VOLUME 7 NUMBER 1 JUNE 2021

JOURNAL ON EDUCATION IN EMERGENCIES

JEiE

Special Issue on Early Childhood Development in Emergencies

Inter-agency Network for Education in Emergencies

JOURNAL ON EDUCATION IN EMERGENCIES

ISSN 2518-6833

Open-source publication; distribution free of charge; available in soft copy only

Inter-agency Network for Education in Emergencies

c/o International Rescue Committee

122 East 42nd Street, 14th floor

New York, NY 10168

inee.org/evidence/journal

journal@inee.org

New York University

International Education Program

246 Greene Street, Suite 300

New York, NY 10003

JOURNAL ON EDUCATION IN EMERGENCIES

VOLUME 7, NUMBER 1

JUNE 2021

Special Issue on Early Childhood Development in Emergencies

JOURNAL ON EDUCATION IN EMERGENCIES

Editorial Note

Author(s): Sweta Shah and Joan Lombardi

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 5-12

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62219

DOI: https://doi.org/10.33682/m5tn-wvc9

REFERENCES:

The *Journal on Education in Emergencies (JEiE)* publishes groundbreaking and outstanding scholarly and practitioner work on education in emergencies (EiE), defined broadly as quality learning opportunities for all ages in situations of crisis, including early childhood development, primary, secondary, non-formal, technical, vocation, higher and adult education.

EDITORIAL NOTE

Sweta Shah and Joan Lombardi[1]

Children learn constantly from birth to the age of eight. What happens in these early years, starting with pregnant women's physical and mental health, affects children's long-term health, learning, and behavior. As babies and toddlers explore and learn to play peekaboo, they are developing thousands of neural connections each second. While children gradually gain confidence and independence, their emotional connection with their parents remains important throughout life. Parents and primary caregivers are children's first and most important teachers, their protectors, and their emotional anchors. What a child is exposed to in his or her environment, the love she or he receives from a caring adult, and the opportunities available to him or her are the critical building blocks of life. When these building blocks are strong, children thrive.

When young children experience an emergency due to conflict or a natural disaster, it can change their entire early life experiences and alter their life trajectories. An increasing number of children today are born into crises caused by violent conflicts and environmental changes. There are currently more than 70.8 million forcibly displaced people worldwide: 25.9 million are refugees, 41.3 million are internally displaced, and 3.5 million are asylum seekers (UNHCR 2018). Approximately 35 million of these uprooted individuals are children ages 0-18. In 2018 alone, 29 million babies were *born* in crisis settings (UNICEF 2019).

For many children, protracted conflicts mean a lifetime of displacement and disruption. Young children may sustain deep emotional scars from witnessing violence, migrating under difficult physical conditions, and living in dangerous and stressful conditions for long periods of time. They also may be separated from their parents or primary caregivers. Moreover, crisis-affected children frequently lack access to adequate health care and early learning opportunities, face food and water shortages, and experience the loss of a parent or other caregiver, physical injuries, and other extreme challenges to survival, which increase their mortality rates.

For many years, attention to the effects such disruptions have on the developing child has been severely limited or nonexistent. However, due to the number and nature of recent crises, international aid agencies and other critical actors have started to broaden their focus to include the plight of very young children. In

1 Sweta Shah and Joan Lombardi served as special guest editors for this issue of *JEiE*.

the past 18 months, the COVID-19 pandemic has created a double tragedy for children and families already displaced or caught in conflict.

Early childhood interventions that support development from conception to age eight can create a buffer against the difficulties young children face in emergencies. These efforts can be enhanced by the people who are most important in a child's environment—parents and primary caregivers, teachers, health-care workers, and others. Writing from our position as long-time advocates for young children, we know the time is right to highlight the challenges they confront, and to showcase the programs and the researchers currently working to improve their lives.

This issue of the *Journal on Education in Emergencies (JEiE)* provides a glimpse into some of the work taking place to address the needs of young children and families around the world who were facing emergencies before the outbreak of COVID-19. Early childhood development (ECD) in emergencies is in a relatively nascent stage compared to other aspects of education in emergencies and humanitarian response. Although this area of work is growing, there are few articles and books available on the subject. This special issue of *JEiE* brings visibility to early childhood development in emergencies and highlights some of the lessons being learned through efforts to address the needs of young children and families living in humanitarian situations. This issue is also a call to action to bring additional attention to this critical age group.

We have framed the articles in this special issue within the Nurturing Care Framework for Early Childhood Development, which was launched in 2018 by WHO, UNICEF, and others (WHO, UNICEF, and World Bank 2018). The authors of these articles explain ECD through various lenses: education, child protection, health and nutrition, mental health and psychosocial support, and responsive caregiving. They underscore the importance of focusing not only on children after birth but also on their mothers during pregnancy and through their children's early years.

Emergency settings are highly stressful, ever-changing contexts that affect children and their families and place heroic demands on those working to provide the services that meet their critical needs. It is difficult to collect data when families are moving back and forth across borders or within them. Furthermore, few research tools have been adapted to measure the critical aspects of child development that are grounded in cultural realities and local definitions. With most scholarship dominated by the Global North and published in English, those who are well

placed to develop these tools—scholars from the Global South who are working and writing in a language other than English—face high barriers to access. Thus, there is a paucity of rigorous research focused on young children at different stages (i.e., acute crisis, postdisaster recovery) of various types of emergencies (i.e., conflict, climate-related natural disasters). This dearth of rigorous research and published work about best practices and lessons learned from programming in humanitarian contexts leaves key pieces missing from the kind of work needed to guide funding, policy, and programming decisions.

This special issue includes two research articles, five field notes, three commentaries, and two book reviews. The collection of articles provides an overall approach to the promotion of ECD that reflects three core principles. First is the importance of taking a "life course" approach, which starts by recognizing the needs of pregnant women and of families with very young children up to the age they enter school. The second is the importance of working across various development domains—physical, cognitive, linguistic, social, and emotional—to address the comprehensive needs of young children and families. And, finally, the third addresses the essential need to provide parents with economic and social support so they can be a solid anchor for their children. All three principles are especially critical in times of crisis. Despite the recognition of these key ingredients, programs that provide ECD in emergencies are only able to focus on a fraction of these needs, and often in a piecemeal way. Nevertheless, the contributors to this special issue provide hope that a pathway toward providing greater support for young children and their families in humanitarian contexts is emerging, and that growing experience and increasing evidence are creating a foundation on which programs that provide ECD in emergencies can build.

