studies have provided evidence on this risk factor. The recent systematic review on child-focused stigma reduction strategies in LMIC is a helpful addition to the literature, although the absence of field program evaluations, or the weak dissemination of these program evaluations to the wider humanitarian community, is concerning. Greater efforts to apply a rights-based approach to MHPSS services will enhance efforts to integrate MHPSS service delivery into education, health, and protection services. Children, adolescents, caregivers, and broader community groups should be empowered with information, confidence, and skills to assert their rights to quality preventive and promotive mental health services. Capacity gaps for quality service delivery should be assessed to inform advocacy and programming to increase universal, non-discriminatory access to MHPSS services.

Moreover, the UN Human Rights Council (2019) has called for broader efforts to address stigma. The root causes of mental health problems are often structural and when we continue to use individualized, causal models to identify determinants of mental health, such as youth violence and self-harm, it results in interventions that focus on immediate, individual behavioral factors, rather than adequately addressing the root causes (UN Human Rights Council, 2019). In order to create supportive and enabling environments that foster mental health and well-being, states have an obligation to create supportive and enabling environments that involve measures to enable everyone to participate actively and meaningfully in decision-making; and civil action, as well as State accountability, is needed. A shift to shared policy action is required, and while it does not fit easily into one silo or one ministry, innovation in the promotion of mental health must be defined and created at the local level with communities, individuals, and families (Ibid.).

**Evidence Gaps:**

It is evident that there are significant gaps in evidence regarding types of stigma and their impact on children and adolescents in humanitarian settings. The scientific community needs to go beyond the stigma associated with HIV/AIDS and association with armed groups. Increased efforts are required to understand the mental health dimensions of stigma arising from a range of other characteristics (e.g., gender or sexual identity, disability, refugee status, care status, etc.). The lack of quality evidence on effective stigma-reduction strategies for children with disabilities is evident and warrants significant attention. Further evidence is required to inform types of interventions that may be effective and feasible in this area and how best to engage and work with key groups to reduce stigma and discrimination against children and adolescents in humanitarian settings. Researchers are urged to conduct replication studies of promising interventions.

**PROTECTIVE/PROMOTIVE FACTOR**

## 4.2 Community participation and Social support

**Strongest evidence:**

**A** – Systematic review(s)

6-18 years

**Introduction:**

*"Participation is not an activity or programmatic area like early childhood development, nutrition or economic strengthening. It is a way of being, seeing, and doing within an organization or community which contributes to the healthy development of the community as a whole and different groups with the community" (REPSSI, 2009).*

Within the IASC MHPSS Guidelines, activating and supporting family and community-level social supports is considered a key activity within Level 2 interventions on the MHPSS intervention pyramid. Community participation is increasingly recognized as a key mechanism to support relevant design, implementation, and uptake of MHPSS programs in humanitarian settings and supports efforts to mobilize community members and groups to strengthen social support networks and services (e.g., Bangpan et al., 2017; Kohrt et al., 2018). Furthermore, a wide range of MHPSS programs for children in humanitarian settings include components focused on rebuilding and strengthening social supports within the community in order to protect children from further harm and to address issues of inclusion and discrimination.

**Epidemiological Evidence:**

Systematic reviews of children's mental health and well-being in humanitarian settings identify the potential role of social support in influencing resilience and promoting successful reintegration (Reed et al., 2011; Betancourt et al., 2013). In Adhikari and colleagues' study of risk and protective factors related to the reintegration of former child soldiers in Nepal, social support was found to be the most significant predictor of psychosocial well-being and mental health. Specifically, support at the community-level was associated with better outcomes in relation to anxiety and post-traumatic stress disorder and served as a protective factor in relation to depression (Adhikari et al., 2014). Despite strong evidence confirming community support as a protective factor, studies have also identified an "inconsistent picture" of findings on social support (Tol et al., 2013). In a systematic review of factors influencing resilience, Tol et al. (2013) identified that social support can be protective for some groups and not others (for example, boys vs. girls) or that it can be protective for some outcomes and not others (for example, depression vs. internalizing and externalizing symptoms). The review found that protective effects of community-level variables, including social support, "have been observed in child soldiers, but not in generally conflict-affected children" (Tol et al., 2013).

Hall et al.'s (2014) study sought to assess the relationship between cognitive social capital (perception of trust, cohesion, and reciprocity) and various factors, one being social support, and the resulting impact on youth's mental health and functioning in the Burundian context. The study found that high levels of cognitive social capital were associated with higher levels of

received social support that, in turn, was associated with protective effects on mental health (i.e., depressive symptoms) and functionality (Hall et al., 2014). Vindevogel and colleagues (2012) conducted a study in Northern Uganda to assess the perspective of formerly recruited youth on the potential contributions and prioritization of formal and informal supports that can benefit reintegration. Youth indicated a variety of positive attributes across various types of support, including that support from their family was perceived to be related to the development of their knowledge and skills, livelihood, and physical health. Furthermore, support from friends was perceived to be related to the development of knowledge and skills, mental health, social ecology, social connectedness, and social support (Vindevogel et al., 2012).

Community participation processes allow greater opportunities to identify and build upon existing informal social support networks and enhance uptake of MHPSS services. Recent studies have found that community participation in MHPSS assessments, design, planning, and implementation helps to ensure a more holistic understanding of the situation based on local socio-cultural contexts and restores the dignity, satisfaction levels, well-being, and ownership of the target groups (Bangpan et al., 2017; Besselink, 2016; UNICEF, 2018; Weissbecker et al., 2019). Community participation strengthens people's feelings of self-efficacy and self-determination (UNICEF, 2018b). The systematic review conducted by Bangpan, Dickson, Felix, and Chiumento (2017) draws together primary research on MHPSS programs for people affected by humanitarian crises in LMICs, investigating both the process of implementing MHPSS programs and how they are received by affected populations, as well as assessing their intended and unintended effects. Of the 82 studies included in their review, 26 RCTs evaluated the effects of MHPSS interventions delivered to children. The authors found that community engagement was a key mechanism in supporting the successful implementation and uptake of MHPSS programs in humanitarian settings. They found that i) mental health sensitization, mobilization strategies, and the need to develop effective partnerships with local communities and government were understood as pivotal in increasing program accessibility and reach; and ii) establishing good relationships with parents may also be important when there is a need to communicate the value of children and young people participating in MHPSS programs. These findings are reinforced by Healy et al. (2018), who argue that the delivery of interventions by non-specialists may be an effective strategy to facilitate the dissemination of mental health interventions in low resource contexts when human resources are limited.

The absence of community involvement in MHPSS interventions was noted by Kamali et al. (2020), who undertook a systematic review on the delivery, coverage, and effectiveness of MHPSS for conflict-affected women and children in MLICs. While more than 40% of included publications reported on interventions targeted at children and adolescents, very few reported on interventions engaging parents/caregivers along with their children. This lack of focus on engaging caregivers is concerning, especially considering i) the crucial importance of parents and caregivers as natural support systems for children and ii) the significant toll that conflict and displacement take on children and families by destroying pre-existing community structures and social networks (Kamali et al., 2020). Similarly, despite knowing the relevance of faith and faith-based support for individual and collective well-being, very few studies described MHPSS interventions that were promoted or delivered by religious leaders or through faith-based delivery channels (Ibid.). The authors suggest that "inadequate use of these networks is a missed opportunity to increase the reach of MHPSS interventions" (Kamali et al., 2020, p. 8).

In a meta-review, including nine reviews covering child and adolescent mental health, Kohrt et al. (2018) found that community components are vital to address global mental health needs

and to rectify the stark gap between the burden of mental disorders and access to appropriate evidence-based interventions in LMICs. They identified that i) community platforms were an alternative to primary care to enhance the reach of services; ii) community components could augment clinical services, such as enhancing medication adherence; iii) community programs were also implemented to increase the likelihood of family involvement, which would, in turn, improve quality of life, functioning, and inclusion; iv) community platforms also had economic benefits not observed in primary care and specialty settings, and v) community platforms are used to promote social inclusion. The authors also found that community-based services enhanced the delivery of care that was easily accessible to persons with mental illness. Furthermore, community services (including school-based services) can promote social inclusion because community-based settings can be less stigmatizing than visiting a mental health care facility (Fazel et al., 2014; Jorm, 2012; Kohrt et al., 2018). A recent study on the psychosocial well-being of Royingya refugees emphasized the importance of the community in supporting MHPSS needs (Tay et al., 2018). Qualitative data from FGDs indicated that male and female adults and older persons with MHPSS needs were primarily seeking treatment services from traditional healers and that Rohingya men, women, boys, and girls will only enter the formal healthcare system (to access mental health care) if there is a physical problem associated with their condition (Tay et al., 2018, cited in Harrison et al., 2019). Adolescent boys and girls reported very rarely (if ever) using the health clinics in the camp, preferring to seek MHPSS from their peers and parents (Harrison et al., 2019). Kamali et al. (2020) identify the crucial role of local community members and training of outreach workers who are able to support referrals to relevant services, particularly in project areas where humanitarian staff are not permitted to visit due to insecurity or other political factors.

However, Kohrt et al. (2018) also found potential harms and risks in community-based interventions. These include poor adherence to treatment in community settings, high economic costs of comprehensive community programs, maintaining motivation among non-specialists while competing with other professional, familial, and social demands, training and supervision to achieve minimum competency standards, and the stigmatization of the community-based providers. In some contexts, community services may provide limited additional benefits over primary care services alone (Kohrt et al., 2018). For example, in a cohort study in Nepal, persons with psychosis received community counseling and participated in peer support groups. These individuals did not have different outcomes when compared with a control group only receiving primary care services and medication (Jordans et al., 2017).

**Intervention Evidence:**

No relevant systematic reviews of interventions focused on increasing or improving social support and community participation were identified, although several evaluations of interventions have assessed the extent to which improvements in social support impact children's mental health and psychosocial well-being in humanitarian contexts.

Community-based approaches to MHPSS in emergencies are based on the understanding that communities can be drivers for their own care and change and should be meaningfully involved in all stages of MHPSS responses (IASC, 2019). Social support and community-based MHPSS interventions have been found to facilitate caregivers, families, groups, and communities to support and care for others in ways that encourage recovery and resilience, as well as providing important informal networks of support to children and adolescents themselves (IASC, 2019; Department of Health & Human Services, 2018; Combaz, 2016; Rabaia, Saleh, & Giacaman, 2014; Harrison et al., 2019).

The benefits of group-based programs include providing an opportunity to connect with people from similar circumstances and backgrounds and share stories, helping to promote greater social cohesion and reducing social isolation (Bangpan et al., 2017). It is critical that MHPSS interventions and group-based programs build upon, and do not undermine, informal social support networks, especially knowing the risk that MHPSS programs can slightly decrease social support perceived by children and young people (Bangpan et al., 2017). Borja et al. (2019) confirmed the importance of the meaningful engagement of the community in a study of Save the Children's child-centered, cross-sectoral MHPSS interventions in the Rohingya response in Bangladesh. They found that structures such as child-friendly spaces (CFS), community centers and organizations, temporary learning centers (TLC), and health and nutrition posts serve as entry points for MHPSS services. Based on their experience, they report that community-based approaches that promote the capacity of its members to support the most vulnerable groups, including children, encompassing preventative, promotive, and responsive services, not only have the most significant impact but can also be cost-effective.

