Field Realities: Measuring the Impact of Psycho-social Support Services with Refugees and Internally Displaced Populations

1 Introduction

In this paper, we share the challenges faced and lessons learned when providing Psycho-social Support (PSS) services to Syrian refugee children in Lebanon and children of Internally Displaced People (IDP) in Syria with the hope that our work can inspire and improve similar work. We specifically focus on a PSS program called The Helping Hand (HH) which is widely implemented in Norway, translated to many languages and culturally adapted to several contexts, among these to Arabic-speaking children in Lebanon and Syria. When delivering PSS services like HH in field work with Syrian refugee and IDP children, there are unique challenges with data collection, data management, and measuring impact. It is difficult to use conventional standards, methods, and tools to measure impact in these circumstances, particularly when these programs are delivered on a shoestring budget.

Here, we use the data which was collected over a thirty-month period of implementing the HH program in the field in Lebanon and Syria to highlight challenges, and to make recommendations for improvements so that future data collection and impact measures can stand up to scientifically rigorous research standards, and serve to justify the program Return of Investment (ROI) and resource utilization.

This is not to say, that we do not have successes. On the contrary, we have experienced that PSS programs do make a difference in these children's lives. These differences are observable from one day to the next, or over time, or in a moment on a child's face. However, this emotional growth is not always reflected in the one-point-in-time post-program impact data collection at the end of the PSS program. The reality is that the qualitative, intangible impact of PSS programs is difficult to capture and report on in this environment. The positive impact on an individual child's life even if just felt or observed for a brief moment, cannot be neatly quantified and packaged for ivory tower consumption.

2 Challenges when Implementing PSS with War-effected Children

Typically, when reporting on PSS, we employ quantifiable assessments, metrics, data collection, and tallying to justify resource utilization, demonstrate accountability, return on investments (ROI), and how we substantiate the value and impact of our work. The main goals with PSS for children, is in addition to improving well-being, is to prevent the development of mental health disorders and associated problems (Chabbott, Sinclair & Smart, 2019). For assessing the effects of *preventive* PSS services where the long-term goals are to prevent mental health disorders and to build skills for life important not only for life long health, but for learning and well-being throughout life. Longitudinal epidemiological studies have given valuable information about universal interventions. In richer and more digitalized parts of the world with broadly implemented public health- and data-systems, interventions have been found to effectively improve life skills (Heckman et al 2014) and intervention effects are shown to persist over time (Heckman et al 2013).

While these are necessary, realistic, reasonable, good, and fair expectations in western, conflict-free, relatively stable political and economic environments, the same paradigm can prove to be very challenging in environments where war and displacement is prevalent; where there is abject poverty, famine, hopelessness, complete loss of any form of personal safety and security, as well as, the loss of basic human rights and dignity.

Important barriers for better mental health care include lack of resources, stigma and low mental health literacy (WHO, 2005). Overcoming these barriers is essential for the delivery of improved access and more effective mental health services. In most Arab countries, mental health care services are scarce and people with mental health difficulties are often associated with poverty and illness stigma (Dardas & Simmons, 2015), linking mental health difficulties with additional negative properties. Low mental health literacy is associated with low mental health service utilization (Slewa-Younan et al., 2014). Access to health care on a larger scale can be effectively facilitated through community-based psychosocial activities and other health promoting interventions which can be implemented efficiently in large groups, increase mental health literacy and avoid, and hopefully also reduce, stigma associated with help seeking (Hassan et al., 2016).

When children grow up during war like the IDPs in Syria, or as displaced Syrians in a fragile state like Lebanon, we need to find more applicable and effective ways of data collection, and measuring impact and outcomes, when providing PSS services (UNHCR 2019b). Strategic and pragmatic measurement is needed to evaluate for improvement (Chabbott & Sinclair, 2019). However, even in the west, “objective” quantifiable data can be problematic when we wish to draw statistically sound conclusions or use the data to guide clinical practice. With some variation, we face these same dilemmas and challenges when providing PSS services in conflict zones. Additional unique challenges are encountered when implementing PSS programs with children who have experience the ugly realities of war and its ongoing devastation of their lives.

3 Context: The Reality of Syrian Refugee Children and Children of Internally Displaced Syrians

Syrian children have been through a lot. The war in Syria and long-term forced displacement as refugees (and, in many cases, multiple displacements) has created extra needs for psychosocial support. Syrians are the largest forcibly displaced population in the world, and the neighbouring countries of Syria are now hosting millions of Syrian refugees (UNHCR, 2019a). More than 70% of the 1.5 million Syrian refugees in Lebanon live below the poverty line (World Bank 2018).

The process of displacement can be divided into three phases: pre-flight, flight, and post-flight phase (Thomas & Thomas, 2004). Each of these phases is associated with specific risks and exposures (Kirmayer et al., 2011). The Syrian refugees in Lebanon are still in the flight phase; that is, they have been exposed to multiple factors associated with the pre-flight phase, such as disruption of community networks, disruption of education, loss of social support and roles, separation from family, and traumatic events.

Children returning to their homes after a HH session in the Beqaa, Lebanon. Most Syrian refugee children in Lebanon are living in tents with sparse electricity and access to water. The tents typically get too cold during winter and too warm during summer in Beqaa. These children in poverty typically grow up without access to formal education and with few or no toys.

Refugees face exposure to violence, harsh living conditions, poor nutrition, and uncertainty about their future (Kirmayer et al., 2011). They endure multiple losses throughout their displacement process. In addition to losing their communities, homes, loved ones, and their nation, refugees also experience the partial or total destruction of a meaningful cultural framework to make sense of both the joys and pains of life (Porter & Haslam, 2001). Importantly, a high proportion of refugee and IDP children do not get access to education, so

also with Syrian children (World Bank, 2018). Lack of education affect cognitive development and socioemotional learning through multiple mechanisms and are associated with negative long-term consequences (Sager, Dajani & Amso, 2019). Together with the tremendous amount of losses and risk factors refugees endure, a high level of psychological distress can be expected. Even if most refugees are exceptionally resilient (Hassan et al., 2016), the estimated prevalence of mental health disorders is one in five people of populations who are in post-war and conflict areas (Charlson et al., 2019).

The children with whom we implemented the HH program, together with their families, have fled incomprehensible pain and suffering in war torn Syria. Dr. Hamza, an American Syrian Psychiatrist has described the mental health condition of Syrian refugees and IDPs, as "Human Devastation Syndrome" because, he argues, there is no other appropriate mental health term that describes the level of human suffering they have endured because of the conflict. Men, women, and children throughout all corners of Syria have been tortured, bombed, starved, and targeted. Children have seen their friends and families die before their own eyes, buried under the rubble of their homes, or killed in a mass celebration of power and tyranny. They have watched their schools and hospitals being demolished. They were denied food, medicine and vital aid. They have been torn from their own families and friends. Most importantly, dignity and humanity were forcefully stripped away from their lives. Many have lost their childhood. They fled the known daily catastrophic massacres to the unknown, and the unknown was not as merciful as they had hoped. Their human devastation continues in the refugee camps, taking different shapes that threaten to destroy what little is left of their lives and sanity (SAMS 2018).