The issue starts with two research articles, one that highlights mixed methods research conducted in Nepal after the 2015 earthquake, and one that describes a qualitative study of the impact of wildfires on a community in Canada. In "Effects of Two Early Childhood Interventions on the Developmental Outcomes of Children in Post-Earthquake Nepal," Jonathan Seiden, Valeria Kunz, Sara Dang, Matrika Sharma, and Sagar Gyawali illustrate the results of two quasi-experimental impact evaluations of a project implemented by Save the Children. Their research looks at the impact of two complementary models: one focused on the parents and caregivers of children from birth to three years old, and another focused on ECD outcomes for children ages three to six in centers established after the earthquake. The impact evaluation shows mixed results for these models. The intervention focused on parents and caregivers did not show any effect, whereas the model focused on ECD centers showed a positive impact. The researchers

illustrate these results while also providing a critical examination of the challenges of conducting research in emergencies and possible reasons for the varied results.

In the second research article, "Early Childhood Development in the Aftermath of the 2016 Wildfires in Alberta, Canada," authors Julie L. Drolet, Caroline McDonald-Harker, Nasreen Lalani, Sarah McGreer, Matthew R. G. Brown, and Peter H. Silverstone describe their use of qualitative methods to examine the experiences of children and families after the 2016 wildfires in Alberta, Canada. Their research illustrates the effects climate-related disasters, such as wildfires, have on children. They focus in particular on the psychosocial difficulties, but also on how parents are affected when infrastructure and services are not in place to support families. The authors illuminate how critically important it is for policymakers to prepare infrastructure and key services to provide for young children before, during, and after an emergency.

The research articles are followed by five important field notes that provide a context for the work taking place around the world to respond to the needs of young children and families experiencing emergencies. These field notes, which are authored by practitioners and practitioner-researchers, showcase emerging innovations and link practice with research. The conditions, responses, and approaches to service delivery vary, but a focus on mitigating stress and supporting parents' and caregivers' relationships with their children underscores most efforts. While four of the field notes address refugee families who have been displaced from their countries due to war and conflict, one addresses the stress of family violence—an everyday crisis many children face. The geographies included provide a glimpse of the hotspots around the world that are home to an increasing number of children born and raised in such settings.

The first field note makes a case for adapting a strong evidence-based home visiting model to the conflict-affected settings of Jordan, Lebanon, and Syria. In "Home Visiting in the Middle East: Reflections on the Implementation of Reach Up and Learn," Katelin Swing Wilton, Aimée Vachon, Katie Maeve Murphy, Ayat Al Aqra, Abdullah Ensour, Iman Ibrahim, Anas Tahhan, Kayla Hoyer, and Christine Powell describe the implementation of this model in all three countries and share their observations and reflections from the first two years of the multiyear project. The authors provide background by describing the original Jamaican Home Visiting Program on which the Middle East program is based, as well as the important process of piloting and adaptation. They discuss the success of the implementation, the challenges faced, and the emerging results that demonstrate the importance of documenting these authentic experiences.

Moving to a different context in "Building Resilience and Mitigating the Impact of Toxic Stress in Young Children: A Model for Transforming Parenting and Male Caregiving in El Salvador," Fabiola Lara describes her concrete experiences with another type of emergency: family violence. Unfortunately, many very young children around the world are living in countries with high levels of domestic violence, as well as community conflict. In her field note, Lara describes a model for addressing violence prevention and response that draws from a range of approaches used in education, child protection, and health and nutrition. This integrated approach is critically important to the promotion of ECD.

The next three field notes all describe work with the Rohingya refugee population. They again demonstrate the importance of working on multiple levels to address the needs of families, particularly to provide emotional support. In "Implementing a Humanitarian Needs Assessment Framework for Early Childhood Development: Informing Intervention Design for Displaced Rohingya Communities in Bangladesh," Kim Foulds, Naureen Khan, Sneha Subramanian, and Ashraful Haque present a framework for conducting a needs assessment in humanitarian settings that reflects the value of understanding and incorporating community perspectives. The authors describe their rigorous, systematic approach to carrying out a needs assessment and in so doing set a higher bar for collecting the kind of reliable and nuanced data that are critical to designing contextually relevant research. Their experiences operationalizing this approach reinforce the essential step of assessing needs across sectors.

Further insights into direct service delivery are provided in the final two field notes. In "BRAC Humanitarian Play Lab Model: Promoting Healing, Learning, and Development for Displaced Rohingya Children," Erum Mariam, Jahanara Ahmad, and Sarwat Sarah Sarwar discuss the power of play and psychosocial supports in promoting child development in a humanitarian setting. The Play Lab model they describe uses a community participatory approach that strongly emphasizes the importance of employing indigenous practices to foster healing and create a sense of belonging. The description of key features of the model provides a clear understanding of the important ingredients of effective programming.

The critical need to focus on emotional supports that is evident throughout this special issue is underscored by Samier Mansur in "Accessible Strategies to Support Children's Mental Health and Wellbeing in Emergencies: Experience from the Rohingya Refugee Camp." In this field note, Mansur documents the pilot study No Limit Generation, which was conducted to develop a video training platform for frontline aid workers, parents, and guardians. Mansur emphasizes the importance

of innovation, including the use of new technologies, to reach caregivers and support their ability to ensure the wellbeing of vulnerable children, in particular those experiencing the detrimental effects of prolonged stress.

The field notes are followed by three critically important commentaries, a new feature of *JEiE*. These concise articles provide critical insights into a specific issue, question, policy matter, or research topic of current relevance to education in emergencies. These three commentaries highlight burgeoning areas that are critical aspects of ECD in emergencies. The section starts with "Newborns in Fragile and Humanitarian Settings: A Multi-Agency Partnership Roadmap" by Saverio Bellizzi, Lori McDougall, Sheila Manji, and Ornella Lincetto. As the authors point out, an estimated one-third of the annual neonatal deaths worldwide occur in humanitarian and fragile settings. They call for a coordinated response to support newborns and the relationship between newborn and maternal health, and for collective action across stakeholders to address these pressing issues.

"Supporting Maternal Mental Health and Nurturing Care in Humanitarian Settings," by Bernadette Daelmans, Mahalakshmi Nair, Fahmy Hanna, Ornella Lincetto, Tarun Dua, and Xanthe Hunt, reinforces the critical need to focus on the mental health of mothers. This is an increasingly recognized theme in ECD in general but particularly during high-stress and protracted emergencies.

In the third commentary, "Children with Developmental Disorders in Humanitarian Settings: A Call for Evidence and Action," Xanthe Hunt, Theresa Betancourt, Laura Pacione, Mayada Elsabbagh, and Chiara Servili point out that the impact of emergencies is magnified for children with disabilities. Services for these children are often extremely limited, if they exist at all; the damage this lack of services causes is particularly harmful when compounded by other vulnerabilities. Good practices, increased investment, and additional research are urgently needed to meet the needs of children with special needs and to provide critical supports for their families.