Despite the rhetoric about the importance of participation, many interventions lack community involvement in their design, implementation, monitoring, and evaluation (Harrison et al., 2019; Kamali et al., 2020). Reflecting on limited participation opportunities, members of the MHPSS working group in Bangladesh recommended stronger involvement of the camp population, including traditional healers and religious leaders, in the design and delivery of MHPSS services. This involvement would include the recruitment of community volunteers (Rohingyas) and the sensitization of Imams so they can conduct outreach activities within the camps and shelters, as well as supporting peer-to-peer support (including child-to-child support) and community-led initiatives and support groups (Harrison et al., 2019).

Effective community-based interventions require approaches that facilitate the active engagement of community members in building on their own belief systems and capacities that promote resilience and protection and respond to risk without discrimination. As stated in a child protection lessons learned document related to the Ebola response, the initial messaging on safe burials and other life-saving practices was perceived as threatening to deep-rooted social values, resulting in the widespread rejection of key health messages (UNICEF, 2015). Reflecting on the change in approach to engaging with communities and traditional leaders, the study noted the "shift from community anger and rejection to community engagement: communities started to trust and…engage in the solution." There is a need to manage issues of group power and gender dynamics through culturally sensitive approaches (The Alliance for Child Protection in Humanitarian Action, 2020). Bangpan, Dickson, Felix, and Chiumento (2017) identify additional enablers of implementing and receiving MHPSS interventions delivered to populations affected by humanitarian emergencies. These include having sufficient numbers of trained MHPSS providers and ensuring that MHPSS programs are socially and culturally meaningful to local populations. The importance of connecting with others from similar circumstances in group-based programs, building trusting and supporting relationships to maximize participant engagement, and increasing the impact of programs were also identified as key requirements.

Recognizing weaknesses in the monitoring and documentation of community engagement, Kohrt et al. (2018) have elaborated guidance to support systematic reporting of community mental health. They have identified components in 12 domains for reporting: 1) involvement of service users and family members; 2) involvement of other stakeholders; 3) rationale for the use of community components; 4) procedures to assure equity, promotion of human rights, and protection from stigma and discrimination; 5) scope of activities to address mental health literacy and prevention/promotion; 6) treatment and rehabilitation services; 7) platforms for

service delivery; 8) cadres and competencies of community-based service providers; 9) integration into existing healthcare systems; 10) implementation procedures for establishing, sustaining, evolving, and scaling-up services; 11) technologies used for community components, and 12) diverse events and unintended outcomes. Through implementation science, studies can be designed and implemented to compare community components, delivery platforms, and other factors (Ibid.).

Comprehensive community MHPSS programs can be expensive, and it can be a challenge maintaining motivation among non-specialists (who have competing demands on their time) (Ibid.). Kohrt et al. (2018) urge careful efforts to be made to avoid demanding too much of community volunteers while avoiding large unsustainable payments to community members. They found that introducing large sums of financial or material resources (including payments to individuals for their participation in activities) can weaken community ownership and limit sustainability (Kohrt et al., 2018). Exceptions may be made for small supports (such as phone credit, notebooks, refreshments, or uniforms) that are given in exchange for performing agreed-upon responsibilities. In such cases, interagency coordination is required to decide how best to provide and standardize support. It may be worth considering financial support to whole-community initiatives, as opposed to resourcing individuals (2016 in The Alliance for Child Protection in Humanitarian Action, 2020). There is also a risk of poor quality services being provided by non-specialists if there is not sufficient training and supervision; and risks of poor adherence to treatment in community settings (Kohrt et al., 2018).

**Mental health and psychosocial support for youth, IMC**

*Evaluation without control groups (level D)*

The International Medical Corps' Adolescent Health Taskforce works to develop and address multi-sectoral, integrated adolescent programming with a focus on integrating mental health and psychosocial support, gender-based violence, sexual and reproductive health, nutrition, and gender into current International Medical Corps programs. It does so through child- and adolescent-friendly spaces, youth empowerment program (YEP), and "Makani" (My Space). A recent program review from three years of this program showed that after completing YEP, participants demonstrated significant improvements in social skills, relationships with parents, community connectedness, and experienced significant reductions in depressive mood, anxiety, and negative feelings (IMC, 2017).

**Evaluation example: IMC's Urban Soccer Program Evaluation (2009)** *[ages 12-22]*

*Pre-post survey and FGDs, no control groups (level D)*

During its 2010 programming year, IMC implemented the Urban Soccer Community Project (USP) as part of its mental health and psychosocial activities. The project was divided into two phases. Phase one included the renovation of two urban soccer pitches in Amman and Zarqa, a governorate 30 kilometers northeast of the capital. Renovations were in collaboration with GAM and Zarqa municipalities. Both Zarqa and Amman municipalities were active in the selection of the urban soccer pitches and provided financial contributions. Positive impacts observed on youth: 1) engagement in organized activity, 2) friendship between Iraqi and Jordanian youth, 3) improved parent engagement, 4) female participation in sport, and on parents 1) engagement with the youth and community, 2) constructive activity for parents, 3) addressing stereotypes of female participation in sport, and 4) promoting soccer, thus promoting physical health.

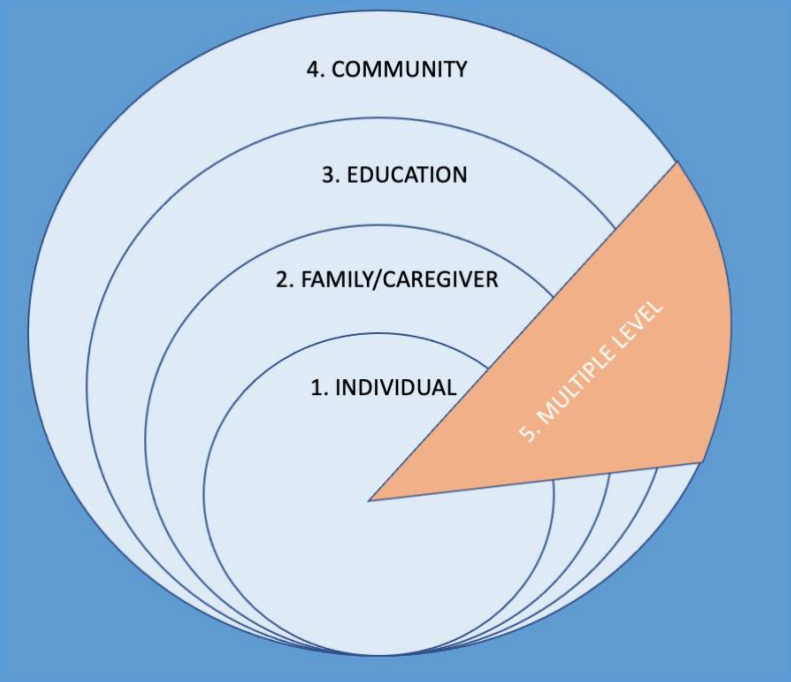
**Conclusions and Implications for Research and Field Practice:**

The IASC MHPSS Guidelines, based on expert consensus, indicate a central role for community participation and enhancing and improving social support as a means towards addressing MHPSS needs in emergencies. A limited number of studies have shown that social support can be assessed and measured and has associations with improvements to adverse mental health outcomes amongst children in conflict-affected settings. The field needs less reliance on expert-driven approaches and much wider use of slower, community-driven, bottom-up approaches to children's well-being (Wessells, 2015). In order to better understand and strengthen existing informal social support networks, more attention needs to be paid to engaging with children, adolescents, caregivers, traditional and religious elders, local teachers, health workers, and other relevant stakeholders. Furthermore, systematic and contextualized engagements could increase linkages and referrals to more formal systems of support.

**Evidence Gaps:**

Researchers and practitioners are encouraged to explore the impact of social support and community participation on the mental health and well-being of children in humanitarian contexts. More systematic efforts are needed to document and measure the process and outcomes of community participation and to strengthen informal social support networks.

# Section 5: MULTI-LAYERED APPROACHES




Recognizing the interplay between protective and risk factors at different layers of the socio-ecological framework requires increased efforts to research and understand how factors at one level influence factors in another level, and it necessitates greater multi-sectoral, multi-layered interventions and robust evaluations. Miller and Jordans (2016) found that while "change the child" MHPSS interventions aimed at strengthening children's self-esteem are theoretically and empirically sound approaches, more multi-layered efforts, including interventions with families, communities, and wider societal structures, are needed to reduce drivers of poor mental health. This penultimate section of the report outlines the following factors:

**5.1 Violence against children and gender-based violence** (risk)
**5.2 Children's participation** (protective/promotive)
**5.3 Multi-layered approaches** (protective/promotive)

**RISK FACTOR**

## 5.1 Violence against children and gender-based violence

**Strongest evidence:**

**A** – Systematic review(s)

0-18 years

**Introduction:**

Violence against children (VAC) negatively affects children and adolescent's mental health and well-being, impacting not only their childhoods but also adversely affecting their longer-term physical and mental health into adulthood (Bhatt, 2017; Devries et al., 2017; Gilbert et al., 2009; Leach et al., 2014; OSRSG-VAC, 2014; The Alliance for Child Protection in Humanitarian Action, 2018). Violence can be physical, sexual, and emotional (emotional abuse and or neglect). Driven by inequitable gender norms, gender-based violence (GBV) is violence that affects persons of a particular gender disproportionately, encompassing different manifestations such as domestic violence against women, increased risks of sexual abuse and early marriage of girls, and female genital mutilation.

Risks of children and women experiencing violence (including GBV) within and outside of homes increase in humanitarian settings, especially in contexts affected by armed conflict, political instability, and displacement (Asghar, Rubenstein, & Stark, 2017; Combaz, 2018; Murphy et al., 2019; Rubenstein & Stark, 2017; Stark & Ager, 2011; Seddighi, 2019). Children and adolescents may witness and experience violence across multiple settings, including their homes, schools, communities, workplaces, on the streets, and when on the move (Pinheiro, 2006; OSRSG-VAC, 2013; UNICEF, 2014). Moreover, experiencing violence in one setting, such as the household, increases risks of experiencing other types of abuse from other perpetrators in other settings (Arth, 2015; Finkelhor et al., 2009; Frías & Castro, 2011), and adults and adolescents with post-traumatic stress disorder are at increased risk of perpetrating interpersonal violence (Catani, 2010; Catani et al., 2009; Rubenstein & Stark, 2017). Thus, mental health and psychosocial support should be integral to protection responses to enhance resilience and recovery (Tol et al., 2013; WHO, 2012), and violence prevention should be integral to MHPSS programming (Panter-Brick et al., 2014), with integrated initiatives to prevent and sensitively respond to violence against women (VAW) and VAC (Rubeinstein et al., 2020).

**Epidemiological Evidence:**

There is substantial evidence of the devastating short- and long-term negative consequences of violence against children on an individual's mental health and well-being, cognitive emotional and behavioral development, physical development, risk-taking behaviors, and interpersonal behavior (Bhatt, 2017; Combaz, 2018; Devries et al., 2017; Gilbert et al., 2009; Leach et al., 2014; OSRSG-VAC, 2013; Pinheiro, 2006; UNICEF, 2017). Increasing evidence confirms that exposure to violence can impair brain development, especially during certain sensitive developmental stages, including in early childhood and early adolescence (Devries et al., 2019; Hillis et al., 2016). Children who are exposed to violence often suffer from anxiety, depression, aggression, eating disorders, and have difficulties with attachment (Brewerton, 2007; Brodsky & Stanley, 2008; Gilbert et al., 2009; Pinheiro, 2006). Violence against children is also linked to drug and alcohol misuse in adolescence and adulthood (Brown et al., 2009; Jewkes et al., 2006). VAC, VAW, and GBV also have negative consequences for the social fabric of families, schools, and society in general (Gilbert et al., 2009; IRC, 2015; Pinheiro, 2006; Rubenstein & Stark, 2017; Tol et al., 2013; UNICEF, 2014; WHO, 2012). For example,

exposure to violence negatively affects social networks, relationships, and family functioning (Jordans & Tol, 2015; Borba et al., 2016; Jordans & Tol, 2017; Silove et al., 2017).