4 Overview of the Helping Hand (HH) Program

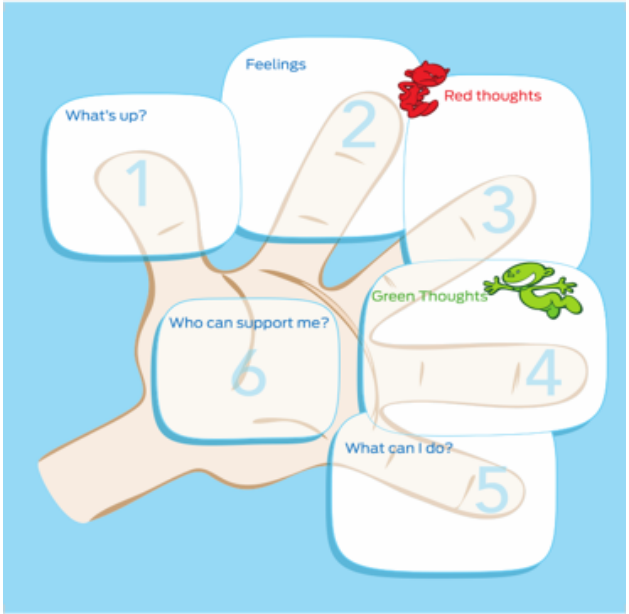
- The HH program supports positive psychosocial development and prevents mental health disorders, as indicated by the results of the Strengths and Difficulties Questionnaire (SDQ), field observations, and feedback from participating children, their teachers, social workers, and psychologists who have been implementing the program.

- HH engages children regardless of their literacy level, age, or gender. The program is designed with a variety of activities which allow for children at different skills levels to actively participant in all sessions.

Children from grade 1 at Swasia learning centre in Al Amal school in Beqaa practicing a heartwarming activity as an introduction to talking about associations between situation, thoughts, feelings, and behavior.

As children grow, throughout their formative years, they develop their necessary skills for life and their foundations of how to interpret life situations is learned and shaped. Learning and mental health is affected by life situations and how they are interpreted and processed. Children can learn to identify, accept, and express their emotions and thoughts. Using the main principles of the cognitive model, we can teach children how their thoughts effect their feelings and problem-solving abilities in emotionally difficult situations. Children can be trained to learn to cope with anxiety, how to deal with bad memories, and how to ask for help when needed. Such skills are helpful not only in childhood, but also in all other challenging life situations regardless of economic circumstances. Children´s mental health is a long-term investment in their well-being, health, and learning abilities, which is crucial for their healthy participation in society, especially in modern, communication- and knowledge-based environments. Therefore, PSS programs for children which focus on cognitive behavioral development help them learn skills to overcome the negative impacts of trauma and anxiety. Investment in children anywhere is also investment in peace and human dignity for future generations.

HH is a PSS program targeting children between the ages of 5 through 13. HH is a cognitive behavioral-based program where the child learns how to problem solve, not for learning only, but for their healthy development. HH was developed in Norway and is widely implemented in Norwegian schools and school health systems, known as “Psykologisk førstehjelp” (Raknes, 2010a, 2010b, 2014). In Norwegian schools, when run by school health nurses, the program has been found to be highly effective in decreasing anxiety (Haugland et al., 2020). HH has been translated into many languages, including Arabic. In 2017 the program was culturally adapted to be used with Arab children living in Lebanon and Syria.



The Helping Hand problem solving system

Thumbs - What's up?
Identify the problem. Try to describe the situation in a neutral and precise way.
The index finger - Feelings
Put words into emotion(s) and their intensity on a scale from 1–10, and describe how you know this feeling in your body.
The middle finger - Red thoughts
Not helpful thoughts that might make the situation more difficult to deal with.
The ring finger - Green thoughts
Helpful and rational thoughts that make coping easier.
Little finger - What can I do? All kinds of ideas on what can make you happy and confident in the longer perspective. Advices you would give to a friend in the same situation.
Palm - Who can help me?
Who can you talk to, get advice from, who can give you comfort? Who are your supporters?

The program can be implemented either in small groups or to a full classroom of children. The program consists of 10 group sessions where each session is 60 minutes long with many activities and training lessons for children. Each session has its own goals and activities. Some activities are related to conversations and discussions, others are related to art, drawing, role playing, imagining, reading, and writing, along with presenting pictures and models. All activities are developed to help the child learn the cognitive behavioral model.

The HH program consist of 10 sessions:

- **Session 1:** Creating a safe group. Relationship is built between children and group-leader(s), and the group is formed with its rules, starting with focusing on happiness and shyness.

- **Sessions 2 and 3:** Deeper conversations and learning activities about emotions, including sadness, anger, and fear, linking them with previous experiences and situations.

- **Sessions 4 and 5:** Deeper conversations and learning activities focusing on negative automatic thoughts, linking them with painful emotions such as sadness, anger and fear (red thoughts), and alternative thoughts, linking them with positive emotions such as happiness, safety and self-confidence (green thoughts).

- **Session 6:** Raising awareness on coping strategies and how to improve them by activities and thinking patterns to feel better.

- **Sessions 7 and 8:** Raising awareness of active cooperation and supportive resources, how to strengthen relationships.

- **Session 9:** Raising awareness about confidence, honesty, and support, increasing the children's awareness on their rights and skills in setting the needed limits. The session includes activities designed to improve the children's skills in communicating about very difficult life situations.

- **Session 10:** Raising awareness of the importance of happy endings, improving skills to end work in decent ways.

In HH Session 10, the child gets a crochet teddy and the Helping Hand booklet. The green teddy can inspire play, important for kids with few toys, and serve as a reminder of green thoughts and what they have learnt and experienced during the HH sessions. The figurines are handmade by Syrian refugee women in Beqaa, strengthening local engagement in the HH program, as well as representing a small but important income for the crocheting women. To keep costs low and stimulate local economy, booklets are produced locally. For many of the Syrian refugee children in this class, pupils at “second shift” on a public Lebanese school in Beqaa, the booklet was the first one they could bring home as their own.

5 Framework for Culturally Adapting the Helping Hands Program

Inspired by Naeem et al. (2016), mixed methods were used in the process of culturally adapting the HH program. Discussions, field observations, focus groups, in-depth interviews and surveys were used to assess participant satisfaction, get ideas for changes needed. The SDQ was used to assess changes in mental health, as an indication of positive outcome on mental health associated with participating in HH. Table 1 below provides an overview of the process of cultural adaptions.