As the field of ECD in emergencies continues to grow, there are ever more books on the subject. This issue offers two book reviews, one that highlights how to conduct research in the early years and in humanitarian contexts, and one that offers insights into programmatic approaches to support young children in emergencies. Amy Jo Dowd reviews *Collaborative Cross-Cultural Research Methodologies in Early Care and Education Contexts,* edited by Samara Madrid Akpovo, Mary Jane Moran, and Robyn Brookshire. She explains that the book illustrates ways to conduct collaborative cross-cultural research for young children

while delving deeper into the myriad nuances and dilemmas of doing research for and with young children. Dowd comments that, even as a seasoned researcher, this book gave her ways to improve her own research practice.

Reviewer Kate Schwartz explains that *Early Childhood Development in Humanitarian Crises: South Sudanese Refugees in Uganda* by Sweta Shah aims to reach a broad audience that includes researchers, practitioners, and policymakers. Schwartz describes how the book illustrates the challenges of conducting research in refugee contexts, including a mixed methods investigation of an ECD model used with South Sudanese refugee children living in Ugandan refugee settlements. She notes that the book provides a primer and a comprehensive picture of ECD in humanitarian settings: what it is or is not, what it could be, why we need it, and why it is not already more widespread. Both books provide useful insights for new and seasoned researchers, practitioners, and policymakers.

It is our fervent hope that the articles in this *JEiE* special issue provide evidence that we can, and should, support young children and their families in emergencies, starting when their mothers become pregnant and through their primary schooling and beyond. We also know that we have much more to learn to ensure the effectiveness of early childhood development in emergency interventions. We therefore call upon researchers to adopt new methods that will help them gain a better understanding of the impact of new and innovative interventions, particularly implementation research. Much can be learned from nongovernmental practitioners and frontline workers engaged in ECD in humanitarian contexts. For documentation of those experiences to be useful, it must clearly articulate goals, provide details of both the conditions and the implementation, and offer reflections on what was learned along the way. We believe it is both timely and essential that researchers and frontline workers are given many more opportunities to come together to share and learn from their respective experiences.

If we have learned anything from the decades of research done on the developing child, it is that we must invest early, and that investing in families and communities is critical to successful child development, especially in humanitarian contexts. We call on those who have resources available to invest in programming and research that enables the field of ECD in emergencies to continue to expand. We hope that our readers will be inspired by the efforts already taking place around the globe to nurture and protect a generation of children so that they may thrive wherever they live, and that these efforts will help to create a world in which conflict will give way to a peaceful and a more sustainable world.

ACKNOWLEDGMENTS

We are grateful to Editor-in-Chief Dana Burde, Senior Managing Editor Heddy Lahmann, and Deputy Managing Editor Nathan Thompson, for their support, partnership, and leadership throughout the publication process. We would like to thank the *JEiE* Editorial Board members for approving the selection of this topic for a special issue. This issue was made possible by funding from Porticus Foundation, LEGO Foundation, and the Open Society Foundations, all of which are members of the Moving Minds Alliance. In particular, we would like thank Jessica Hjarrand, Anita Anastacio, and Tina Hyder for being champions for ECD in emergencies. New York University, which hosts *JEiE* through the Department of Applied Statistics, Social Science, and Humanities and the International Education program, provides critical administrative services, meeting space, library services, and more. Editorial assistants Claudia Segura, Sneha Bolisetty, Deanna Pittman, and Ruqaiyah Zarook provided essential support, as did technical reviewers Amanda Blewitt and Haider Fancy. We acknowledge with gratitude the work of Dean Brooks, Sonja Anderson, and others at INEE to advance *JEiE* 's goal of curating and disseminating rigorous evidence within the field of education in emergencies. Dody Riggs, our copy editor, and Patrick McCarthy, our designer, also deserve our sincere thanks for their hard work. We also would like to thank the many anonymous peer reviewers who gave generously of their time and expertise. Lastly, we would like to thank the many researchers and practitioners who contributed to this issue, and who work every day to provide safe, healthy, and supportive environments for young children and families in emergencies.

REFERENCES

UNHCR (United Nations High Commissioner for Refugees). 2018. *Global Trends: Forced Displacement in 2018*. https://www.unhcr.org/5d08d7ee7.pdf.

UNICEF (United Nations Children's Emergency Fund). 2019. *29 Million Babies Born into Conflict in 2018: UNICEF Calls for Increased Support for Parents Forced to Raise Their Babies and Young Children in Conflict-Affected Areas*. https://www.unicef.org/press-releases/29-million-babies-born-conflict-2018.

WHO (World Health Organization), UNICEF, and World Bank. 2018. *The Nurturing Care Framework for Early Childhood Development: A Framework for Helping Children Survive and Thrive to Transform Health and Human Potential*. Geneva: World Health Organization. https://nurturing-care.org/ncf-for-ecd.

Moving Minds Alliance works to scale-up the financing, policies, and leadership needed to effectively support young children and families affected by crisis and displacement everywhere. Originally established in 2017 by a group of philanthropic foundations, today Moving Minds Alliance is a multi-stakeholder partnership of 20+ organizations combining programmatic, funding, and research expertise to support prioritization of the youngest refugees and their caregivers. This publication was generously funded by Porticus, LEGO Foundation, and the Open Society Foundations.

JOURNAL ON EDUCATION IN EMERGENCIES

Effects of Two Early Childhood Interventions on the Developmental Outcomes of Children in Post-Earthquake Nepal

Author(s): Jonathan Seiden, Valeria Kunz, Sara Dang, Matrika Sharma, and Sagar Gyawali

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 14-53

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62220

DOI: https://doi.org/10.33682/te08-ce5p

REFERENCES:

EFFECTS OF TWO EARLY CHILDHOOD INTERVENTIONS ON THE DEVELOPMENTAL OUTCOMES OF CHILDREN IN POST-EARTHQUAKE NEPAL

Jonathan Seiden, Valeria Kunz, Sara Dang, Matrika Sharma, and Sagar Gyawali

ABSTRACT

Natural disasters create immense challenges for young children by exposing them to a high degree of adversity. Interventions designed to build resilience in the aftermath of a natural disaster may help buffer the negative consequences of these adverse experiences. In this article, we report the results of our quasi-experimental evaluations of two interventions designed by Save the Children to improve children's developmental outcomes and parental engagement during a critical period. These interventions provided resources across eco-developmental levels to young survivors of the 2015 earthquake in Nepal's Sindhupalchok district by targeting children's families, teachers, and communities. The first was a caregiver-focused intervention aimed at improving parents' and caregivers' ability to provide early stimulation and responsive, positive caregiving for children ages 0-3; the other was a facilitator-focused intervention at an early childhood development (ECD) center that aimed to improve the quality of learning environments, family engagement, and psychosocial supports for children ages 3-6.