The epidemiology of violence differs by age, gender, disability, and other factors, and there are interactions between inequalities based on gender, disability, income, class, caste, ethnicity, sexual identity, and age (Devries et al., 2017; Leach et al., 2014; Parkes, 2015; Rubenstein & Stark, 2017; The Alliance for Child Protection in Humanitarian Action, 2018). In humanitarian settings, significant gaps and measurement challenges are contributing to limited evidence on the prevalence and causes of different forms of violence in humanitarian settings disaggregated by age, gender, and other relevant variables (Devries et al., 2017; Murphy et al., 2019; Stark & Ager, 2011). There is, however, increasing evidence that a combination of economic and social drivers underpin risks and vulnerabilities related to VAC, VAW, and GBV, including gender inequitable norms, cultural attitudes and practices, environmental degradation, political conflict and violence, and institutional weaknesses, as well as health shocks, poverty, and migration (GBV AoR Helpdesk, 2018; IRC, 2015; Jones et al., 2012; Pinheiro, 2006).

In situations of armed conflict and political insecurity, there is growing evidence indicating that women and children experience the most violence within their own households (Rubenstein et al., 2020). Furthermore, during the COVID-19 pandemic that resulted in confinement to the home, there is growing evidence of increased calls to hotlines from children and women reporting domestic violence in diverse socio-cultural political contexts (Peterman & O'Donnell, 2020; SD Direct, 2020; World Vision, 2020; UNICEF, 2020c). A Save the Children global study with over 17,000 caregivers and 8,000 children revealed that income loss due to COVID-19 was associated with a higher reporting of violence in the home, reduced psychosocial well-being of caregivers, and increased negative feelings of children (Ritz, O'Hare, & Burgess, 2020).

There is evidence that common interconnected drivers of VAW and VAC, and VAW and VAC often co-occur in the same households (Asghar, Rubeinstein & Stark, 2017; IRC, 2015; Rubenstein et al., 2020). Five common predictors to both VAW and VAC in humanitarian settings include conflict exposure, alcohol and drug use, income and economic status, mental health/coping strategies, and limited social support (Rubeinstein et al., 2020). Lack of housing and overcrowded living conditions also exacerbate the risks of child abuse and exploitation in humanitarian settings (Rubenstein & Stark, 2017; Seddighi et al., 2019).

Miller and Jordans (2016) argue that the high visibility of war-related violence, such as rocket attacks and armed assaults, can make it easy to overlook the violence that children may be subjected to in the privacy of their homes. Harsh parenting and witnessing intimate partner violence have a detrimental impact on children's and adolescents' well-being and reduce the family care and support that has the potential to mediate the relationship between armed conflict and children's well-being (Miller & Jordan, 2016). A scoping review by Bhatt (2017) identified that family violence was a predictor of mental health issues and depression in children and, notably, that child exposure to family violence was a stronger predictor of poor psychological and psychosocial functioning than exposure to war or natural disasters.

Additional studies identify associations between conflict and violence within the family (Bhatt, 2017; Combaz, 2018; Panter-brick et al., 2011; Panter-Brick et al., 2014; Palosaari et al., 2013; Sim, Bowes, & Gardner, 2018). Research with conflict-affected populations in Lebanon (Sim, Bowes & Gardner, 2018), Northern Uganda (Saile et al., 2014), and Sri Lanka (Catani et al., 2008), for example, suggests that caregivers' own exposure to war and subsequent mental health problems (e.g., depressive and post-traumatic stress symptoms) are associated with an increase in child maltreatment, which, in turn, elevate the risk of child mental health problems (Sim et al., 2019; Bryant et al., 2019). A longitudinal study in Afghanistan found that higher levels of family violence and family conflict significantly predicted several worsened adverse mental health symptoms (Panter-Brick et al., 2011). The researchers identified that family violence and maternal mental health were both strongly linked to multiple dimensions of children's mental health status (Panter-Brick et al., 2014). Furthermore, a study on political violence and mental health in Gaza revealed that exposure to political violence increased

men's distress, as well as their use of harsh parenting behaviors (Palosaari et al., 2013). These, in turn, adversely affected children's attachment, security, and level of post-traumatic stress symptoms (Palosaari et al., 2013).

Children with disabilities face heightened risks of violence in households (OSRSG-VAC, 2013; Save the Children and Handicap International, 2011; The Alliance for Child Protection in Humanitarian Action, 2018). Disability can aggravate poverty and violence, as families of children with disabilities face social exclusion, enhanced family stress, and additional costs for medical care, housing, transport, or other needs (OSRSG-VAC, 2013; Save the Children and Handicap International, 2011).

Evidence also indicates that school-related gender-based violence and violence in communities is more prevalent in times of social and political upheaval, disaster, crisis, and conflict (Devries et al., 2019; NGO Advisory Council, 2011; UNGEI- UNESCO, 2013). Conflict, disasters, and climate change create or exacerbate the conditions that precipitate street involvement and lead to increases in children arriving on the streets (Consortium of Street Children and Plan, 2011). Disasters render children from the poorest families increasingly vulnerable to trafficking and exploitation, psychosocial distress, child marriage, and physical and sexual abuse (Human Rights Watch, 2015; IRC, 2015; OSRSG-VAC, 2013).

**Intervention Evidence:**

There is emerging evidence on interventions to prevent and respond to VAW and VAC in humanitarian settings (Asghar, Rubenstein, & Stark, 2017; Murphy et al., 2019), although more rigorous evaluations and longitudinal studies are required to address weaknesses and evidence gaps (Asghar, Rubenstein, & Stark, 2017; Murphy et al., 2019). Many different types of interventions are designed and implemented to address a wide spectrum of VAW/VAC-related outcomes, including improved mental/physical health, changes in social norms and attitudes, reduced incidence of violence, and increased access to key services. Recent reviews of interventions to prevent and address violence against women and girls, especially household-level violence, in conflict and humanitarian settings identify that multi-component interventions show promise (Asghar, Rubenstein, & Stark, 2017; Murphy et al., 2019; Parkes, 2015).

Multi-strategy interventions that combined either social norms (to address inequitable gender norms and cultural beliefs concerning domestic violence and or corporal punishment of children) or the empowerment of women and or children with one or more additional strategies, such as improved livelihoods, access to social protection schemes, or improved access to services, have been widely used (Asghar, Rubenstein, & Stark, 2017). Changing attitudes about VAW, VAC, and gender norms are important components of prevention and response programs (IRC, 2015; Murphy et al., 2019). Programs such as Beyond Borders' Rethinking Power in Haiti and refugee assistance programs in Kenya (CARE) and Thailand (IRC) have shown decreases in accepting violence against women and girls or improved acceptance of equal gender norms (see Beyond Borders, 2013; Falb, 2011; Holmes & Bhuvanendra, 2014; Mwangi, 2012). Some programs, including Save the Children's REAL Fathers in Uganda (Ashburn et al., 2016) and IRC's Women's Protection and Empowerment project in Thailand (Holmes & Bhuvanendra, 2014; IRC, u.d.) include effective efforts to engage men and or boys to prevent and respond to violence against women and girls.

As described in section 2.1, there is emerging evidence of positive parenting interventions in humanitarian settings to reduce harsh parenting to prevent emotional and physical punishment of children, to strengthen communication, and to enhance positive parent-child relationships in order to enhance protective factors for children's mental health and well-being *[see Area 2.2].*

Humanitarian programs employing livelihood and or social protection strategies, such as IRC's EASE program, have demonstrated reductions in at least one form of measured violence (especially when combined with the exploration of gender and power dynamics) and improve communication and conflict management skills (Asghar, Rubenstein, & Stark, 2017; Holmes & Bhuvanendra, 2014; IRC, 2015; Murphy et al., 2019).

School-based interventions to reduce violence and bullying among students, to prevent corporal punishment by teachers, and to enhance peer support and social networks among peers are also relevant (Combaz, 2018; Miller & Jordan, 2016). Rubenstein et al.'s (2020) systematic review of interpersonal violence in humanitarian settings has also emphasized the potential of programs that cultivate social support networks among adolescent girls to reduce violence. While not yet evaluated in a humanitarian setting, evaluations of the Good Schools Toolkit in Uganda, which includes education on sexual and emotional violence and relationship power among adolescents aged 11-14 years, have reported significant reductions in levels of violence (Devries et al., 2017).

**INSPIRE, WHO et al.**

*RCTs (level B)*

INSPIRE is a technical package to end violence against children, developed by WHO in collaboration with UNICEF, UNODC, PEPFAR, USAID, World Bank, US Department of State, Centers for Disease Control and Prevention, Together for Girls, and End Violence Against Children. INSPIRE provides seven strategies to prevent and respond to physical, sexual, and emotional violence against children based on available evidence. These seven strategies in INSPIRE were selected based on existing evidence to address both risk and protective factors for preventing violence against children using the social-ecological model. The strategies include: **I**mplementation and enforcement of laws, **N**orms and values, **S**afe environments, **P**arent and caregiver support, **I**ncome and economic strengthening, **R**esponse and support services, and **E**ducation and life skills.

**REAL Fathers, Northern Uganda, Save the Children**

*Quasi-experimental using mixed methods (level C)*

Save the Children's intervention REAL (Responsible, Engaged, and Loving Fathers in Northern Uganda) organized structured group sessions and mentoring with young fathers and wider community dialogue to explore gender norms and non-violent communication and behaviors with their female partners and children. A quasi-experimental study using mixed methods found that men who participated in at least one individual mentoring session and one group session were significantly less likely to report the use of any form of Intimate Partner Violence (IPV) against their partner at end line (10-month) and long-term (12 months for one cohort, 18 months for another) and follow-up, compared to men who did not attend any sessions (Ashburn et al., 2016). There were also significant reductions in self-reported use of physical punishment against children at the long term follow-up, but not before (Ashburn et al., 2016).

**Evaluation example: Economic and Social Empowerment for Women (EASE), Burundi, IRC**

*Randomized evaluation (level B)*

IRC's Economic and Social Empowerment for Women (EASE) Program in conflict-affected Burundi combined social empowerment of women by integrating Talking about Talking (TaT) within a traditional Village Savings and Loan Association (VSLA) intervention. Through the TaT, both women and men had the opportunity to engage in six facilitated conversations on financial decision-making. A randomized evaluation over a 16 months with two groups (VSLA only and VSLA + TaT) identified a statistically significant decrease in the incidence of IPV among women at high or moderate risk in the intervention group. Furthermore, the VSLA + TaT group was associated with an increase in decision-making, increased negotiation skills, and a reduction in the acceptance of violence (Holmes & Bhuvanendra, 2014; IRC, n-d reported in Murphy et al., 2019).

### Conclusion and Implications for Research and Field Practice:

There is increasing recognition that violence prevention is critical to promote effective MHPSS support for children and families in humanitarian settings, with more integrated approaches needed to address different forms of violence against women and children (Combaz, 2018; Miller & Jordan, 2016; Panter-Brick et al., 2014; Ritz, O'Hare, & Burgess, 2020; Rubenstein et al., 2020; The Alliance for Child Protection in Humanitarian Action, 2018). Furthermore, emerging evidence on the effectiveness of multi-strategy intervention indicates the need for increased inter-sectoral collaboration among child protection, women protection, MHPSS, education, livelihood, health, and other sectoral staff (Hillis et al., 2016).