Framework	Area of adjustment	Focus of adjustment	Adjustments made
Philosophical orientation	Culture-related attitudes in explanatory models of suffering, problems, and help-seeking behavior.	Attitudes to health and suffering, understanding the causes of suffering, reasons for seeking help.	Discussed with expert therapists to find acceptable terminology. For many teachers and children, the idea that mood and health can be influenced by the way we choose to think, was a new idea – they needed time to absorb this concept.
Practical considerations of social and health-related factors	Capacity and factors affecting help-seeking.	Number of hours, location, group composition in terms of number and gender, segregation, racism, stigma assessments. Who pays what for whom how long?	To reach children with difficulties, HH was implemented at learning centers which they attend or within informal settlements where they live. The program was implemented by teachers if social worker or psychologists were not available or led to extra costs.
Adaptation of methodology and skills	Identify barriers to relief and cultural formulations that can be used in the intervention.	Use of culturally appropriate metaphors and use of cultural opportunities social, practical, auditory, and visual for socialization to the cognitive model.	Connected with what the children already knew about emotions by talking about the heart and keeping the heart warm. Used “mtabbal” in relaxation exercise.
Theoretical adjustment of concepts	Observe the use of individualistic / collectivist concepts and therapeutic attitudes.	Understanding the client’s perspective and worldview.	Systematic feedback from Arabic children, teachers, social workers, and psychologists’ therapists involved in the implementation. Examples of bombing, child labor and crime added to get closer to the participating children´s experiences.

Table 1. The above framework is Inspired by Naeem et al. (2016) framework for cultural adaptation of cognitive measures, systematic work over years has been done to adapt the HH to Arabic-speaking children living in poverty.

6 Implementing HH with Syrian Refugee children and IDP Syrian children

The HH program implementation with Syrian refugee children in the Governorate of the Beqaa Valley in Lebanon was a collaboration between the Clinical Psychologist/Program Developer Dr. Solfrid Raknes from Norway and the Syrian American Medical Society's (SAMS) Mental Health program in Lebanon. In the autumn of 2017, the program was piloted in the Beqaa Valley and then expanded to Arsal from 2018 onwards. Inside Syria, in the city of Aleppo in August 2019, the program was implemented as a collaboration between Dr. Raknes, Caritas Germany, and Caritas. The program is ongoing in both locations.

Starting in August 2017 over a thirty-month period, we followed the below processes for the implementation of the HH program in the Lebanon and Syria.

1. Translated the HH program into Arabic and printed all the program materials in Lebanon
2. Provided a 2- to 3-day training for teachers, social workers, and psychologists on how to implement the HH program (n = 40 trainees; later referred to as "HH partners")
3. Trained teachers and administrative staff to administer the SDQ which is the assessment tool used for the HH program as a pre- and post-program implementation measure
4. Recruited children in schools (entire classes) and in the Informal Settlements in Lebanon for participation
5. Implemented the 10 sessions of HH with Syrian refugee children in Lebanon and with IDP children in Syria (N = 675 children)
6. Videotaped some of the sessions
7. Provided video-based supervision to the implementation team
8. Evaluated the implementation of HH by quantitative evaluations and qualitative measures:
   a. Quantitative – Using the SDQ, assessed each child's general mental health status. In most cases, the SDQ was administered pre- and post-intervention
   b. Qualitative – Self-reported evaluation from some children about their experience
   c. Qualitative – Feedback from teachers, social workers, and psychologists about the implementation methodology and their observations of the children's reactions to the sessions
   d. Qualitative – Field observations over 30 months by the program developer and the primary trainer in Lebanon who is an experienced Syrian Psychologist

7 Measuring Impact

In the Beqaa, the program was implemented with both Syrian and Lebanese children. Majority of Syrian refugee children live in tents and/or who attend the informal schools, In Syria, the program was implemented in Karm al Jazmati in the Eastern part of Aleppo, at a community center. This part of the city is still mostly destroyed due to the war. All these children in both Lebanon and inside Syria live in poverty and with the horrors of exposure to war.

7.1 About the SDQ

The SDQ (Goodman & Scott, 1999) is a standard questionnaire, validated translation in Arabic[1], attached in Appendix. It is a 25-item behavioral screening questionnaire designed for 3 to 17-year old children and it consists of five subscales:

- Emotional Symptoms (5 items)
- Conduct problems (5 items)
- Hyperactivity/inattention (5 items)
- Peer relationship problems (5 items)
- Pro-social behavior (5 items)

On the SDQ each subscale is scored from 0 to 10. The total difficulty score ranges from 0 to 40 and is calculated by adding the emotional, conduct, hyperactivity, and peer problems subscales. Each of the five subscales is classified as normal, borderline, and abnormal.

In Aleppo, the SDQ was completed in collaboration between the HH teacher in pre session 1 and post session 10.

[1] https://www.sdqinfo.com/

7.2 A Snapshot of Quantitative Outcomes

Table 2 below provides an overview of where HH has been implemented and evaluated. By evaluated we mean, where the SDQ was administered to get a pre-implementation and a post-implementation assessment of each child who participated, and where the authors of this paper have access to the evaluation data. The HH has also been implemented by e.g. by Doctors Without Borders in Lebanon and by several smaller NGOs in Lebanon. The pre-implementation data was collected before Session 1 and the post-implementation data was collected after Session 10. If the program was implemented at a school, a non-formal education center, a childcare center or in a PSS center, then the teacher/PSS worker completed the pre and post SDQ. If no teacher new the child before the program stated, the HH partner completed the pre and post SDQ with the parent or care giver of each child, or together with the child directly. The SDQ was completed in the field using paper and pencil, and then the data was entered into an electronic database at a different time – as time permitted.

Using this data collection methodology and electronic capture process, we have identified several challenges, namely:

- **Accuracy and consistency** of how the data was collected varied from environment to environment, from teacher to teacher, and/or from HH partner to partner.

- **Manual data collection and manual data transfer** into the electronic database is subject to human error and omissions.

- **Field team is focused on delivery and engagement.** While our field/delivery team is very dedicated and enthusiastic about implementing HH,, they are not trained researchers. Their focus has been more on the actual implementation and engagement with the children rather than on the data collection.

- **Resources restraints**. Once data is captured into the database, we have not had the human resources or expertise available in real-time, to scrub the data to ensure for completeness and accuracy. When we eventually focused on the data management and analysis, too much time had lapsed to go back and address the data gaps.

For example: At a Kayani school in the Beqaa, Lebanon, in Spring 2018 (see [*] in Table *2*) HH was implemented with a 4th grade class of 27 students. We did not collect the pre SDQ data, we had only the post-implementation data. However, ironically, we also had data for children in another 4th grade class at the same school, with whom the HH program was not implemented; in effect, a “control group” of students in the same grade, and data collected at the same period of time.