We found that the interventions had a mixed impact. The age 0-3 components had no detectable effect on developmental outcomes, whereas the age 3-6 components had a positive impact on children's early learning and development, particularly their pre-academic skills. Neither intervention improved parental engagement. We highlight the challenges of implementing family-focused interventions in emergency contexts and the importance of the delivery agents in ECD programs. Despite the null effects for the 0-3 group, these evaluations demonstrate that bolstering the quality of early learning environments and the skills of ECD facilitators can have a meaningful impact on child-level outcomes, even in postdisaster and emergency settings.

Received May 2, 2019; revised February 14, 2021, and April 17, 2021; accepted May 5, 2021; electronically published June 2021.

Journal on Education in Emergencies, Vol. 7, No. 1

ISSN 2518-6833

INTRODUCTION

Natural disasters threaten children's lives, stability, safety, mental health and wellbeing, and emotional development. Children under five are at particular risk when a natural disaster strikes; they often have the highest mortality rates and are at increased risk of developing disabilities (UNICEF 2014). Nepal's massive earthquake on April 25, 2015, dealt a devastating blow to children and families across the vast mountainous regions surrounding the capital of Kathmandu, killing thousands of children and destroying a massive amount of the education infrastructure (Nepal Education Cluster 2015). After the earthquake, representatives from international nongovernmental organizations (NGOs) poured into the country to provide humanitarian relief; their efforts also raised billions of dollars in international donor pledges.

Often overlooked in the immediate response to a disaster are the longer-term challenges young children and their families face months and even years afterward. Even though it is known that young children in emergency settings are at higher risk for developmental difficulties, there is a lack of evidence on how and why early childhood programs can improve their outcomes in humanitarian settings. Interventions that provide young children and their families with improved resources across ecological levels (at the individual, family, and community levels) may be able to support their learning and development, and help buffer the long-term consequences of natural disasters. However, few credible causal evaluations have been conducted of such interventions (Murphy, Yoshikawa, and Wuermli 2018).

This evaluation helps to address this gap by reviewing two interventions aimed at improving children's developmental outcomes and parental engagement in the wake of the 2015 earthquake in Nepal, and at helping young children build resilience.[1] Implemented in Sindhupalchok, a district particularly hard hit by the earthquake, the programs focused on equipping caregivers to provide nurturing homes to children from birth to age three, and on providing quality early learning opportunities for children ages three to six in their homes and in early childhood development (ECD) centers.

Save the Children worked in conjunction with the coordinating humanitarian agencies and local government officials to select village development committees (VDCs) in which to implement the interventions. We then nonrandomly selected a

1 The project this study covers was financed by Swiss Solidarity and other donors through Save the Children Switzerland.

set of sociodemographically and geographically similar VDCs that did not receive the intervention to serve as a comparison group. By tracking children over time and examining changes in their developmental status in both the intervention and the comparison groups, we attempted to capture the intervention's effect on early learning and developmental outcomes.

Our evaluation found that these interventions had mixed results. We found that the components targeting children ages 0-3 had no detectable effect on their cognitive, motor, or socioemotional development outcomes. The program for children ages 3-6 did have a positive effect on their early learning and development, most significantly on their emergent numeracy and literacy skills. These findings suggest that the project's efforts to increase caregiver engagement in early learning and responsive care, and thus to strengthen family resilience, were unsuccessful for both age groups. Noteworthy is the fact that the project did not provide families with resources such as housing, livelihood support, social protection, or mental health and psychosocial services. This may have left the parents and caregivers who were struggling to meet their family's basic needs unable to engage their children in a way that led to improved developmental outcomes.

This evaluation provides the first evidence of the effectiveness of Save the Children's approach to improving early learning outcomes in emergency settings, herein demonstrating the ability of ECD center-based programs to build resilience and buffer the negative effects of disasters. It also highlights the need to support children's resilience in emergency contexts by improving the provision of family-level resources.

Our article continues as follows. We first discuss how natural disasters can affect young children and review relevant interventions that aim to build resilience and mitigate the negative effects such disasters have on children. We then describe the nature of the interventions we evaluated in detail and provide a context for the effects of the earthquake in Sindhupalchok district. In the next section, we describe our quasi-experimental studies, including the sample-selection process, quantitative measures used, ethics considerations, and sample composition. We follow with our main findings, as well as our interpretations of the study results and how they can inform future ECD interventions in the wake of natural disasters. We then address the limitations of our study and conclude by suggesting key areas for future research.

BACKGROUND

The Effects of Natural Disasters on Young Children

Very young children are often overlooked during emergencies because of the assumption that they are both resilient and well cared for by their families (Moving Minds Alliance 2018). However, emergencies expose young children to traumatic experiences that can have serious lifelong consequences (National Scientific Council on the Developing Child 2015; Vernberg et al. 1996). Being exposed to adverse experiences in the early years is associated with increased long-term risk for impaired behavior, learning, and physical and mental health (National Scientific Council on the Developing Child 2005).

Preschool children's response to traumatic experiences is often cognitive confusion, decreased verbalization, increased anxious attachment behavior, and other regressive symptomatology (DiNicola 1996). After the 1994 Northridge earthquake in California, for example, mothers reported that their young children felt fearful, had recurring thoughts about the earthquake, and had difficulty sleeping. Most of the children still experienced these symptoms eight months after the quake (DiNicola 1996).

Resilience is the ability to recover from traumatic experiences. Children who are more resilient tend to recover quickly from negative experiences, whereas less resilient children require additional support across eco-developmental levels, including social supports within the community and relational and family protection from those closest to them. A child's temperament and disposition lie at the core of this difference. However, resilience can be nurtured in all children by addressing the diverse eco-developmental levels that surround them.

RESILIENCE

Understanding resilience involves identifying the characteristics of children who have healthy development despite being exposed to adverse events. Luthar, Cicchetti, and Becker (2000, 543) perceive resilience as a "dynamic process encompassing positive adaptation within the context of significant adversity." Threats and diminished resources are stressors that can evolve into trauma, as Lieberman and Van Horn (2011, 35) explain: "Stress becomes trauma when the intensity of frightening events becomes unmanageable to the point of threatening physical and psychological integrity."

Resources that nurture resilience in older children following a natural disaster have been found to include both internal and external protective factors (Terranova, Boxer, and Morris 2009). A study conducted in Aceh, Indonesia, after the 2004 tsunami identified resilient adolescents who survived the event. Hestyanti (2006) found that these children had both internal and external protective factors. The study emphasized that, when studying resilience in disaster settings, it is important to take into account both a child's internal appraisal mechanism and their external supports.