Most research on VAC and VAW in humanitarian settings has focused on settings affected by armed conflict. Some recent systematic reviews have focused on VAC and natural disasters (Cerna-Turroff et al., 2019; Seddighi et al., 2019). These studies reveal interesting and mixed findings (Cerna-Turroff et al., 2019). For example, while some studies report increased VAC in settings affected by disasters (Schumacher et al., 2010; Seddighi et al., 2019), other research reveals that social support and interpersonal relationships have strengthened in families and communities during the aftermath of disasters (Cerna-Turroff et al., 2019; Fukuma et al., 2017; Kaniasty & Norris, 1995; Quarantelli & Dynes, 1977; Quarantelli, 2008).

### Evidence Gaps:

More robust ethical research and evaluation of interventions across multiple layers of the socio-ecological framework are needed to better understand and assess the effectiveness and impact of interventions designed to prevent violence and improve children's mental health and well-being in humanitarian settings (Rubenstein & Stark, 2017; Murphy et al., 2019). This requires:

- Advances in standardized definitions and measurement tools for measuring violence, GBV, mental health, and well-being (Hossain & McAlpine, 2017), and greater attention to reliable measures of child, adolescent, female and male caregiver, and family dimensions (Bhatt, 2017).
- An exploration of how structural inequalities (such as poverty, discrimination) impact the roles, behaviors, and well-being of different family members.
- Increased longitudinal observations of children, families, and communities from before the emergency to recovery, and improvements to ongoing global surveillance systems (Rubenstein & Stark, 2017).
- Increased research in contexts affected by disasters, including health pandemics such as COVID-19, especially in current times when we are increasingly affected by disasters due to the climate crisis (Cerna-Turroff et al., 2019).
- Greater investment in research with children and adolescents across different age groups, particularly research with children under the age of eight years.
- Increased disaggregated data collection and analysis based on age, gender identity, sexual identity, disability, sibling order, ethnicity, religion, care status, refugee/on the move status, and other factors (Combaz, 2018).
- More attention to community engagement, access to confidential protection services in real-time, and careful consideration of the safety of staff and volunteers (Combaz, 2008).
- More implementation research, including monitoring of unintended outcomes (Stark & Ager, 2011).

**PROTECTIVE/PROMOTIVE FACTOR**

## 5.2 Children's Participation

**Strongest evidence:**

**A** – Systematic review(s)

6-18 years

**Introduction:**

Children and young people have the right to participate in decisions that affect them (UNCRC, 1989). Children's participation in international development and humanitarian interventions has received increased attention in recent years (Ruiz-Casares et al., 2017). This is supported by research which shows that children and young people often wish to, and can, participate in issues related to their own protection and well-being (O'Kane & Barros, 2019; Taft, 2019; van Bijleveld et al., 2015) which, in turn, has positive effects on their subjective well-being (Vis, 2010). Children and young people's participation in child protection procedures, for example, have been found to result in decisions that incorporate children and young people's input, as well as early identification of child maltreatment cases (Vis et al., 2010).

Reviewing available evidence on the quality and outcomes of children's participation is complicated by different interpretations of what child participation means and debates on how to measure the process and outcomes of children's participation (Adair et al., 2015; Griebler et al., 2014; Hart, 2008; van Bijleveld et al., 2015). Participation has ranged from "simply taking part in activities, to being informed or consulted, to having significant influence over the decisions" (Griebler et al., 2014, p. 2). In this review, children's participation refers to the right of the child to express their views in matters affecting them and for their views to be acted upon as appropriate (Kennan et al., 2018). Children and adolescent expression and participation in decision-making are relevant at different levels – individual, family, community, school, and in wider programming, practice, and policy levels (UNICEF, 2020).

**Epidemiological Evidence:**

There is limited evidence with an explicit focus on children's participation in MHPSS programming in humanitarian contexts. However, systematic reviews on children's participation in healthcare, protection, and education in non-humanitarian contexts provide evidence that children's participation in decisions affecting them is a protective and promotive factor enhancing their care, protection, and well-being (Griebler et al., 2014; Kennan et al., 2018; Lloyd & Emerson, 2017; Marcus & Cunningham, 2016; Vis et al., 2011). The process of participation has been found to result in more trusting relationships, increased self-confidence and self-esteem, and an increased sense of mastery and control (Griebler et al., 2014; Kennan et al., 2018; Lloyd & Emerson, 2017; Marcus & Cunningham, 2016; Moore & Kirk, 2010; Vis et al., 2011). A sense of mastery and control is especially important for children's well-being, as evidence shows that children's trauma is characterized by hopelessness and powerlessness (UNICEF, 2018b).

Program evaluations and literature reviews of child, adolescent, and youth participation in peacebuilding (McGill et al., 2015; Promundo & Sonke Gender Justice, 2018; United Nations General Assembly Security Council, 2018) and participatory action research with adolescents affected by conflict (McKay et al., 2011; Tdh & IICRD, 2019), provide additional evidence relevant to humanitarian settings. Furthermore, research and documentation concerning the participation and organization of working children offer further insights on the benefits of children's participation that are relevant to MHPSS practitioners (Liebel, 2003; O'Kane et al., 2018; O'Kane & Barros, 2019; Taft, 2019). The Lancet Commission Report on Adolescent Health identified that

adolescents and young people are a "force for change and accountability within communities" (The Lancet, 2016).

Studies in non-humanitarian contexts provide an empirical evidence base for a positive correlation between child well-being and children's rights to participation (ARK, 2010; Casas et al., 2013; Lloyd & Emerson, 2017; Lloyd & Schubotz, 2014; UNICEF Spain, 2012). Recent research in Ireland using data from the Kids' Life and Times (KLT), an annual online survey of approximately 3800 primary school-going children aged 10-11, integrated a "rights-based" measure of children's participation in school and the community (a Children's Participation Rights Questionnaire [CPRQ]) with an established measure of subjective well-being – KIDSCREEN-10. The questionnaire encompassed different dimensions of well-being, including physical and psychological health, relationships with parents and friends, and autonomy. The CPRQ was developed in conjunction with a group of child co-researchers, drawing on an established children's rights-based approach to research (Emerson & Lloyd, 2014; Lundy & McEvoy, Emerson, 2012). The findings showed a statistically significant positive correlation between children's overall scores on the KIDSCREEN-10 subjective well-being measure and their perceptions that their participation rights are respected in school and community settings. The results indicated that it is the social relations/autonomy questions on KIDSCREEN-10 that are most strongly related to children's perceptions that their rights to participate are respected. Exploration of the findings according to gender showed that there were no significant differences in overall well-being; however, girls had higher scores than boys on the social relations/autonomy domain of KIDSCREEN-10. Girls were also more positive than boys about their participation in school and community.

Griebler et al. (2014) undertook a systematic review of existing evidence on the effects of student participation in designing, planning, implementing, and or evaluating school health promotion measures.[2] The 26 articles included for data synthesis discuss 24 studies/projects. Student participation in school health promotion measures resulted in increased satisfaction, motivation, and ownership (15 studies); increased skills, competencies, and knowledge (12 studies); personal development (11 studies), including increased self-confidence, self-esteem, and self-efficacy; positive health-related effects (10 studies), and a positive influence on students' perspectives – shifting the focus towards personal and social resources rather than on deficits (9 studies).

Research and evaluations on child, adolescent, and youth participation in peacebuilding also provide evidence that participation enhances self-confidence and personal development; contributes to reduced violence, including gender-based violence, bullying, and child marriage; helps reduce discrimination, and increases social cohesion and access to support (Marcus & Cunningham, 2016; McGill et al., 2015; Promundo & Sonke Gender Justice, 2018; United Nations General Assembly Security Council, 2018). Each of these outcomes is related to improved well-being, as children and adolescents build upon their strengths, harness social support networks, and reduce risks and negative outcomes associated with violence and discrimination. Moreover, evidence shows that as part of the process of growing up and detaching from parents, adolescents have an evolutionary need to belong to a collective. This should be translated into programmatic approaches that can respond to this need and direct it towards constructive outcomes (UNICEF, 2018b).

Research with working children in diverse contexts (including refugee working children and children from ethnic minority groups) has identified collective participation (e.g., in working children's associations/committees) and individual participation in decisions about their work as protective factors (O'Kane et al., 2018). Regular participation in working children's committees/associations has increased children's confidence to express their views in public and private settings (O'Kane & Barros, 2019). Working children's associations help children and adolescents to defend their rights collectively, protect themselves, and negotiate improved working conditions or compensation if they have an accident (see also Liebel, 2003; Taft, 2019). Working children make friends and have increased solidarity, support, and self-respect through their groups (O'Kane & Barros, 2019). When children and adolescents have opportunities to express their

[2] Of the 90 full text articles screened, 26 papers encompassing 24 studies/projects met the inclusion criteria.

views in decisions affecting them in their homes, workplace, and wider settings, more relevant efforts can be made to reduce the risks children face and to enable them to prioritize their studies. Adolescents explained that when their parents, caregivers, or employers consider their work type and working hour preferences, their protection and well-being increase.

Lack of opportunities for girls and boys (and other genders) to express their views and the exclusion of children from decisions affecting them is a risk factor, as it increases children's vulnerability to abuse and exploitation (Feinstein & O'Kane, 2009; O'Kane et al., 2018; Vis et al., 2011). This can increase fears and anxiety and reduce children's and young people's willingness to share their experiences in the future (Coyne et al., 2011). Professionals' objections to participation mainly stem from the socio-cultural image of children as vulnerable and in need of adult protection, as well as a lack of understanding about what participation actually entails. The absence of participation can create a sense of being ignored or overlooked, sadness, and despair, leading to decreased self-esteem and self-worth (Leeson, 2007; Winter, 2010).

**Intervention Evidence:**

Marcus and Cunningham (2016) reviewed evidence on the impact of interventions and initiatives that aim to support adolescents' involvement in development processes as "agents" leading and implementing initiatives and as "advocates" participating in and influencing political and decision-making processes. More than 300 studies were reviewed referring to one or more low- or middle-income countries, and over a third of studies focused on sub-Saharan Africa. The vast majority of primary studies (266) used an observational design; only 38 studies used experimental or quasi-experimental designs, five of which were randomized control trials.[3]

Marcus and Cunningham (2016) present evidence on three key outcomes: personal development outcomes for young people, participation outcomes, and wider developmental outcomes. Personal development outcomes of participation include the development of self-confidence and resilience, improved communication and technical skills, changes in attitudes and behavior, stronger social relationships, and an increased sense of inclusion. Of these, increased self-confidence and enhanced skills were the most common (discussed in, respectively, 191 and 144 studies). A wide range of interventions led to increased resilience, aspirations, and self-confidence. The most common types of intervention that yielded personal development outcomes of this kind were: peer-to-peer education projects, projects involving adolescents in participatory design and planning or research, arts and drama projects, media or video projects, socially-oriented youth groups, and youth networks. Ten studies, each of conflict resolution training and structured volunteering programs, also recorded positive changes in resilience, self-confidence, or aspirations (Ibid.).