Date	Location	Organization	Venue	No. of Groups	No. of Children
Autumn 2017	Beqaa	SAMS/MAPS	Sawasia (School)	2	49
Spring 2018	Beqaa	SAMS	Kayani (School) [*]	1	27
Autumn 2018	Beqaa	SAMS	Ajami camp	1	7
			Camp Omar Rajab	1	14
			Marj (School)	2	24
			Saad Nael	2	28
			Sawasia (School)	1	21
2017 and 2018 Totals				**10**	**170**
2019	Beqaa	SAMS/MAPS	Sawasia (School)	3	80
			Saad Nael	2	59
		SAMS	Al Hamdania	1	9
			Al Makassed	3	54
			Cup of Teach (School)	7	40
			Dama	3	32
			Jasmina House	4	43
2019	Arsal	SAMS	Al Hamad	1	7
			Al Ali	2	15
			Al Masri	6	30
			Mulham	2	25
			Al Aqaba	1	6
			Al Atfal	5	30
			Dama	3	32
2019	Aleppo	Caritas	Karm al Jazmati	2	42
2019 Totals				**45**	**504**
30 Months Total				**55**	**674**

Table 2. An overview of where the HH program was implemented and evaluated in Lebanon and Syria from 2017 to 2019.

As stated previously, while the data collection was uneven and has some gaps, below we provide a snapshot of the impact of the HH program with select data slices that are conducive to statistical analysis.

7.2.1 Age and Gender

Most of children who participated the HH program were between 9 and 12 years old. Nearly as many participants were between 5 and 8 years; and a small proportion were between 13 and 16 years old. As for the gender composition, on average there is an almost even split of girls and boys.

For example: The age of children who participated in the HH program at Multi Aids Programs (MAPS) informal schools, in collaboration with SAMS, from summer 2018 to 2019 is reported in Table 3 below. This data is for 2 schools, a total of 5 HH groups, involving 139 children; see Table 2. Of these children, 52% were girls and 48% were boys.

Age group	Percentage of children who have participated in the program by age group
5-8	43.52%
9-12	48.03%
13-16	8.44%

Table 3. Age composition of children who participated in the HH program at two Multi Aids Programs (MAPS) informal schools in the Beqaa. Total participant numbers see in Table 2.

7.2.2 Changes in General Mental Health, quantitative assessment

Quantitatively, the general mental health of children who participated in the program was measured by the Strengths and Difficulties Questionnaire (SDQ) (Goodman & Scott, 1999). The SDQ consists of 25 statements (e.g. "I try to be nice to other people. I care about their feelings", and "I finish the work I'm doing. My attention is good"). All items were ranked on a three-point scale (range 0–50, the lower score the better mental health), and the scale contains of five sub-scales. Decrease on the SDQ measures on the metrics for emotional, conduct, and peer problems, as well as hyperactivity indicates positive impact of the program. These four scales added up, makes a "total difficulties scale". For the prosocial scale, the post measure should increase to show a positive impact of the program. The SDQ was analyzed to measure changes in the children's general mental health from before the HH intervention was implemented, to after.

7.2.3 The full dataset when pre- and post-measures are compared at group level

We found a significant decrease of mental health problems from pre to post, both in the total difficulty scale and on each of the four problem scales. However, on the prosocial scale, we did not find the expected positive results.

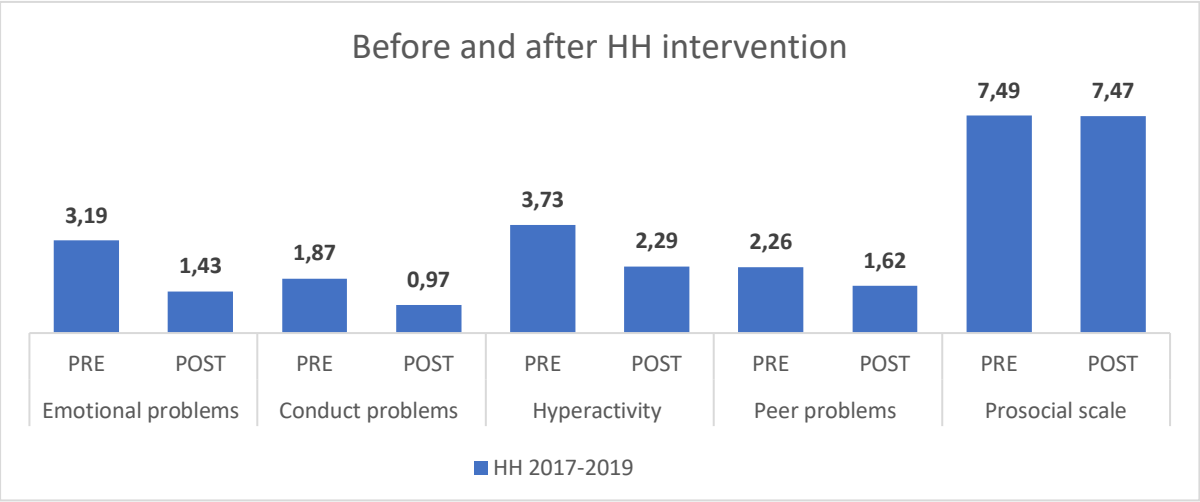


Figure 1. Changes in the general mental health problems as measured by the SDQ, pre- and post-implementation of the HH program with 647 children in Lebanon and Syria from 2017 to 2019.

7.2.4 A small dataset with a "control group"

For one site we have SDQ data from one classroom of children (n=27) where the HH was implemented (HH participants), and one classroom of children (n=28) where the HH was not implemented (Control Group). The children were all in the 4th grade at the same school, and they were all Syrian refugees at The Kayani school in Beqaa, age 9 to 14 years old; see Table 4 for demographics.

Type of Group	Girls	Boys	Totals	Mean Age
HH Participants	12	15	27	10.8
Control Group	18	10	28	11.8

Table 4. Demographics of two classrooms of children at the Kayani school in Beqaa; one classroom implemented the HH while the other did not.

As shown in the data in below, at a Kayany-school in Beqaa, the children (n=27) in the class where the HH was implemented (HH participants), showed overall lower mental health problems than the children (n=28) in the classroom where the HH was not implemented (Control Group), and this was the case in all problem areas assessed by the SDQ (emotional problem, peer problem, conduct problem and hyperactivity), reflected in an overall big difference in the total difficulty subscale.