While studies on how to build resilience in young children in a postdisaster setting are scarce, research has shown that those who are able to overcome serious hardship and thrive have at least one stable relationship with a nurturing and responsive caregiver (National Scientific Council on the Developing Child 2015). These caregivers protect young children from developmental disruption by helping to strengthen their internal and external protective factors. Children's internal protective factors include a belief in their own capacity to overcome hardship, and their key adaptive capacities such as executive function and self-regulation skills. External protective factors include a stable, caring, responsive relationship with an important adult, and the support of affirming religious or cultural traditions. This combination of internal and external protective factors is the foundation of resilience in early childhood (National Scientific Council on the Developing Child 2015).

Interventions to Build Children's Resilience

The most effective interventions are those that cater to children's internal and external resources to help them build resilience, while also recognizing that the primary goal is to help the children develop the ability to maintain their emotional equilibrium (Bonanno 2004). The interventions we describe are examples of programs that strengthen resilience at three eco-developmental levels—schools, families, and the children themselves.

School-focused programs: Schools are suitable venues in which to implement programs that reduce older children's distress and posttraumatic symptomatology. Enhancing Resiliency Among Students Experiencing Stress (ERASE-Stress) Sri Lanka, a program for tsunami-affected children between 9 and 15 years old, significantly reduced the severity of their posttraumatic stress disorder, depression, functional problems, and somatic complaints while also improving their self-reported measures of hope scores for months after the intervention (Berger and Gelkopf 2009).2 The School Reactivation Program in Turkey also sped up

2 As measured by the Adult Hope Scale (Snyder et al. 1991).

children's recovery from an earthquake in 1999, including reduced posttraumatic stress, grief, and dissociative symptoms. This improvement was observed six weeks after the intervention, whereas a control group took another three years to reach the same reduction in symptoms (Wolmer et al. 2005). Both of these programs used schools as venues to organize students and deliver the sessions.

Offering ECD programs that mirror school-based programs involves setting up temporary learning spaces, rebuilding ECD centers, and training ECD facilitators in how to create predictable and playful early learning environments. After the 2009 earthquake near Padang, Indonesia, Plan International set up ECD services in schools and child-friendly spaces. Parents of those who attended reported that their children were more independent and had attained basic literacy and numeracy awareness (Plan International 2013). Primary school children who attended a similar Plan International program after 2009's Tropical Storm Ondoy in the Philippines had better social and problem-solving skills than children who did not, according to ECD workers and primary school teachers (Plan International 2013).[3]

Family-focused programs: Caregivers living in crisis contexts face significant obstacles to healthy parenting, such as their own traumatic experiences, insecurity, and a sense of hopelessness. Family-focused programs strengthen resilience by providing access to support services, including family unification, protection, livelihoods, and mental health and psychosocial support (Moving Minds Alliance 2018). Low-intensity programs, which require fewer resources, tend to focus on disseminating key messages through the media on responsive care, early learning, and caregivers' mental health; medium-intensity programs set up parenting support groups to build their skills and support caregiver mental health; high-intensity programs involve home visits and individual or small-group support for families whose children have disabilities or substantive health issues (World Health Organization 2020).

Child-focused programs: Beneficial child-centered interventions are those that protect children's mental and emotional wellbeing by helping them recognize, verbalize, and calm their emotions. Fear is an obvious consequence of traumatic experiences, and helping children to identify and express their emotions is a simple but valuable technique. For example, Sri Lankan children who were anxious about returning to school or playing on the beach after the 2004 tsunami were taught to understand and gradually overcome their fears (Nikapota 2006). An

3 Typhoon Ketsana is known in the Philippines as Tropical Storm Ondoy.

intervention for child tsunami survivors in Chennai, India, encouraged them to express their negative emotions, and a year after the disaster many were able to express more positive emotions. Moreover, as the children became able to express their emotional distress in calmer ways, their hyperactive behavior became less frequent (Vijayakumar, Kannan, and Daniel 2006).

Child-focused interventions that take place at home can help caregivers develop more responsive caregiving skills, including the ability to recognize and respond to their young children's needs. Responsive care can buffer children from the detrimental effects of adversity, especially during their first three years of life. Child-focused interventions also take place in ECD centers. For example, Save the Children's Healing and Education through the Arts (HEART), a program implemented in emergency contexts around the world, uses the expressive arts to help children above the age of three to understand and express their feelings and learn to process stress (Phiri et al. 2016).[4] Young children who participated in the program were reportedly more confident, attentive, expressive, and better able to regulate their emotions (Phiri et al. 2016).

Natural disasters threaten children's lives, stability, safety, mental health, and emotional wellbeing. The threats that remain after a disaster and the resources available to minimize them contribute to survivors' degree of resilience. Depicting resilience as a dynamic internal construct mediated by available resources and subjective perceptions offers the opportunity to cultivate it as a quality every child can develop through carefully designed early childhood programs.

The 2015 Earthquake in Nepal

The magnitude 7.9 earthquake that hit Nepal on April 25, 2015—the country's worst disaster in more than 80 years—and a second major quake two weeks later killed over 9,000 people, including nearly 2,300 children, and damaged or destroyed more than 875,000 homes, as well as schools, health facilities, and other infrastructure (Ministry of Education, Department of Education 2016). The quake destroyed 35,986 classrooms across the country and another 16,671 were partially damaged, leaving more than one million children without access to education—approximately one in nine (Nepal Education Cluster 2015). The Sindhupalchok district, some 70 kilometers from Kathmandu and the geographic focus of our evaluations, was the epicenter of a high-magnitude aftershock that

4 HEART is an arts-based psychosocial support approach developed by Save the Children for children affected by serious or chronic stress. HEART helps children and youth between the ages of 3 and 20, as well as adults, process stress and engage with their peers in a fun and creative way.

devastated the local education infrastructure (UN Office for the Coordination of Humanitarian Affairs 2015). After a school structure assessment, 89 percent of classrooms in the district were deemed unsafe and more than half required total demolition and reconstruction (Nepal Education Cluster 2015).

The earthquake damage extended beyond the infrastructure. Save the Children and its partners conducted a children's consultation with nearly 700 children on the effects of the earthquake and recovery, which revealed that the "compounding fears and feelings of instability are starting to have psychosocial effects on children. A staggering 50 percent of children stated that a year after the earthquake, they continue to overreact to loud noises and 23 percent do not sleep as well as before the earthquake" (Plan International et al. 2016).

Save the Children has operated in Nepal since 1976 and has been engaged in community-based development work there for decades (Save the Children International n.d.). As a result, the organization was well equipped to take immediate action after the earthquake. Save the Children's ECD-sector response to the Nepal earthquake centered around a three-phased approach: (1) providing temporary learning centers to meet the immediate need for safe spaces children could learn in; (2) making ECD services available and accessible by rebuilding damaged ECD centers; and (3) focusing specifically on improving the quality of the local early childhood care and development centers, ECD facilitators' capacity, and parent and community engagement.