Arts initiatives, mentoring, and peer education were most commonly associated with improved family relationships, enabled greater changes in discriminatory attitudes, and reduced engagement in harmful practices as adolescents were able to speak up about their feelings and needs (Marcus & Cunningham, 2016; see also Tdh & IICRD, 2019). In contrast, autonomous youth activism, socially engaged youth groups, participatory research, peer education, and conflict resolution and peacebuilding training were commonly associated with expanded social networks, often resulting in greater political or policy engagement (Marcus & Cunningham, 2016). Media-based projects were one of the most common interventions examined in this mapping (44 studies). These projects had an impact on both the personal development of the adolescents, including enhanced self-confidence, communication skills, and an increased sense of inclusion, and changes in the wider developmental context. Wider developmental impacts varied, but changes in discriminatory attitudes was notably the most common (reported in 16 studies), with five studies each reporting changes in harmful practices, changes in access to services, and changes in community infrastructure. Studies of youth media projects also note impacts on social cohesion (4 studies), the quality of services (4 studies), and local

[3] The quasi-experimental and experimental studies almost all examined peer education initiatives designed to improve sexual and reproductive health. Moreover, there was limited evidence of interventions targeting marginalized adolescents, other than activities with adolescents from marginalized ethnic or racial groups or low-income households (21 and 46 studies, respectively).

organizations' capacity (5 studies). Media-based projects increase adolescent engagement in policy, governance, and political processes.

Kennan et al. (2018) undertook a systematic literature review to explore the effectiveness of participatory processes commonly used in social work practice to support children's participation in decisions concerning their personal welfare, protection, and care. The review explores the effectiveness of using advocates, a child's attendance at an assessment, planning, or review meeting, Family Welfare Conferences, and recording a child's views in writing. The included studies were primarily small qualitative studies focusing on the participation of children aged 7-18, and the level of evidence documented was mostly indicative, drawing on service-user and service-provider testimonies. There is indicative evidence that the use of advocates is an effective means of supporting children's participation (Kennan et al., 2018).

Involving children and young people can be time-consuming, requiring time to secure informed consent from adult stakeholders, as well as time to build up a rapport with children and young people so that they feel safe and motivated to share their views and experiences (Ruiz-Casares et al., 2016). Systematic efforts to ensure ethical and safe participation are especially important when engaging children and adolescents on sensitive MHPSS topics (Wessells, 2017). It is crucial to ensure the availability of facilitators who are experienced in responding sensitively to children and adolescents who express distress or disclosures and who have knowledge of available response and referral mechanisms to ensure timely care and follow-up (Feinstein & O'Kane, 2009; The Alliance for Child Protection in Humanitarian Action, 2020). If participation opportunities do not ensure sufficient focus on quality processes,[4] there can be negative impacts on children's participation. For example, children or adolescents may feel ignored or not taken seriously, participation may interfere with their school work, or children may be scolded or harmed as a result of their participation (Griebler et al., 2014; Marcus & Cunningham, 2016; O'Kane & Barros, 2019; United Nations General Assembly Security Council, 2018).

## INTERVENTION EXAMPLES

### YouCreate, Tdh, and IICRD

*Participatory evaluation (level C)*

YouCreate is designed to strengthen well-being, resilience, and leadership among youth. It is a Participatory Action Research (PAR) Project that supports adolescents and youth (aged 14-20) to lead their peers in implementing participatory arts-based research projects and "Art Actions" to address challenges concerning them with the support of Adult Allies (Tdh & IICRD, 2019). Pilots took place in Egypt and Iraq in 2018, involving 252 youth in Iraq and 700 youth in Egypt. Through their projects, youth addressed different challenges concerning them in their communities, including violence, racism, discrimination, and the need for safe spaces for arts, freedom of speech, and active citizenship. Youth used a variety of art forms, including short storytelling, poetry, dancing, short movies, sketches, art exhibitions, and signing and rapping to address challenges affecting them (Tdh & IICRD, 2019). Key findings from these pilots closely mirror the project's original objectives and include supporting youth participation, resilience, empowerment, social cohesion, and well-being (Tdh & IICRD, 2019). Even short projects – ranging from 3-6 months – were found to result in positive impacts on hopefulness. Positive impacts were found at personal, family, and community levels. Gaining social respect and increased acceptance of their abilities by their parents allowed youth to more meaningfully engage in community spaces and contribute to creating more inclusive communities (Tdh & IICRD, 2019). The project encouraged people of different gender, race, ethnicity, age, and ability to live in harmony and be more actively involved in the community. Several challenges were identified, including the

[4] Participation that is i) transparent and informative, ii) voluntary, iii) respectful, iv) relevant, v) child friendly, vi) inclusive, viii) supported by training, ix) safe and sensitive to risk, xi) accountable

orientation needed for Adult Allies and trainers, overwhelming logistics for youth leaders, insecurity in reaching project locations, and the need for stronger communication with parents (Tdh & IICRD, 2019).

**Boxes of Wonder, Save the Children/C31**

*Program description with a rich description of participatory methods (level D)*

"Boxes of Wonder" is an intervention implemented by Save the Children and local partner C31, with children on the move in Serbia to promote their active participation and ensure MHPSS support (Avramovic & Stamenkovic, 2018; Save the Children, 2018c). The participatory methodology was piloted with children on the move at country borders and in Child-Friendly Spaces and Adolescent Corners in Drop-in Centers and reception centers. Activities included facilitating child-led tours of the camps, participating in decision making, video making, and the use of other creative tools. The "Box of Wonder" is both a method and set of physical boxes that become meeting places for children and facilitators offering a set of materials and initial ideas for activities within certain thematic frameworks. Children and adults are invited to jointly explore and discover potential areas of program development based on topics and activities that are meaningful for children and bring them opportunities to express themselves, play, learn, and enjoy. There is a strong focus on cultivating close relationships between the children and the program facilitators, as well as relationships with peers, to enhance an enabling environment for children's expression and a positive sense of well-being. The "Box of Wonder" includes a rich variety of creative arts, mapping, and theatre activities to explore topics such as "This is me," "My journey," "Catch a good feeling," and "Our Wishes." During the development and testing of the approach, it was found that many of the activities combined PSS and learning components and could overcome the serious gap in access to educational opportunities for children on the move. It also became clear that the increased emotional stability gained through MHPSS interventions supported learning processes (Save the Children, 2018c). The Kirkpatrick model was used to track changes in the practice and evaluation of training and capacity-building (Kirkpatrick, 1959). In addition to data collection, children and caregivers gave feedback through structured activities, group discussions, and a multi-media suggestion box. The project focused on confidence building, bolstering resilience, and engagement in school as opposed to skill development, and was found to be an effective intervention for children on the move. Children and adolescents demonstrated increased motivation to learn, more confidence, improved self-awareness, and an understanding of their rights (Save the Children, 2018c).

**Evaluation example: Child and youth participation in peacebuilding**

*Participatory evaluation with a rich description of participatory process and methods involving children and youth as evaluators (level C)*

A participatory evaluation of child and youth participation in peacebuilding was undertaken in Colombia, the Democratic Republic of Congo (DRC), and Nepal (McGill et al., 2015). Adolescents, youth, and adults were involved as evaluators in Local Evaluation Teams (LETs). A qualitative, multi-method approach was applied, including focus group discussions (FGDs) and participatory evaluation tools with different age groups that included a Timeline, a Before and After Body Map, online mapping, interviews, drawing, stories, and analysis of available secondary data. In Colombia, ten CYP initiatives that proactively engaged children, adolescents, and youth as peacebuilders were evaluated. In the DRC, 18 organizations that involved children, adolescents, and or youth in peacebuilding activities were evaluated. And in Nepal, peacebuilding activities undertaken by 17 child clubs and 17 youth clubs were evaluated. The interventions included child/youth clubs, peer education, awareness-raising, and actions to prevent violence (including GBV) and discrimination. The evaluation results revealed that child and youth peacebuilders have positively contributed in four key areas: 1) young peacebuilders often became more aware and active citizens for peace, 2) young peacebuilders increased peaceful cohabitation and reduced discrimination, 3) young peacebuilders reduced violence, and 4) young peacebuilders increased support to vulnerable groups. The evaluation also identified 11 factors that influenced the impact of CYP peacebuilding, including attitudes, motivation, and commitment of children and youth and family attitudes and support (McGill et al., 2015).

### Youth Living Peace

*Evaluation without a control group (level D)*

Youth Living Peace was implemented between 2015 and 2017 in Brazil and the DRC, focusing on preventing and responding to SGBV against adolescent girls (aged 13-19) in post-conflict and high-urban violence settings (Promundo & Sonke Gender Justice, 2018). The intervention aimed to help adolescents heal from experiences of violence and to provide school-based training for violence prevention. Group education activities and individual and group therapy focused on changing attitudes around gender equality, the use of violence, and self-efficacy in relationships. Other activities included school-wide campaigns and advocacy with key stakeholders in schools, government, and civil society organizations on policies and programming to prevent and respond to violence against adolescents. The project was coordinated by Promundo-US and implemented by HEAL Africa and the Living Peace Institute in the DRC, and by Instituto Promundo in Brazil, with support from the UN Trust Fund to End Violence Against Women. An external evaluation found the approach to be effective in both countries. Participating girls in Brazil, for example, experienced a 28% decrease in being insulted or humiliated in the previous three months, and boys who participated experienced a 37% decrease in verbal and psychological violence. In the DRC, adolescents developed a greater ability to gain control over and improve their lives, denounce acts of violence, take action, and increase social support through solidarity. Girls experienced more self-confidence and more opportunities to play active roles at school. Sixty-three percent of participants in the pre-test reported tense relationships with their parents, and in the post-test, 100% of adolescents had begun to ask their parents about sexuality, relationships, and family plans. Community members supported the efficacy and need for expansion of the project (Promundo & Sonke Gender Justice, 2018).

### Adolescent Kit for Expression and Innovation: Adapted resource package for COVID-19, UNICEF (2020)

*Program description and earlier evaluation without a control group (level D)*

UNICEF has adapted the Adolescent Kit for Expression and Innovation to provide adolescents (aged 10-19 years) with a resource that can be self-administered to promote their mental health and psychosocial well-being and learn new skills while staying at home, or another location, during the COVID-19 pandemic (UNICEF, 2020b). In its original form, the Kit activities are carried out in group sessions led by trained facilitators. The activities use expression and innovation to promote positive outcomes for adolescents' mental health and well-being and build their skills in communication and expression, coping with stress and managing emotions, creativity and innovation, hope for the future and goal setting, problem-solving and managing conflict, and empathy and respect. The adapted version offers instructions for parents and caregivers to support the activities at home or through platforms such as radio, TV, or WhatsApp. There are positive experiences of using this Kit with adolescents during the COVID-19 pandemic, especially with adolescent-led adaptations in Colombia. Although evidence of the adapted version is not yet available, a study of outcomes associated with the original Kit undertaken in Indonesia (UNICEF, 2018b) reports positive outcomes. Adolescents reported increased self-confidence and self-expression, increased socialization with friends, a safe space to learn to develop more tolerance, for example, and more engagement in positive activities (UNICEF, 2018b).

### Conclusion and Implications for Research and Field Practice:

Lloyd and Emerson (2017) suggest that the social/relational aspects of both participation and well-being lie at the heart of the relationship between child well-being and participation. Different studies indicate the significance of a child's relationship with significant adults, including parents, caregivers, and social

workers/caseworkers (Bessell, 2011; Kennan et al., 2018; Lloyd & Emerson, 2017; Riviera & Santos, 2016; van Bijleveld et al., 2015). Positive adult attitudes towards girls and boys (recognizing the child as a competent social actor) and trusting relationships between children and adults at different levels, including families, schools, communities, NGOs, and wider policy forums, are critical to creating an enabling environment for children's participation. Moreover, good relationships and opportunities for girls and boys (and those with other gender identities) to express their views in personal settings increases children's confidence to speak up and engage in decisions affecting them in wider civic and political settings (Riviera & Santos, 2016).