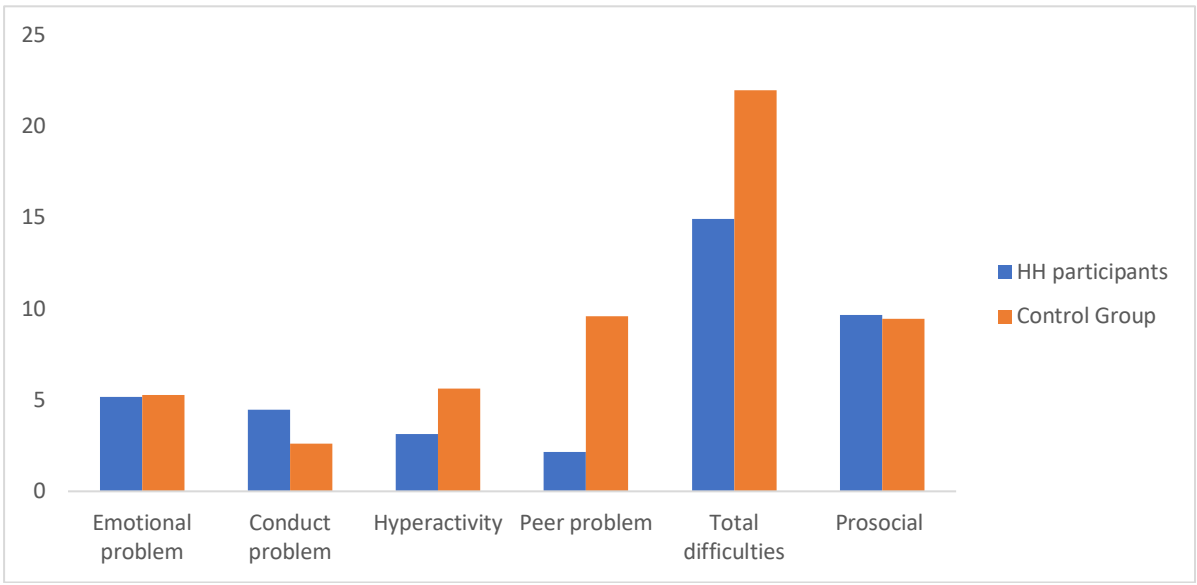


Figure 2. The graph shows a comparison between two classes of 4th graders at the Kayany school in Beqaa; one classroom of kids where the HH program was implemented (HH Participants, n=27), and another where the HH program was not implemented (Control Group, n=28).

In cognitive behavioral PSS programs such as the HH, we expect that children can learn how to better deal with their emotional difficulties. If a child is improving, than it can be expected

that the scores on the "emotional problem scale" would decrease. This scale is highly associated with anxiety and depression, and previous research in the western context has shown that direct intervention using HH can result in a decrease in emotional problems. We see the same outcomes with children at the Kayani school who participated in HH, when compared with the non-participating "Control Group". The area where we are seeing smaller changes is in the prosocial scale. This is an area that needs to be further explored.

7.2.5 Comparing Outcomes on Emotional Problems Year-over-year and across localities

Pre- and post-intervention scores on the SDQ subscale "Emotional Problem" have decreased systematically from one year to the next in Lebanon, which indicates a positive outcome. See Table 5. However, when we analyze the percent improvement in emotional problems each year, we find that in the first year of implementation in Lebanon (in 2017) the percent improvement is smaller than in subsequent years in Lebanon (in 2018 and 2019). Our best outcomes are in Lebanon in 2018. One explanation for this is that we used the same group of implementation partners who became more familiar and proficient in delivering the HH program. In 2019, we added new partners, newly trained, and we saw a slight decrease in improvement to 2018, indicating that it takes time for newly trained implementation partners to make a bigger impact. We have found the same result in our first round of implementation in Syria – we see a relatively smaller improvement (just as it was in Lebanon 2017).

Locality	Pre-Implementation	Post-Implementation	% Improvement (*)	Pool of Implementation Partners
Lebanon 2017 (n = 49)	2.98	1.94	35%	Newly trained and only few
Lebanon 2018 (n = 94)	3.32	0.44	87%	Same group as in 2017
Lebanon 2019 (n = 462)	2.79	0.66	76%	Added newly trained partners
Syria 2019 (n = 42)	3.67	2.66	28%	Newly trained and only few

Table 5. Emotional problems improvements across different localities and years, as percentage of improvement; see data in Figure 3 below.
(*) A reduction is score needs an improvement on the particular scale.

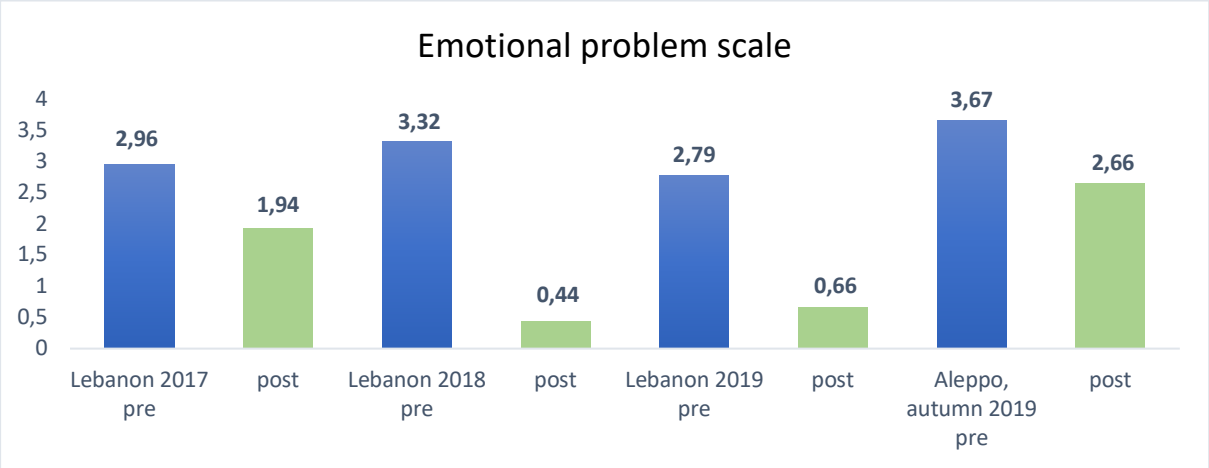


Figure 3. The pre- and post-intervention scores on the SDQ subscale "Emotional Problem" decreased systematically from pre to post in Lebanon in 2017 (n=49); in Lebanon in 2018 (n=94); in Lebanon in 2019 (n=462) and in Syria in 2019 (n=42).

Reduction of emotional problems, like anxiety and depression symptoms, in children is good for the child´s learning, health, and well-being. Previous research has shown that interventions which reduce child anxiety problems, *prevent* mental health disorders associated with child anxiety and depression, such as poor educational outcomes (Esch et al 2014), increased risk of NEET status (not in education, employment, or training) (Veldman et al. 2015; Cornaglia et al 2015), as well as anxiety, depression and drug abuse in adulthood (Essau et al. 2014).

7.3 Changes from before to after intervention in each and every child

It is exciting to observe the positive impacts on the group level, but the changes for each individual child during the HH program are even more interesting to analyze. It would be particularly important to take a closer look on what happens with children with identified symptoms of mental health problems.

Based on the SDQ, children´s mental health can be classified as "normal", "borderline", or "abnormal". The data collected in Beqaa until July 2019 was analyzed with this classification as the basis. The data (n = 418 children) indicated that the number of the children classified as "borderline" and "abnormal" has decreased significantly from pre- to post-intervention; and the number of children classified as "normal" on the various subscales of the SDQ has increased; see Figure 4. We had the same observation in the data from Arsal in 2019 when the same type of classification was used. Figure 5 shows details of the decrease of emotional health problems among the children (n = 222) in Arsal who participated in HH in 2019.