Save the Children's ECD Interventions in Sindhupalchok

Save the Children's ECD program in Sindhupalchok consisted of two high-intensity components designed to improve children's developmental outcomes and parental engagement. A younger group component for children ages 0-3 focused on strengthening child- and family-based resources. The other component was for a preschool group for children ages 3-6 that focused on improving child, family, and ECD center resources. The overall program was based on the hypothesis that offering resources across eco-developmental levels would enable young children to achieve positive outcomes despite vital threats to their development.

Younger Group's Health Mother Group and Home Visits Intervention

The younger group component focused on children from birth to age three. Aimed at strengthening child-level resources by improving caregiver-child interactions

and supports, the program offered monthly groups at which parents were taught to provide early stimulation, responsive caregiving, and positive parenting, and to help their children process stress, regulate their emotions, feel loved, and enjoy a safe, playful, and predictable home environment. This program built on content from Building Brains, a Save the Children Common Approach that is aligned with the Nurturing Care Framework, an evidence-based framework for how to support optimal childhood development and ensure that children survive and thrive (Pisani, Karnati, and Poehlman 2017; World Health Organization, World Bank Group, and UNICEF 2018).

Building Brains comprises socially interactive activities of increasing complexity that allow for developmentally appropriate variations. The program's aim is to equip caregivers with the ability to develop a stable, nurturing, and responsive relationship with their children starting at birth. Over the course of nine sessions, caregivers bond with their children and learn how to become responsive to their needs, to engage them in positive and playful experiences, and to help them develop self-regulation. Seven sessions focus on early stimulation, one session teaches positive discipline methods and responsive care, and one session covers safety from common accidents.

From January 2017 to June 2018, Nepal's Female Community Health Volunteers (FCHVs), a national network of more than 50,000 government-supported female volunteers (Kandel and Lamichhane 2019), integrated the Building Brains sessions into their regular Health Mother Group meetings and home visits in the intervention areas. The group sessions, each of which was held twice, took place every month for 1.5 hours; the 87 FCHVs delivered a total of 1,503 sessions. To ensure that the caregivers shared their new knowledge with other family members, the FCHVs and Save the Children's partner NGO staff conducted regular home visits to practice the activities with caregivers one-on-one. Each family received a minimum of eighteen home visits over six months.

Working through the FCHVs to achieve sustainability, the program attempted to build the capacity of volunteers who were already supported by the government and present in each community. However, this model posed challenges, such as overburdening FCHVs who had limited education and facilitation skills with additional content. The Building Brains sessions were then integrated into the Health Mother Group meetings the FCHVs ran with mothers of children 0-3 years old. Early stimulation activities were practiced and discussed during those group sessions, along with health and nutrition topics.

Preschool Group's ECD Center and Facilitator Intervention

The component designed for preschool-age children focused on strengthening resilience at the child, family, and ECD-center levels. The project adopted Save the Children's HEART approach with children in emergency settings, which provided psychosocial support and helped them process their emotions (Save the Children n.d.). For families, the project provided a monthly parenting program to strengthen family engagement in children's learning. At the ECD centers, the project used the Quality Preschool Framework developed by Save the Children to review and improve the quality of the ECD center and the parenting program. The Quality Preschool Framework has eight components: (1) community partnership, (2) the learning environment, (3) the ECD center curriculum and routine, (4) teacher quality and support, which uses Save the Children's foundational training, (5) parental engagement, (6) nurturing care, (7) transitions, and (8) monitoring, evaluation, and improvement. The framework provided a comprehensive quality enhancement design that went beyond teacher training.

Save the Children used the framework to adapt the program to the post-emergency context in several ways. In terms of community partnership, from the start the project engaged school management committee members, children's club members, and the local government to address postdisaster needs, enroll out-of-school children, design the resilience-building approach, and engender community ownership. Save the Children also allowed the foundational training to be recognized as an accelerated training for ECD facilitators that was equivalent to the one-month basic government training. Given that many ECD facilitators were no longer available after the earthquake, offering a program that provided accelerated equivalent training was an important component of the post-emergency programming.

In terms of the learning environment, Save the Children found at the start of the project that no ECD centers had even the minimum materials needed. The project therefore supplied storybooks, puzzles, and other materials needed in a basic learning environment. In response to the curriculum and ECD center routine, Save the Children adapted and enhanced its foundational training for ECD facilitators to ensure that it put greater emphasis on those routines, and on safety, play-based learning (self-directed and teacher led), and how to build a positive relationship between the children and the ECD facilitators. The curriculum also used materials from HEART and the early literacy and math (ELM) approach. The ELM approach aims to develop school-readiness skills through play-based early literacy and math activities. It has been used in more than 20 countries around the world in both center-based and home-based programming (Borisova et al.

2017). To ensure teacher quality and support, the project gave the foundational training to more than 207 ECD facilitators, incorporating the ELM and HEART approaches. They shared their challenges and best practices at monthly meetings held for clusters of six to ten ECD centers.

To improve parental engagement, ECD facilitators were trained to run monthly ELM parenting sessions on how to make literacy and math games at home using simple materials. To improve nurturing care, the project focused on safety, the distribution of lunch boxes, and on water, sanitation, health, and hygiene. Caregivers and ECD facilitators were trained in disaster risk reduction and how to meet safety standards. The ECD centers received basic supplies to meet hygiene requirements, and hand-washing was incorporated into the daily routine.

To support transitions, the project gave grade-one teachers ECD training and developed plans for sessions that would support young children's transition into the first grade, which were integrated into the grade-one curriculum. A rapid baseline assessment was used to design a project implementation plan that included monitoring, evaluation, and improvement. The project was monitored regularly by Tuki, the partner organization, to identify and address gaps.

Findings from Earlier Implementations

There is a dearth of impact evaluations of ECD programs in humanitarian settings around the globe (Murphy, Yoshikawa, and Wuermli 2018), thus the results of similar earlier programs guided the design of the interventions in Nepal.

Randomized control trials of Building Brains in Bangladesh (2013), Rwanda (2017), and Bhutan (2018), tested programmatic elements similar to the components implemented for the younger group, which showed that the programs had significant effects on both parenting practices and child development outcomes (Abimpaye et al. 2019; Aboud et al. 2013; Seiden, Dowd, and Chetri 2019). In Rwanda, Save the Children helped community-based workers offer "playful parenting" group sessions and home visits that were reinforced by a highly effective radio program offered by Save the Children (Abimpaye et al. 2019). A playful parenting pilot conducted in Bhutan included group sessions for all families with children ages 0-3 in the tested communities and individual counseling for children with developmental delays (Seiden, Dowd, and Chetri 2019). In Bangladesh, a community-based parent support model and modified government service delivery brought similar improvement to a center-based model in comparison to a control group (Aboud et al. 2013).