The manner of providing assistance has a big impact on the level of satisfaction and the MHPSS well-being of individuals and families affected by humanitarian crisis (UNICEF, 2018b). Programs should be designed and implemented in ways that restore the dignity, ownership, and participation of target groups to strengthen people's feelings of self-efficacy and self-determination (UNICEF, 2018b). The UN Human Rights Council (2019) has emphasized the importance of innovation in the promotion of mental health in the civil, political, and social realms, defined and created at the local level, with communities, individuals, and families (A/HRC/41/34). Moreover, the specific challenge of engaging children and adolescents in peacebuilding requires support sustainability that transcends the dividing-line between the phases labeled as "conflict" and "post-conflict" or between "emergency" and "development" programming (UNICEF, 2009).

**Evidence Gaps:**

Systematic and longitudinal research, and evaluations on the participation of children and adolescents in MHPSS in humanitarian settings are required, both to further examine and gather evidence on the links between children's participation as a protective factor for well-being and to better assess the impact of participatory MHPSS interventions (Ruiz-Casares, 2016). Research and evaluations should encompass a life-course focus, including an increased focus on the early years, as younger children have been excluded from consultations and research on services affecting them in humanitarian settings (Keenan et al., 2018; O'Kane, 2015). Gender-equitable participatory programming with adolescents can further support adolescents' evolutionary need to belong to a collective as part of the process of growing up and detaching from parents (UNICEF, 2018b). In research and evaluations, there should be an increased description of the socio-political-cultural context and a more rigorous analysis of children's and adolescents' roles and influence in each stage of the project cycle, including project analysis, planning, implementation, and monitoring and evaluation (Ruiz-Casares et al., 2016; Marcus & Cunningham, 2016).

To enhance meaningful participation, more opportunities should apply the nine basic requirements for effective and ethical participation as a planning tool (Lansdown, 2011; UNICEF, 2020) and comply with each element of the Lundy's (2007) model: space, voice, audience, and influence (Kennan et al., 2018; UNICEF, 2020). Sensitive and principled strategies for engagement, guided by the principle of do no harm and the best interests of the child, have been identified as particularly important when working with survivors of gender-based violence and marginalized groups (UNICEF, 2020).

**PROTECTIVE/PROMOTIVE FACTOR**

## 5.3 Multi-layered approaches

**Strongest evidence:**

**B – Randomized control trial(s)** 6-18 years

*"To ensure that psychosocial and mental health needs are met, MHPSS should be integrated as part of a continuum of care that is multi-layered." (Ran, M. eds., 2019)*

**Introduction:**

The evidence-based recognition of addressing multiple risk and protective factors as part of an effective MHPSS response is increasingly understood. Multi-sectoral programming and coordination was identified at the Wilton Park Conference in 2018, for example, as the first of four key pathways in a global roadmap to address the MHPSS needs of children and young people affected by conflict (Save the Children, 2018b).[5] Adopting a multi-layered approach is also prioritized in the IASC Guidelines, which proposes an adequate focus on the provision of basic services, establishing or re-establishing social and community networks and support systems, providing focused and non-specialized services to especially vulnerable children, women, and men, and providing specialized care to the significantly smaller percentage of the population who require them (IASC, 2019).

Several of the systematic reviews and studies that include multiple risk and protective factors have already been outlined and discussed in this report. Therefore, the following intervention evidence and examples largely focus on child-friendly spaces (CFS), a set of interventions explicitly developed to address multiple types and levels of support provided to children affected by conflict, reflecting elements of the Intervention Pyramid, and following a public health approach by using multi-tiered interventions. CFS often explicitly target several aspects of child protection and psychosocial well-being and therefore represent interventions that seek to target multiple risk and protective factors. Linkages between multi-layered peacebuilding and MHPSS approaches are also mentioned.

**Epidemiological Evidence:**

Interventionists have encouraged moving from single intervention approaches to multi-sectoral, multi-level, ecological or systems-oriented intervention programs for some time (Stichick, 2010; Wessells, 2008, 2015; de Jong, 2002; Sieger et al., 2004; Saltzman, 2003, cited in Jordans et al., 2010). This recognition is confirmed by increasing examples of contextually appropriate multi-layered systems of support that build on existing resources, with aspects of mental health interventions being delivered outside of primary care or specialized mental health support settings (Kohrt et al., 2018; Mattingly, 2017). Although MHPSS has traditionally fallen under the scope of child protection, it is now widely recognized that to be effective, MHPSS interventions need to be integrated across other sectors, such as education, health, shelter, and nutrition (Save the Children, 2018b). There are also increasing efforts to connect MHPSS and peacebuilding, in recognition that both require a multi-level socio-ecological approach addressing structural barriers and cultivating social relations among individuals and groups in order to build healthy and peaceful societies where

[5] The four pathways are: 1. Multi-sectoral programming and coordination; 2. Engaging young people; 3. Supporting caregivers; and 4. Strengthening national capacity

individuals and communities can flourish (Tankink, Bubenzer & van der Walt, 2017). The relevance of participation in social reconstruction and peacebuilding has been identified as beneficial to individual and community wellbeing, as well as to wider peacebuilding efforts (Tankink, Bubenzer & van der Walt, 2017). Silove's (2013) ADAPT model (Adaptation and Development after Persecution and Trauma) is relevant to both MHPSS and peacebuilding as it focuses on the importance of repair and strengthening across five core pillars of work, including (1) Safety/Security; (2) Bonds/Networks; (3) Justice; (4) Roles and Identities; and (5) Existential Meaning.

Although no systematic reviews have been found that focus on this area alone, the impact of taking a multi-layered, systems approach to MHPSS interventions has been considered in the systematic review conducted by Kohrt et al. (2018), who mapped the landscape of evidence-based community components of mental health interventions to draw lessons about their implementation. The authors found examples where community mental health for younger children and mothers was integrated into nutrition and other maternal and child health programs. For example, the Lady Health Workers in Pakistan delivered the Thinking Healthy Program in the context of their standard perinatal maternal and child health programs (Rahman et al., 2008). While there is scope for further research into the impact of current programming approaches (Hermosilla, Metzler, Savage, et al., 2019), the integration of coordinated MHPSS service provision within and across sectors has been found to have positive impacts on the mental health and well-being of children (and adults) in humanitarian settings, including contributing to addressing stigmatization and discrimination (e.g. Jordans et al., 2010) *[= Area 4.1].* In addition, such an approach enables services to be provided at scale and in a holistic manner for affected individuals, families, and communities (Ran, M. eds., 2019). However, a systematic review by Dickson and Bangpan (2018) on the barriers to, and facilitators of, implementing and receiving MHPSS programs delivered to populations affected by humanitarian emergencies in low- and middle-income countries, found that the integration of MHPPS programs with local health and social care systems can support or hinder program fidelity and impact (WHO, 2015; Van Ommeren et al., 2015).

Metzler et al. (2019) argue that if interventions in humanitarian contexts are to substantially influence longer-term trajectories of well-being and adjustment, they will need to be more effective in connecting children to resources in conditions of protracted displacement. A multi-sectoral response requires MHPSS needs to be realized through coordinated and complementary actions within the multiple sectors and clusters of the humanitarian response, including (but not limited to) child protection, community-based protection, sexual gender-based violence prevention and response, health, education, and nutrition (Ran, M. eds., 2019). Such a multi-layered approach relies on (a) capacity-building of appropriately skilled, community-level, frontline humanitarian workers, MHPSS professionals, and government officials; (b) strong referral networks, and (c) investment in other components of the system (including governance, service organization, monitoring of progress and impact, national preparedness and response planning, and establishment of long-term financing) (Ran, 2019). Save the Children (2018b) warn that without a significant change in the current humanitarian architecture around cluster co-ordination, leadership and who will take responsibility will remain key challenges.

**Intervention Evidence:**

Despite guidelines, consensus, and research on multi-layered MHPSS for children in humanitarian settings, there has been a paucity in clinical practice in the field of mental health and psychosocial support in low- and middle-income countries.

Drawing on evidence of Save the Children's work with children in Cox's Bazaar in Bangladesh, Borja et al. (2019) support the argument that interventions can best reach children and families when they are integrated within sectors rather than as stand-alone programs. In Save the Children's Rohingya response, for example, structures such as CFS, community centers and organizations, Temporary Learning Centers (TLC), and health and nutrition posts serve as entry points for MHPSS services. There is also an opportunity to formally integrate

MHPSS within the education sector through social and emotional learning. The use of a child-centered, cross-sectoral MHPSS programming approach presents the potential for improved program outcomes. Recognizing that the humanitarian situation in Cox's Bazaar is predicted to become protracted in nature, they encourage linking humanitarian gains achieved during the emergency and early recovery phases to long-term systems development approaches to ensure a cost-effective way of meeting any mental health and psychosocial needs of both Rohingya refugees and host communities across the Rohingya response (Borja et al., 2019).

Child-friendly spaces (CFS) are often the first MHPSS intervention in an emergency (Kaufmann, 2016), although recent studies confirm mixed results about their effectiveness in humanitarian settings, particularly for different age groups. The concept is simple and replicable, readily scalable, and by using community resources, large numbers of children can access the programs in a short period. In addition, gathering children in a protective safe space can provide opportunities to identify children with special emotional or physical needs related to the conflict and can reduce the risk of children being vulnerable to other protection factors such as malnutrition, child labor, sexual abuse, recruitment as child soldiers, drug abuse, etc. (Kaufmann, 2016). Caregivers and children, including adolescents, expressed feeling safe in CFS and GFSs as part of SC's Rohingya response in Cox's Bazaar (Borja et al., 2019). They reported that the physical space seemed to help improve their mental health and psychosocial well-being. In fact, a recent evaluation exercise showed 80% of adolescents aged 11–17 and 70% of children aged 4–10 had improved well-being outcomes compared to the last year (Borja et al., 2019). Metzler et al. (2019) found that children that attended a CFS in a refugee settlement in Uganda maintained better mental health and psychosocial well-being and secured greater development milestones after three to six months, with the strongest impacts in better-run CFS. However, a year later there were no significant differences between children who had attended or not attended a CFS during their early months in the refugee settlement, although scoring in the latter showed greater variation. Another study found that CFS can provide – albeit inconsistently – a protective and promotive environment for younger children, but show no impact with older children and in connecting children and caregivers with wider community resources (Hermosilla et al., 2019).

A 2015 collaborative study by UNICEF, World Vision, Columbia University, and Save the Children found that while CFS are instrumental in promoting children's well-being, they are weaker in engaging communities. This limits community ownership and resilience and the likelihood of sustaining the longer-term impacts of MHPSS interventions (Metzler et al., 2015) [*see also Area 4.2*]. Additionally, while unstructured play in a safe space can be a protective factor for children facing certain risks, unstructured play does not have the same potential impact for positive growth in terms of healing and recovery for children who have experienced very stressful or traumatic events (Ibid.). Accordingly, for CFS to ensure children's mental health and psychosocial well-being, it was found that they need to be established and operate in a way that engages or strengthens support systems within families and communities. When CFS activities are provided by staff or volunteers trained in MHPSS principles – such as children's reactions to stressful events at different ages and appropriate activities for calming, expression, and socialization – children's psychosocial well-being is protected and may also improve.