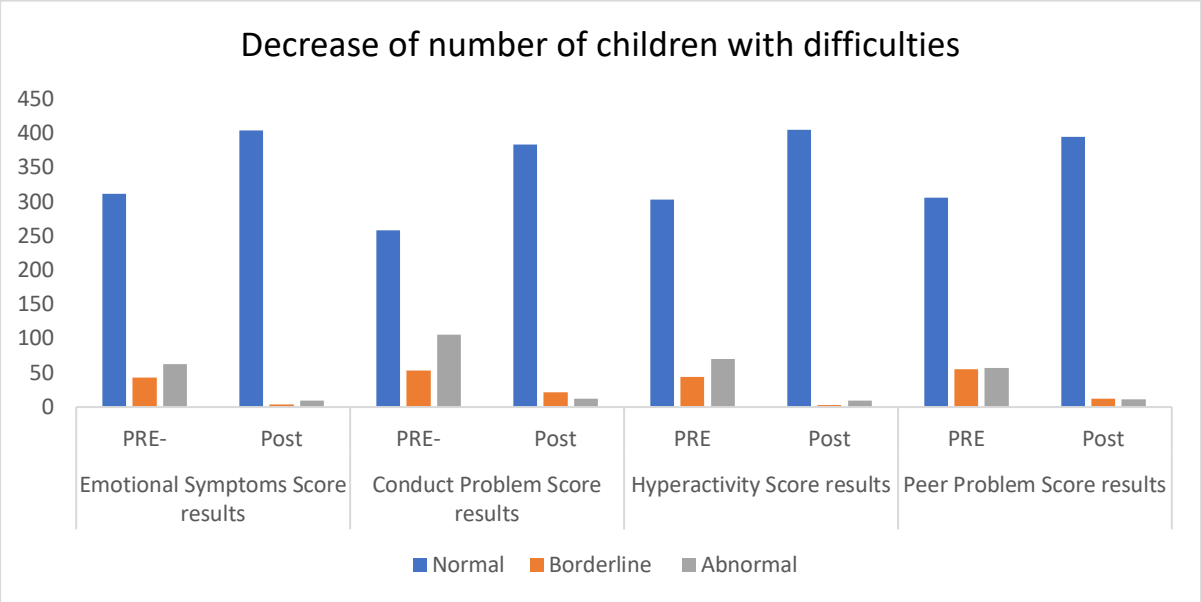


Figure 4. Among the children (n = 418) who received the HH program in Beqaa from June 2018 through July 2019, the number of children with signs of mental health problems, as assessed on the Strength and Difficulties questionnaire completed by their teachers, highly decreased.

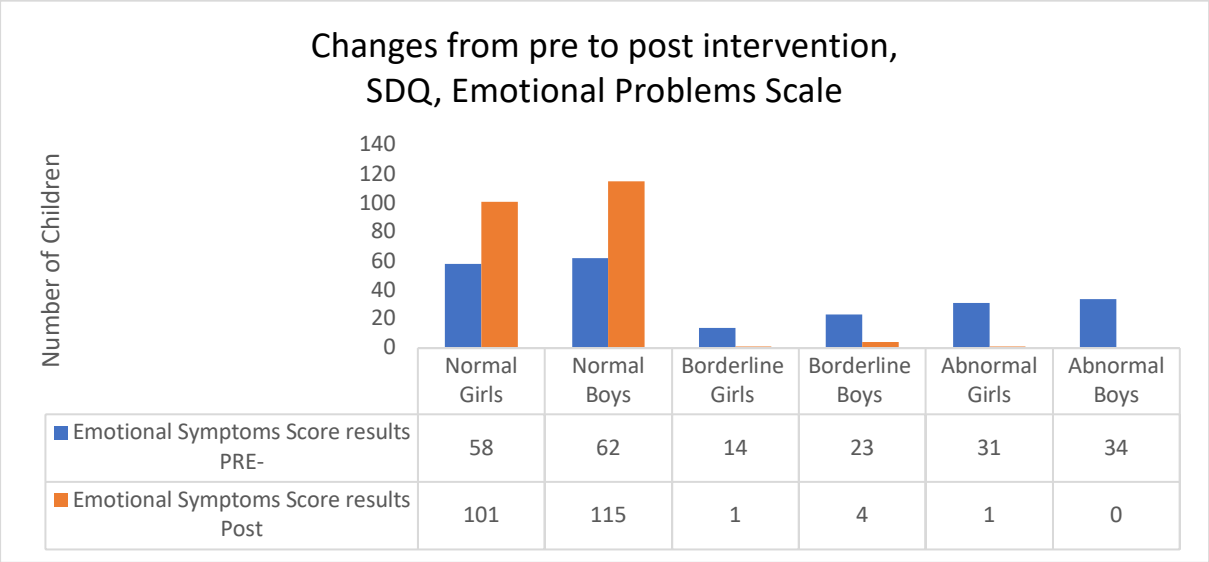


Figure 5. Among the children (n = 222) who received the HH program in Arsal in 2019, the number of children with signs of mental health problems, as assessed on the Strength and Difficulties questionnaire completed by their teachers, highly decreased.

7.4 Qualitative Observations

7.4.1 Children´s evaluation of the HH program

A small sample of the participating children (n = 13) in Aleppo the autumn of 2019 were invited to give their feedback on the HH program. The results indicate that the children found the program helpful to deal with emotional difficulties. In line with field observations from the program developer, teachers, social workers, and psychologists involved, the children seem to thrive and love the chance they get to focus on their own and others' feelings and thoughts.

The HH program is a 10-session manualized PSS program, can be run in full classrooms, and includes a range of various activities like drawing, roleplay, identifying red and green thoughts, and story telling about emotions of all types.

The children were asked the following questions: the tables represent their responses.

How was it for you to talk and share your feelings during the PSS group sessions?

% (No of responses)	
84.61% (11)	It was fine I don't have any problem with it
15.39% (2)	It was at the beginning difficult but later on I gained confidence to talk
0%	I was not feeling comfortable at all
0%	I never really took actively part at the conversation

Do you think that the possible ways discussed during the PSS session on how to deal with daily challenges were interesting?

% (No of responses)	
61.54% (8)	Yes, the discussion/suggestions were very interesting for me
38.46% (5)	The discussion/suggestions were only partially interesting for me
0% (0)	No, the discussion/suggestions were not at all interesting for me

Do you think that the suggestions or way on how to deal with challenges will help you to improve your abilities to cope with your challenges*?*

% (No of responses)	
92.31% (12)	Yes, I feel that my abilities to cope with challenges have improved
7.96% (1)	I have the feeling that my abilities have only partially improved
0% (0)	I didn't feel more capable to cope with my challenges

7.4.2 Anecdotal impact

7.4.2.1 Reduced sadness, more social interaction, and joy

A. S. is 9 years old girl who lives with her family in a Tfail Camp in Arsal, located in a remote mountainous area and little visited by NGOs. She has no brothers nor sisters, and lives with her father and stepmother after her mother died during displacement from Syria.