Studies of the ELM program for preschool children ages 3-6 in Ethiopia (Borisova et al. 2017; Pisani and Amente 2015), Malawi (Phiri et al. 2016), and India (Bora et al. 2018; Seiden and Karnati 2019) have also shown positive results. In Ethiopia, children participating in an ELM program for seven months through ECD centers and parent education showed the strongest improvement in learning and development (Borisova et al. 2017; Pisani and Amente 2015). In Malawi, children in community-based childcare centers benefitted from the implementation of the ELM and the HEART programs. A randomized control trial in India found that the teacher-training, parental engagement, and community support components of ELM resulted in children learning 50 percent more than those in the control group on the International Development and Early Learning Assessment (Bora et al. 2018; Seiden and Karnati 2019).

METHOD

We asked two primary research questions for each intervention:

1. Did Save the Children's post-earthquake ECD interventions in Nepal strengthen young children's resilience and promote their developmental outcomes?

2. What effect did Save the Children's post-earthquake ECD interventions have on responsive caregiving and positive parental interactions?

We sought to answer these questions by conducting two quasi-experimental impact evaluations that compared the outcomes of children and caregivers in an intervention group to those in a comparison group, as described below. The quasi-experimental nature of this evaluation rests on the assumption that the comparison group represents a credible counterfactual to the intervention group.

To answer our research questions, we first defined our primary outcome as children's developmental status. We also examined whether the interventions improved how caregivers engaged with young children—a more distal outcome measure—by assessing whether caregivers changed the types of stimulating activities they engaged in. Research and Inputs for Development and Action, an independent Nepalese research and data-collection firm, assisted with the study design, helped identify a suitable comparison group, collected all the data, conducted preliminary analyses, and wrote the endline reports (Lohani and Basnet 2018a, 2018b).

Intervention and Comparison Sample Selection

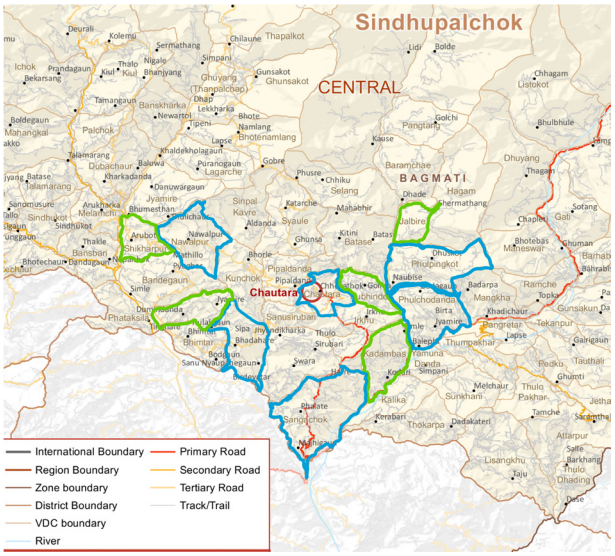
This study includes data from two separate samples, one consisting of younger children ages 0-3 at baseline (referred to as the younger sample) and one consisting of children ages 3-5 years at baseline (referred to as the preschool sample). The comparison and intervention samples of children are from VDCs in Sindhupalchok District.

Sindhupalchok can be roughly divided into two areas: mountains above 3,500 meters, and the more densely populated hilly areas (UN Office for the Coordination of Humanitarian Affairs 2015). The population is largely agrarian, even though the farmland is not very fertile and thus has a low yield (Sindupalchowk District Coordination Committee Office 2018). According to the 2015-2016 Ministry of Education Flash Report, Sindhupalchok's ECD-age children are 58 percent ethnic minority (Janajati), 10 percent Dalit, and 32 percent "other." Sindhupalchok is home to 353 ECD centers, which have a 16.7 child-to-ECD center ratio (Ministry of Education, Department of Education, Monitoring, & Management Section 2016). The district government worked with Save the Children to identify five priority VDCs for the younger children intervention and six for the preschool intervention to ensure minimal overlap with other development and relief agencies.

Quasi-experimental effects rest on the assumption that comparison areas represent a credible counterfactual for what would have happened in the intervention area in the absence of the program in question. To select a comparison group, the local research consulting firm, Research and Inputs for Development and Action, worked with the district education office to identify a set of VDCs that shared important sociodemographic characteristics with the younger and preschool intervention groups. To match each VDC with a suitable comparison, the research firm considered several factors. First, each was required to be geographically close to the intervention VDCs, to be in the hilly areas rather than in the mountains, and could not be involved with similar programs from other development partners. To select the most suitable list of comparison VDCs, the research firm then considered the urbanicity of the intervention VDCs, the ethnic and linguistic composition of the residents, and the degree of damage the earthquake caused. A list of the intervention and comparison VDCs for the younger and preschool samples is displayed in Figure 1.

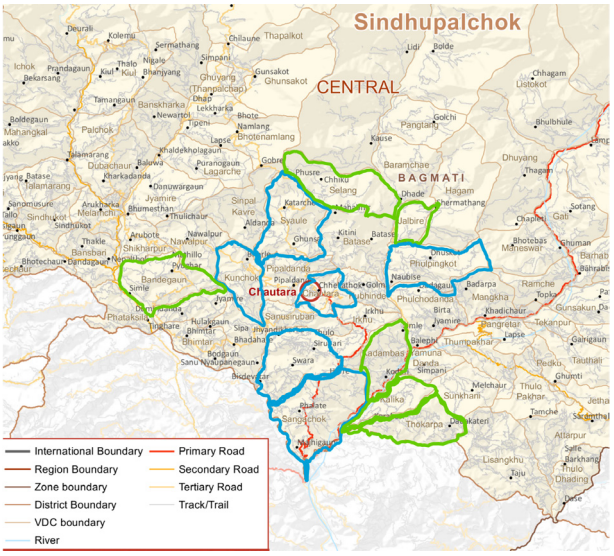
Figure 1: Map of Village Development Committees in Intervention and Comparison Groups

Panel 1: Younger group



Intervention in blue: Bhotasipa, Choutara, Fulpingdandagau, Fulpingkot, Nawalpur, and Sangachok
Comparison in green: Jalbire, Kadambas, Kubhinde, Sikharpur, and Sipapokhare

Panel 2: Preschool group



Intervention in blue: Choutara, Fulpingkot, Kuncholk, Sangacholk, Shaule, and Thulosirubari
Comparison in green: Badegaun, Jalbire, Kadambas, Kalika , Selang, and Thokarpa

Map based on OCHA/ReliefWeb

We selected a representative sample of children within each VDC through random sampling, with a cluster-randomization sampling strategy at the ward and preschool levels. The data collection and sample selection were conducted independently, and the timing was in keeping with the programming targeting each group. We present their characteristics separately below.