The evaluation of UNICEF's Psychosocial Support Response for Syrian Children in Jordan found that participation in CFS has positive effects on children's emotional and social well-being and allows them to gain new skills and knowledge (UNICEF, 2015b). This program was found to be highly relevant in terms of its overall objective to work towards minimizing risk factors and strengthening the protective environment by providing children and their family members with free, safe, and confidential access to MHPSS support through child- and adolescent-friendly spaces. CFS provided an array of activities for beneficiaries that were both culturally and socially acceptable, making a distinction between activities for children under 13 years of age and children over 13 years of age. Activities were often distinguished between those for male and female adolescents. Women also benefitted from the opportunities to be more socially active within CFS. Results of focus group discussions with boys and girls aged 9-12 and male and female adolescents aged 13-18 found that attending CFS had the biggest effect on children's emotional well-being (scoring 72 out of the 100 points available).

Within this category, “mood” scored 80%, “emotional regulation” scored 72%, and “feeling safe” scored 59%. Substantial positive effects were identified on social well-being and skills and knowledge, with scores of respectively 51% and 50%. Despite the low level of community engagement, one CFS demonstrated good practice in involving beneficiaries. A group of children and adolescents planned periodic cultural and recreational activities for the entire group. The activities took place on “free” days at the CFS (when programming was more flexible). The adolescents spoke of this as fun and felt it built their confidence and contributed to better relationships between adolescents in the Syrian and host communities (UNICEF, 2015b).

**Classroom-based intervention**

*RCT (level B)*

Jordans and colleagues’ “practice-driven evaluation of a multi-layered psychosocial care package” in Burundi, Indonesia, Sri Lanka, and Sudan sought to assess the efficacy of layered delivery methods of MHPSS support for school-age children in war-affected settings. The multi-level package was comprised of five levels of complementary supports in which participants could simultaneously engage, one population-level support with no inclusion criteria, three intervention levels using selection criteria related to the degree of psychosocial distress, and one level relating to the need for referral to psychiatric services. Once screened for psychosocial distress (Child Psychosocial Distress Screener), children (N=29,292) were assigned to one or more of the three intervention levels (Level 2: group activities targeting resilience and the prevention of adverse psychosocial outcomes for healthy, but at-risk, children; level 3: A 15-session, classroom-based intervention for children experiencing elevated levels of psychosocial distress, and Level 4: counseling or family/parental support for children experiencing severe psychological distress) or children were referred to alternate services. Jordans et al.’s evaluation of treatment outcome perceptions and satisfaction demonstrated problem reduction and satisfaction to be highest among participants who received the classroom-based intervention (CBI). The CBI was associated with improvement in children’s “emotional wellbeing (i.e., reduced fear, sadness, anger and negative thoughts), as well as positive social and behavioral changes (i.e., increased patience, sociability, self-esteem, concentration, unity, tolerance)” (Jordans et al., 2011, 2010).

**Evaluation example: Designing and implementing psychosocial interventions for children with severe acute malnutrition ACF, Nepal**

*Evaluation without control groups (level D)*

ACF’s program in Nepal is an example of integrating MHPSS and nutrition. Identifying the absence of MHPSS and nutrition programs, the authors state that they wanted to assess the effectiveness of a brief MHPSS intervention on child nutrition, health, and development by comparing the effects of a combined MHPSS and nutrition intervention to the stand-alone nutritional treatment of children with uncomplicated SAM aged six to 24 months (Le Roch & Bizouerne, 2018). The research highlighted the value of the program in terms of improved parenting skills and the resulting improvement in child development (gross and fine motor skills, cognitive skills, language, problem-solving, and personal/social development). Mothers and caregivers attended sessions on the stimulation of babies, appropriate child-rearing practices, enhancing mothers’ well-being and self-esteem, and children also received nutrition support. The sessions took place every two weeks at the same time as nutrition support. Community psychosocial workers felt that there was not enough time given to the program to see more lasting change, and the report states that the underlying cultural barriers of lack of education for girls and lack of economic support need more time to be addressed as they are very entrenched. Following the program, parents stated that they were more aware of malnutrition and associated problems, their roles and responsibilities, and felt better able to make decisions that affected their children (Le Roch & Bizouerne, 2018).

**Evaluation example: Child-Friendly Spaces in Ethiopia (World Vision, 2013)**
*Non-randomized, comparison of intervention and control groups at baseline and post-intervention (level C)*

In January 2012, World Vision began implementing CFS for Somali refugees in the Buramino Refugee Camp in Southern Ethiopia. The CFS focused on functional literacy and numeracy skills, MHPSS activities, such as drawing, singing, and recreational play, as well as on-site counseling and a feeding program. The evaluation employed measurement tools used at baseline and post-intervention, to assess three key areas, 1) the promotion of children's social and emotional well-being, 2) the protection of children from risk, and 3) supporting parents and communities in strengthening systems of child protection. Positive findings were identified in terms of skills acquisition (literacy levels) for children attending the CFS. Focusing on psychosocial outcome measures, the study found that all children showed improved mental health and psychosocial well-being after several months in the camp. This was true regardless of their participation in the CFS. Across three selected measures of psychosocial well-being, all children showed an overall reduction in difficulties, increases in pro-social behavior, and increases in developmental assets. Amongst boys, participation in the CFS resulted in substantial decreases in mental health and psychosocial problems (compared to boys who did not attend the CFS), and amongst children with particularly severe MHPSS problems at baseline, involvement in the CFS led to substantial reductions in symptoms.

**Evaluation example: Child-Friendly Spaces in Domiz Refugee Camp, Save the Children's 2014** *[Ages 7-16]*
*Non-randomized, comparison of intervention and control groups at baseline and post-intervention (level C)*

An evaluation of CFS implemented in the Domiz refugee camp, Northern Iraq. Various activities were implemented in the CFS, including music, sports, drawing, drama, English sessions, dance, and "knowledge and competition" sessions with sessions for children five days per week, with three two-hour shifts per day. The evaluation sought to identify the impact of the CFS in terms of 1) the protection of children from risk, 2) the promotion of children's mental health and psychosocial well-being, and 3) supporting caregivers and communities in strengthening systems of child protection. To identify these impacts, the evaluation interviewed caregivers and children at baseline and five months after the implementation of the CFS, comparing children who had attended to those who had not. Caregivers reported more gains in developmental assets for children attending the CFS than non-attenders, which indicates that the CFS program had a promotive effect on children's well-being. However, the findings did not indicate that attending the CFS had a significant impact on reducing children's troubling thoughts and feelings or on counteracting negative coping strategies for children. These findings indicate that the CFS did not meet its objectives in terms of improving the mental health and psychosocial well-being of children utilizing the CFS. However, older children who attended the CFS demonstrated reduced protection concerns compared to non-attendees; this could have longer-term benefits on mental health and psychosocial well-being.

**Evaluation example: Child-Friendly Spaces Implemented in Domiz Refugee Camp, Iraq, MoLSA and UNICEF, 2014** *[Ages 7-16]*
*Non-randomized, comparison of intervention and control groups, post-test (level C)*

This study examines the impact of a CFS implemented in the Domiz Refugee Camp in Northern Iraq in 2012. The CFS, implemented by the Ministry of Labor and Social Affairs for the Government of Iraq, included activities for children aged 4-16, such as singing, dancing, and free play, as well as sessions designed to impart knowledge on child rights and life skills. The CFS began one year before the evaluation. The evaluation is based on a comparison of attendees and non-attendees, after implementation of the intervention, with measurement instruments based on the key objectives of the CFS, including the "promotion of children's psychosocial well-being including the acquisition of skills and knowledge…". Focusing specifically on results relating to perceptions of protection risks and children's psychosocial well-being, this study found that older children attending the CFS reported fewer protection concerns, and caregivers with children attending the CFS reported lower concerns over children's safety but higher

concerns regarding loss of livelihood and lack of food. In terms of psychosocial outcomes, caregivers reported similar levels of resilience for CFS-attendees and non-attendees, and caregivers reported *higher* levels of troubling thoughts and feeling amongst young children attending CFS vs. non-attendees. Given that this evaluation did not have a baseline assessment, it is difficult to interpret this finding (for example, children who attended the CFS may have had worse troubling thoughts and feelings than those who did not attend). However, as the study concludes, "findings provide little evidence of impact on psychosocial wellbeing of attendance at CFS."

**Evaluation example: CFS, World Vision, and partners in Zarqa, Jordan (2015)** *[ages 5-12 and 12-17]*

*Non-randomized, comparison of intervention and control groups at baseline and post-intervention (level C)*

This evaluation focuses on a CFS implemented for Syrian refugees in an urban setting in Jordan. The CFS focused on multiple age groups, implementing activities including "drawing, handicrafts, puzzles, games, storytelling, singing, drama, and informational videos," as well as sessions focused on topics such as life skills and hygiene. Syrian refugee and local Jordanian children were included. Evaluation of the study design involved interviewing children and caregivers before attendance at the CFS, and follow-up with a sub-sample of this baseline group after the first cycle of CFS attendance, identifying caregivers of and children who had attended the CFS in order to compare outcomes in CFS-attendees and non-attendees. The evaluation identified a number of differences between CFS-attendees and non-attendees. For example, a significant difference in the knowledge of community mechanisms of support and referral was identified between CFS-attendees and non-attendees. CFS attendance did not appear to reduce protection concerns or reported caregiver stresses. In terms of psychosocial outcomes, caregivers of children aged 6-9 reported improvements in levels of resilience amongst CFS-attendees compared to non-attendees, but no changes in depression and anxiety symptoms over time. Amongst children aged 10-12, no improvements in resilience, depression, and anxiety symptoms or developmental assets were reported. This difference in impacts on psychosocial well-being for younger vs. older children indicates a potential need to revise the curriculum and approach to better address older children's psychosocial needs.

**Evaluation example: CFS, World Vision, and Save the Children, Uganda (2013)** *[ages 6-12]*

*Non-randomized, comparison of intervention and control groups at baseline and post-intervention (level C)*

This evaluation focused on eight CFS for Congolese refugees in the Rwamwanja Resettlement Center in Western Uganda. CFS activities included literacy and numeracy, local dialect and English language acquisition, traditional song and dance, art, storytelling, organized sports, and unstructured free play. The evaluation aimed to assess the impact of CFS attendance on a number of outcomes for children. The study's design included baseline and post-intervention assessments, interviewing caregivers of children aged 6-12, and through caregiver-reports (validated by attendance records) compared outcomes for children who did and did not attend a CFS during the study period. Protection concerns and caregiver stresses were reported as having reduced over time, regardless of CFS attendance. CFS attendance was significantly associated with a greater increase in developmental assets, especially for girls, indicating that "CFS served to strengthen internal assets (such as positive values and social competencies) and/or external assets (such as support and empowerment), while those not attending a CFS saw erosion of such assets over time." In terms of psychosocial outcomes, CFS-attendees sustained levels of psychosocial well-being over time, whereas CFS non-attendees showed significantly worse levels of psychosocial well-being at follow-up, indicating "potentially important protective influence of CFS attendance." Finally, the rating of CFSs according to standards and quality of programming indicated that higher quality CFS had a greater impact on developmental and psychosocial outcomes.

**Evaluation example: CFS, World Vision, and Save the Children, Goma (2013)** *[ages 6-12]*
*Non-randomized, comparison of recent and long-term enrollees, post-intervention (level C)*

This evaluation focused on the effectiveness of three CFS in Goma, focusing on internally displaced persons. The CFS were in operation before the evaluation, so a baseline study was not conducted, and the sample assessed included children and caregivers who had all participated in the CFS in some way. Therefore, the evaluation design involved a comparison of recent-enrollees (children who had started attending a CFS less than six months ago) and long term-enrollees (children who had been attending for a longer time period [more than nine months]). Caregivers of 6-12-year-olds and 13-17-year-old children were interviewed to assess outcomes based on the key objectives of the CFS. Qualitative data indicated that CFS are seen as an important protection resource by caregivers and children. Qualitative data also indicated that CFS have the potential to improve and increase community collaboration to support child protection.