Before the first sessions of HH, she was highly anxious, she seemed sad and did not participate actively in the first session of the HH.

After encouraging her to participate in group activities like drawing, relaxing tasks, talking about red and green thoughts, and how we can try to adjust our thoughts and feelings through green thoughts, she began to experience more feelings of happiness, joy and communication with

her peers inside the camp. By the end of the program the girl had overcome her anxiety and fear of social relations and now has many friendships within the camp.

7.4.2.2 Reduced anxiety and increased learning

N. S. is 12 years old year boy who lives in a camp with his family. He used to be an active and diligent child who loved school and playing with others, but for nearly one month he had the following symptoms: foolishness, lack of concentration, difficulty sleeping, negative thoughts about himself, tantrums, avoiding certain places, nightmares, lack of interest in daily activities.

During the visit of the team to the camp, during the implementation of the HH program, and after communicating with his parents, we found out that he was subjected to a strong shock while playing in the mountains and he was attacked and bitten on his legs by a mad dog, followed by extensive treatment in the hospital. Since then he has been suffering from panic and anxiety attacks and does not go out of the house unaccompanied.

After the attendance of several sessions during the implementation of HH, including various social activities and talking about his fears, how to reduce anxiety, practicing relaxation activities, he expressed to us his concerns and feelings. After he got help from the team to find appropriate solutions, his self-confidence increased, and he managed to overcome his fears. By the end of the program the child returned to normal life and overcome his fears and is now an active learner at school.

7.4.2.3 Teacher self-confidence and skills to lead classrooms increased

M.S. was one of the teachers trained to run the HH program in full classrooms. During providing the HH sessions, her skills in communicating ideas in a constructive manner developed. Her keenness to know all aspects of the program increased, and her excellence became clear to her peers through her creativity in designing each session separately and sharing her ideas in the teachers' room and in the HH WhatsApp group. She provided great focus and attention to all children who participated in her HH sessions, although there were 35 children within the small caravan classroom. The results of this group were better than we typically see; it was noticeable how much the children were positively affected by the program and how they improved both at home and at school. Over the following years, the supervisor and the field coordinator of the project have noted that there are many children in new groups who have already gotten an idea about the basic concepts in the HH program. The teacher and the children around her often use parts of the program at school and in their neighborhoods, where "red and green thoughts" have become a part of their way to express themselves and remind each other of the importance of emotional problem solving skills.

8 Lessons Learned About Implementing HH in Conflict Zones and Across Cultures

8.1 A low-cost approach can reach a high number of children

Our approach to implement the HH program was based on how to implement cognitive behavioral models at low cost, while still inexpensive to upscale (Bennett-Levy et al., 2010). We have included full classrooms regardless of size, and kept it manageable with 10 sessions, 45-60 minutes each, a short teacher training (one-day workshop) and running the first group session together with an experienced HH leader. HH was highly accepted by children, parents, principals and other stake holders, and we interpret this as a sign of a satisfactory length and content of the program. So far, we have found that a 10-session program that can be extended and used flexibly is a good place to start. Further, the one-day teacher-training is low cost and allows us to build the capacity to upscale the implementation of HH.

8.2 Large group sizes are not ideal

The number of children in each group/classroom where HH was implemented, the number and length of sessions, and the length of teacher/PSS-staff training, are important questions when a PSS program is implemented, and for upscaling a PSS program in the field, since answers on these questions affect the costs of the program. The large number of children in the classrooms and the sub-optimal environment that refugee children typically experience (for example, schools in caravans and over-crowded classrooms with up to 50 children per teacher) is far from ideal for creating a good learning atmosphere. Generally, smaller groups for activities with children are better. This has been validated by the first author when implementing HH sessions and groups of different sizes in different contexts.

Furthermore, when an PSS intervention is implemented in formal or non-formal education, it competes with other learning activities and is interrupted by school holidays and exam periods, and all education comes with a price (Ginsburg et al., 2012).

8.3 Accelerated PSS implementation training allows for scalability

How demanding a program is to learn for teachers and PSS professionals, and how long it takes to complete the training, will affect costs and scalability, particularly in contexts where money matters (Collyer et al., 2019). Methodology that requires short training and can be implemented rapidly is preferable if a central goal is to reach a high number of children with socio-emotional education. In addition to the cost-argument, short-time PSS interventions that conclude with an evaluation, can help teachers to identify children with needs for more and other types of mental health services.

8.4 Teacher/PSS staff also need to be supported

Creating environments for addressing emotional problem-solving skills, sharing feelings, and thoughts of all sorts, is appreciated not only for children, but also for the professionals involved

in the school and PSS services. Traditionally, there is limited space for sharing feelings, especially among boys and men in the Arab culture (Land & Wera, 2019). We have observed that, not only children, but also teachers and principals have improved their psychosocial coping skills when HH was implemented. Teaching coping skills and sharing emotions was also assessed as being painful for several of the teachers and PSS staff who implemented the program. However, these teachers and PSS staff typically reported that they became more aware of, not only the children´s feelings, thoughts, and ways of coping, but also their own socio-emotional feelings. Hence, having PSS and mental health support available for teachers and implementation staff, is important not only for their well-being and health, but also for their capacity to facilitate social and emotional learning to kids (Murphy, Pettis & Wray, 2019).

8.5 PSS programs for all the children are a way to reduce stigma

Stigma associated with mental health problems, and associated negative attitudes among many parents, teachers, and stakeholders about PSS programs represent a real challenge. We have experienced these stigmas on two levels: (1) when recruiting schools, and (2) when recruiting children to the HH programs. One way to reduce stigma is to use our approach which is to implement the HH program with the entire class. We have seen that many parents, teachers, and principals have become more positive the more they learn about PSS and the HH program, this stimulates the children to learn and strengthen their problem-solving skills.

8.6 Drop-out rates can limit the evaluation of impact of PSS programs

Drop-out from PSS programs, as from educational programs in general, is one of the bigger challenges during implementation. Therefore, when it comes to interpreting results from pre to post changes at group level, drop-out from the program does affect the results. For statistical purposes, we have treated missing data post intervention simply as “missing” for pragmatic reasons; however recognizing the statistical problems associated with such a choice (Howell, 2008). The drop-out from the program and school was not systematically tracked and reported in our work, but in the future, we will track this systematically, and explore further.

Moreover, in some of the schools where HH was implemented, sessions have been delayed due to the pressure of the regular educational program in place, especially since many schools already followed contingency plans in education due to lack of resources. This further increases the drop-out rate.

9 Recommendations

When we started using the HH program in Lebanon in August 2017, we chose to use the SDQ to measure impact of the program since this measure was used in Arabic contexts before, validated to Arabic, and used cross-culturally. With our background from health, psychology, and social work, this was a natural choice at that time. However, using a screening tool for program monitoring and evaluation can be problematic. Originally, the SDQ was designed as a screening tool for mental health symptomology to provide referral options for children and adolescents who demonstrate mental health symptomology. This kind of follow-up does not

always exist in our contexts, particularly, where money and access to professionals are a barrier. Besides, starting *treatment* is not always practical in crisis settings.