**Conclusion and Implications for Research and Field Practice:**

Several of the interventions described and discussed throughout this report focus on multiple risk and protective factors. There is an increasing number of multi-sectoral programs that integrate MHPSS, including nutrition, education, protection and peacebuilding. The review found evidence that interventions aimed to address multiple levels of mental health and psychosocial problems amongst conflict-affected children might be feasible and acceptable. Recent CFS evaluations have included control groups and standardized measurement instruments, significantly improving the evidence base for the impacts of these interventions on children's psychosocial outcomes, although results are mixed about their effectiveness.

**Evidence Gaps:**

Increased research on multi-sectoral, multi-layered interventions is required. It is necessary to explore and better understand how strengthened protective factors, or reduced risk factors in one level, impact upon factors and outcomes at other levels. The evidence base for the outcomes and impact of an integrated approach of MHPSS and peacebuilding is limited (Tankink, Bubenzer & van der Walt, 2017). Furthermore, the role and influence of children, caregivers, or other agents of change need to be better understood.

# Section 6: CONCLUSION WITH CROSS-CUTTING ISSUES

## Conclusion with cross-cutting gaps in evidence and practice

This 2020 Review has identified updates in evidence and practice on children's mental health and psychosocial support in humanitarian settings. While there has been a significant increase in relevant evidence since 2015, a combination of key issues has been repeatedly identified across the areas considered in this report.

To ensure that MHPSS interventions are able to reach and support all children in humanitarian settings, the following gaps in evidence and practice need to be addressed:

### Marginalized groups are largely excluded from analysis and interventions

The importance of reaching and addressing the specific needs of the most marginalized groups with context-specific targeted supported programs has been raised by different practitioners and researchers (Burde et al., 2015, cited in Mattingly, 2017; Jones, 2019; ODI, 2018; Punamaki et al., 2014). In practice, MHPSS interventions often fail to reach all groups (Burde et al., 2015). For example, particular challenges are associated with meeting the MHPSS needs of children on the move (ODI, 2018).

There is extremely limited research and intervention evidence concerning specific efforts to address the MHPSS needs of children and adolescents with disabilities. Greater efforts are needed to better understand the unique needs of individuals with physical, psychosocial, and intellectual disabilities, and their caregivers, in order to develop more inclusive, effective MHPSS interventions (UNICEF, 2018b).

The significance of gendered experiences, and the importance of taking a gendered perspective, is also highlighted as critical (Ran, 2019; Samuels et al., 2017). Gender and social norms influence the coping strategies of girls and boys of different ages, especially in relation to where and with whom they feel comfortable to express their feelings and views (Ran, 2019). As evidenced in this report, gender discrimination and forms of gender-based violence are also a risk factor and source of poor mental health (Samuels et al., 2017). Yet, a minority of the studies reviewed included a gender and diversity lens, and there was a lack of focus on the particular MHPSS needs of LGBTQI adolescents during and following humanitarian crises. Greater efforts are needed to understand social norms related to gender and to develop interventions that support the non-discrimination, well-being, and equity of girls, boys, and those with other gender identities.

### There is limited evidence on the youngest children

Consistent gaps have been found relating to children at different development stages; evidence and practice largely fail to consider children under ten years of age, and children below six years of age are excluded even more frequently (Bangpan et al., 2019; Jordans, Pigott, & Tol, 2016). It is encouraging that Hanratty et al. (2019) are preparing a systematic review to assess the effectiveness of MHPSS interventions for preventing PTSD in young children aged 0-11-years-old living in war and conflict-affected societies. Overall, there is significant scope for future studies to focus on strengthening interventions for younger children in contexts affected by conflict and disasters, including infectious disease pandemics, such as COVID-19 (Purgato et al., 2018). An increased focus on the early years, working with caregivers and young children, is crucial, particularly in light of the critical importance of the early years for life-long well-being (Fox et al., 2010; O'Kane, 2015). A life-course approach is necessary to increase the effectiveness of interventions throughout a person's life and should also consider intergenerational determinants of health and well-being.

### Research is needed to expand learning across the ecological framework, with an increased focus on structural issues

Recognizing how child and adolescent protective and risk factors influence and are influenced by variables at different levels, as well as the complexity of interactions across the ecological framework necessitates increased research to better understand these relational aspects. The predominant focus on individual resilience (with insufficient attention to structural factors that shape the lives, opportunities, and well-being of children and their caregivers) has been highlighted in this evidence review. The focus on an individual's resilience can suffer from a decontextualization and depoliticization of the problems faced by war-affected children, for example (Lemke, 2001; Vindevogal, 2017). There must be increased research and evidence-based interventions focusing on macro-structural aspects (poverty, political agendas, etc.) that shape and influence personal, familial, and collective aspects of resilience (Vindevogal, 2017).

The broader focus on structural inequalities and efforts to address the root causes of conflict also enable increased synergies with peacebuilding and social justice initiatives. Greater efforts are required to strengthen the links between MHPSS, peacebuilding, social cohesion, and social justice (UNICEF et al., 2015a; Tankink, Bubenzer & van der Walt, 2017; Wessells, 2017).

### Insufficient capacity limits the delivery of MHPSS interventions

The importance of having sufficient numbers of trained MHPSS providers to deliver MHPSS interventions, and the associated challenges of ensuring this in resource-limited settings, has been emphasized by several authors in this review (e.g. Tay et al., 2019; Borja et al., 2019; Harrison et al., 2019; Bangpan et al., 2018). This is particularly important in contexts where "mental health and psychosocial support" is also a new concept and practice (Borja et al., 2019). Harrison et al. (2019) report on the chronic lack of child psychologists, child psychiatrists, and child development professionals overall in Bangladesh, further amplified by the low number of these professionals in the Cox's Bazar area. This equated to a near absence of local specialized child-focused mental health services to respond to the MHPSS needs of children. Reflecting on the same example, Borja et al. (2019) describe how the short-term assistance provided by international experts in the initial response phase led to strategies changing several times. Without consistent MHPSS experts in place who are knowledgeable about the local cultural context, teams on the ground experience difficulty in the implementation and management of integrated MHPSS programming (Bangpan et al., 2018).

Local language proficiency is crucial to ensure culturally relevant interventions, and increased provision of professional development opportunities are required through investments in training, coaching, and mentoring, particularly for national staff members. Supervision is also required, as well as support for MHPSS staff to preserve and promote their well-being (Borja et al., 2019). Bangpan et al.'s study (2018) emphasizes the importance of building trusting and supportive relationships to maximize participant engagement and increase the impact of programs. MHPSS personnel who could relate to community members by bridging differences, being nurturing, and acting as role models were highly valued (Bangpan et al., 2018).

### Insufficient cultural understanding and engagement of children, families, and communities limits MHPSS outcomes

The importance of proficient knowledge of the local culture, context, and traditional healing methods, obtained from diverse sources, and applied in the design and delivery of culturally appropriate interventions is emphasized by many practitioners and researchers (Bangpan et al., 2017; Jordans, Pigott, & Tol, 2016; Kamali et al., 2020; Promundo & Sonke Gender Justice, 2018; Snider & Hijazi, 2020; Tay et al., 2019; UNICEF et al., 2015a; UNICEF, 2019). There is growing consensus about the need to ensure the development of contextually appropriate, multi-layer systems of support that build on existing strengths and resources

(Jordans, Pigott, & Tol, 2016; UNICEF, 2019).

To date, children, adolescents, caregivers, and religious and community elders have not been sufficiently engaged in the design, implementation, and monitoring of MHPSS interventions in humanitarian settings (Griebler et al., 2014; Kamali et al., 2020). Greater efforts must be made to engage with children, adolescents, caregivers, and the wider community to better understand and build upon informal social support networks; and to analyze patterns of exclusion in order to strengthen social cohesion and support structures that benefit wider numbers, including the most marginalized (Kamali et al., 2020; Kohrt et al., 2018; Vindevogel, 2017).

To enhance MHPSS programming that is informed by a local understanding of cultural beliefs and local practices, there is increased emphasis on the need for participatory programming and collaboration with existing local practitioners (health workers, teachers, social workers, religious elders), as well as researchers from academic institutions within the national context (ODI, 2018; Promundo & Sonke, 2018). Kamali et al. (2020) suggest that cultural appropriateness can be achieved with high-quality training of implementers and mental health professionals specific to the context they are working in, and also through increased delivery of web-based or mobile app interventions where opportunities for face-to-face interactions are limited.

### Sustainable MHPSS support requires system strengthening and MHPSS mainstreaming

In the recent systematic review of MHPSS for conflict-affected women and children in LMICs, almost half of the reviewed literature describes local and international NGOs working independently of each other and government bodies (Kamali et al., 2020). To enhance coverage and sustainability, increased efforts are required to assess and identify entry points to integrate MHPSS services into existing formal systems for education, health, nutrition, protection, and social welfare (Kamali et al., 2020; Kohrt et al., 2018; ODI, 2018; Ran, 2019). Such integration will also increase accessibility and reduce the associated stigma of engaging in mental health interventions (Kamali et al., 2020). The need to strategically integrate MHPSS into domestic and international emergency preparedness and response systems, plans, and budgets, was also emphasized by participants in the "Mind the Mind Now" conference (Ran, 2019). "Build back better" reconstruction and recovery processes can also be harnessed to strengthen MHPSS systems and services (Yoder-van den Brink, 2019).

### Ongoing need for robust evidence and implementation science

The majority of research on MHPSS interventions focus on post-conflict settings, with far fewer studies conducted in the context of natural disasters (Bangpan et al., 2018). Considering the scale of the climate crisis and its relation to disasters and migration, for example, there is an urgent need to increase research and to implement evidence-based MHPSS interventions for children affected by disasters and the climate crisis. Furthermore, recognizing the global scale of the COVID-19 pandemic and other infectious disease outbreaks (e.g. Ebola, SARS, ZIKA), there is a need for ongoing and increased applied research to better understand and respond to the MHPSS needs of children, adolescents, and caregivers, especially the most marginalized. COVID-19 has raised the visibility and relevance of mental health and psychosocial support, highlighting that mental health problems can affect anyone (UNICEF, 2020c). As identified in a recent UNICEF (2020c) report, "This has created a window for dialogue, action and investment. Many governments now view MHPSS as a critical and life-saving component to their COVID-19 response" (p. 14). This interest should be harnessed to mobilize resources for increased applied research and evidence-based interventions.

Research should consider the long-term implications of implementing MHPSS programs in resource-constrained settings (Bangpan et al., 2018). Consistent approaches to measuring MHPSS outcomes across settings should be integrated into study design, including long-term follow-ups for impact and process evaluations.

Ongoing and increased efforts are also needed to translate available evidence into practice (Ran, 2019; UNICEF, 2018). Practitioners and researchers are experimenting with innovative participatory evaluation methodologies that can rigorously evaluate existing programs to produce both context-specific insights and transferable lessons (Panter-Brick et al., 2018). Increased use of implementation science is required to better understand the MHPSS interventions that work, and in what conditions, for whom, and why (Kohrt et al., 2018; Panter-Brick et al., 2018; UNICEF, 2018). As highlighted in the UNICEF (2018) "Rebuilding Lives" expert meeting report, *"It is the responsibility of the MHPSS humanitarian community, including researchers and implementing agencies, to break this complexity down into easily understandable tools and programmatic elements that can help scale up high quality, contextualized programmes"* (p.30).

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