Fortunately, better tools, guides, and recommendations on how to measure impact of Social and Emotional Learning (SEL) have been developed and are available since recently (Smart et al. 2019). In our future implementations, we will investigate the International Social and Emotional Learning Assessment (ISELA) which measures five primary social and emotional competencies: self-concept, stress management, perseverance, empathy, and conflict resolution. Further, rather than measuring mental health problems, WHO´s recommended and free to access five well-being questions (WHO-5) would be better to choose in future HH implementations and studies.

We have seen many signs of improved general mental health among the children after they have been participating in the HH program, and together with the reduction of mental health problems as indicated by the SDQ, the children's very positive evaluation of the program, field observations and the group leaders' enthusiasm about it, we have concluded that HH is a very useful and feasible PSS program for Syrian refugee and IDP children. However, our implementation in the field within several schools and refugee camps and areas, was focused more on immediate support and emotional relief rather than implementing a scientifically rigorous research study. Our field implementation did not have the stringent methodology and tidy data collection and management that most published research papers offer. From pre- to post-implementation we cannot necessarily conclude that the HH program influenced the mental health of a child; for the better or worse. Other factors, other than the HH intervention, could have affected the children's general mental health.

NGOs involved in implementing PSS programs are eager to report positive impacts of the program. Teachers' and PSS staff's need for validation of their efforts may have resulted in "positive bias" outcomes reporting. This leads to the issue of data collection. Most people in the field are not trained researchers. Their focus is on implementation and on "making a difference." We find that the data collection is often uneven and incomplete across implementors of the program. For future implementations of HH we need to better train for the data collection process, perhaps even have dedicated data collection staff, who only focus on the data and research aspects of the program. We have to enter data in more timely fashion and perform better scrubbing, management, and analysis of the data, because, today, there is a huge lag between performing these activities. Having dedicated data collection/management staff will improve data integrity, remove implementor bias, and, generally, make the data collection/management more rigorous and the analysis more accurate.

We found more positive SDQ scores from the pre- and post-tests when the implementor had more experience with the program. These findings need to be further explored and we need to consider doing additional coaching and support for newly trained HH implementors. Since we did not find the expected positive results on the prosocial scale, the reasons for this also needs to be further explored.

Delivering PSS programs in a war zone is not necessarily all about quantitative data and outcomes, but this data does help us understand whether we are being effective or not. That said, for resource utilization and accountability, we need PSS researchers to focus on finding better ways to measure the effectiveness of PSS programs with victims and/or survivors of war

and displacement. Strategic and pragmatic measurement to evaluate for improvement need to be developed and tested.

10 Conclusion

For the most part, academics, researchers, and donors are more focused on making the data and outcome measures a priority. Whereas the delivery team in the field is more focused on touching fragile lives. Both is needed and necessary, that is why we need stronger collaboration between the two. In war zones collaboration is getting more difficult, because of donor fatigue resulting in lack of resources.

Mental health disorders in people who have experienced war and who are living in conflict and fragile states are found frequently (Charlson et al., 2019). Mental health disorders are typically observed with higher frequency among people who are living in poverty than people with higher socioeconomic status. Our findings underline the urgency to make PSS programs more accessible for children who have been victimized by war and poverty.

Based on our experiences, we argue that high-quality PSS services are not only important for Syrian children's health, learning and development, but it is also crucial that we all take responsibility to invest in giving them a fighting chance at having a (good) childhood. In a broader perspective, improving children's life skills is a long-term investment in peace which is important for our future.

11 Appendix

إستبيان مواطن القوة والصعوبة SDQ (4-17 سنة)
للمدرسين

يرجى الاجابة على كل بند بـ : غير صحيح, صحيح نوعا ما , او صحيح بالتأكيد بوضع علامه ☑ تحت الأجابة المناسبة . حاول ان تكون دقيقا فى إجابتك, سوف يساعدنا كثيرا اذا اجبت على كل بند حتى وان كنت غير متأكد او ترى انه غير مناسب. يرجى ان تكون اجابتك حول سلوك الطفل خلال الستة الأشهر الأخيرة او هذه السنة الدراسية .

☐ ولد ☐ بنت

اسم الطفل: .....

تاريخ الميلاد : .....

غير صحيح	صحيح نوعا ما	صحيح بالتأكيد	
☐	☐	☐	يهتم بمشاعر الاخرين
☐	☐	☐	لا يستطيع البقاء او الاستقرار فى مكان واحد . كثير الحركة
☐	☐	☐	كثيرا ما يشكو من صداع او آلام فى البطن او الشعور بالغثيان
☐	☐	☐	يشرك الاخرين بسهولة فيما يخصه{ لعب, أقلام, العاب, حلويات ....الخ}
☐	☐	☐	كثيرا ما تنتابة نوبات من الغضب الشديد أ و سريع الغضب
☐	☐	☐	يحب العزلة, يميل الى اللعب لوحدة
☐	☐	☐	مطيع على وجه العموم, عادة يفعل ما يطلبه منه الكبار
☐	☐	☐	يقلق من اشياء كثيرة, كثيرا ما يبدو عليه القلق
☐	☐	☐	يساعد الاخرين اذا ما حدث لأحدهم مكروه
☐	☐	☐	يتململ او يتلوى باستمرار{جسمه فى حركه مستمره اثناء جلوسه}
☐	☐	☐	لديه على الاقل صديق واحد جيد
☐	☐	☐	كثيرا ما يتعارك مع الاخرين من نفس سنه او يستأسد عليهم
☐	☐	☐	كثيرا ما يكون غير سعيد, حزين او يبكى بسهوله
☐	☐	☐	فى الغالب محبوب ممن هم فى سنه
☐	☐	☐	يتشتت انتباهه بسرعه وقليل التركيز
☐	☐	☐	عصبى او متشبث{متعلق} بالاخرين فى المواقف الجديدة, من السهل ان يفقد ثقته بنفسه
☐	☐	☐	لطيف مع من هم أصغر منه
☐	☐	☐	كثيرا ما يكذب , يخدع او يغش
☐	☐	☐	يستهزأ منه او يستأسد عليه من هم فى سنه
☐	☐	☐	كثيرا ما يتطوع لمساعدة الاخرين{الوالدين, المدرسين, الاطفال الاخرين}
☐	☐	☐	يفكر قبل ان يتصرف
☐	☐	☐	يسرق من البيت او المدرسة او من أماكن اخرى
☐	☐	☐	ينسجم بشكل أفضل مع الكبار عنه مع الاطفال فى نفس سنه
☐	☐	☐	يخاف من اشياء كثيره , من السهل تخويفه
☐	☐	☐	يتابع اداء الواجبات حتى النهايه, لديه انتباه جيد

هل لديك تعليقات أضافيه ؟

من فضلك أقلب الصفحة- هناك أسئلة قليلة أخرى على الوجه الآخر

The Arabic version of the SQD

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