Younger Sample: 0-24 Months at Baseline[5]

The younger sample comprised 363 children ages 0-24 months at baseline, who were randomly selected in December 2016 from 44 wards within selected VDCs in the study area. We selected 22 wards each from the intervention and comparison VDCs without stratification and, after assembling a list of all age-eligible children in the ward, we selected children randomly from each, with probability of selection proportional to size. As such, we had a representative sample of young children ages 0-2 from the intervention and comparison VDCs at baseline. The comparison group consisted of 180 children from five VDCs at baseline, whereas the intervention group consisted of 183 children from six VDCs. The sample was well balanced in terms of the children's sex, with 179 girls and 184 boys.

At endline in December 2017, the data-collection firm was able to follow up with 308 of the 363 children, an overall attrition rate of 15.1 percent. Attrition was significantly different between the intervention and comparison groups: 22.4 percent for the intervention group and 7.8 percent for the comparison group. This attrition pattern is unusual, and we note that it is a significant limitation of our results. The final analytical sample of matched baseline-endline observations consisted of 166 children from the comparison areas and 142 children from the intervention areas. The highly differential attrition observed means that our endline results are subject to substantial bias and that attrition-related bias may exceed 0.05 standard deviations (IES WWC 2014). We nevertheless proceeded with the analysis and discuss the implications of these findings in detail in the limitations section.

5 Note that the intervention is for ages 0-3, but the sample baseline is ages 0-24 months in order for the children not to "age out" of the program.

Preschool Sample: 3-5 Years Old at Baseline[6]

The preschool sample comprises 324 children ages 3-5 at baseline in May 2016 who were selected using cluster random sampling from more than 40 ECD centers in the intervention and comparison VDCs. Of the 324 children, 156 were studying in the comparison ECD centers, 168 in the intervention ECD centers. The sample was relatively balanced in terms of children's sex, with 172 girls and 152 boys.

We collected baseline and endline data for 310 of the 324 children in March 2017, an observed attrition rate of 4.3 percent.[7] The attrition rate was low for both groups, but was higher for the comparison group (6.5%) than the intervention group (2.0%). According to the What Works Clearinghouse, the observed levels of differential attrition (4.5 percentage points) and overall attrition (4.3 percentage points) mean that the attrition-related bias falls below the conservative boundary and is unlikely to bias results by more than 0.05 standard deviations (IES WWC 2014). Further analyses confirm insignificant relationships between attrition and outcomes at baseline, thus we are confident that attrition introduced minimal bias to our results for this sample.

Ethics

Both components of the impact evaluation were vetted by the Save the Children ethics review committee prior to data collection and found to pose no more than a minimal risk to participants. Written informed consent was obtained from each caregiver in both the younger and the preschool samples before their interview, and assent was obtained from children in the preschool sample. Caregivers and children alike were informed that their participation in the study was entirely voluntary and would not be linked to any reward, or to a penalty if they did not participate.

6 The intervention targeted children ages 3-6, but the sample was restricted to ages 3-5 to make sure they did not age out.

7 Research Inputs and Development Action initially reported a higher attrition rate between baseline and endline in their report to Save the Children. However, after re-analyzing the child-level datasets, the observed attrition rate was lower than first reported, due to incorrect calculation. Subsequent follow-up with the firm to clarify this issue was not possible, as the raw datasets unfortunately had been discarded. The calculation we present in the article is based on the authors' child-level datasets. We explore this potential source of bias in the limitations section.

MEASURES

Children's development levels are the primary outcome for this evaluation. We argue that differences in developmental status serve as a proxy for us to determine whether or not the interventions improved children's resilience in the aftermath of the earthquake. We used different instruments for the younger and the preschool samples. We report on developmental outcomes for the younger sample using the Caregiver Reported Early Development Instruments (CREDI) (McCoy, Waldman, and Fink 2018; Waldman et al. 2021; McCoy et al. 2021). The CREDI is a caregiver-reported survey designed for children ages 0-3 that reports on their overall level of development and their cognitive, social-emotional, motor, and language development.[8] Designed to be universally relevant regardless of context or culture, the CREDI was translated into Nepali; it went through minimal adaptation after being prepiloted.

For the preschool sample, we measured early learning and development with the International Development and Early Learning Assessment (IDELA), a globally tested and validated direct assessment of ECD (Pisani, Borisova, and Dowd 2018). IDELA is designed to measure the developmental and learning status of children ages 3-6 through a series of games played with the child. It measures children's overall achievement and their development in four core domains: emergent literacy, emergent numeracy, social-emotional skills, and motor skills. The IDELA version we used for this assessment was adapted to the Nepali context; it has been used in multiple earlier evaluations. This evaluation dropped two motor domain subtasks from the 24 in the full IDELA because improved gross motor skills was not a specific target of the interventions.

To examine our second research question about effects on caregiver engagement, we included several questions about activities parents had done with their children in the previous three days for both the preschool group and the younger group samples. These questions were based on questions from UNICEF's Multiple Indicator Cluster Survey and have been used to measure caregiver engagement in other studies (Joshua Jeong et al. 2016). We also had hoped to measure children's exposure to adversity and to protective factors through a new researcher-designed assessment tool. However, the assessment's psychometric properties were poor and did not lend themselves to this evaluation (Seiden 2018).

8 Data were collected with the CREDI Version 4 and processed according to long-form multidimensional factor analysis algorithms developed by Waldman et al. (2021). This scoring procedure allows individual items to load onto multiple domains and generates a same-scale score with different item sets according to age. In accordance with CREDI guidance, all hypothesis testing was conducted using scaled scores.

RESULTS

Our two interventions yielded mixed results. For the younger group, we observed no significant effect from the program on children's overall developmental outcomes as measured by CREDI nor any of CREDI's domains. For the preschool group, we found that the intervention had a modestly significant impact on children's developmental outcomes as measured by IDELA, with the largest relative improvements in the areas of emergent literacy and emergent numeracy. For both the younger and preschool groups, we found little evidence that the program improved parental engagement or children's exposure to learning activities at home.

Younger Sample: 0-24 Months Old at Baseline

As mentioned above, we had substantial attrition in the sample of younger children. Despite this, we found that the restricted sample of 308 non-attrited children did not exhibit significant observed differences in terms of developmental status, age, or sex, as shown in Table 1. We found that the average CREDI scores and the age and sex of the children in the intervention and comparison groups were very similar. The story is slightly different when examining other covariates, caregiver-child interactions in particular. As Table 2 shows, among children who did not attrite, the intervention group had significantly higher baseline levels of playing with the child and reading books with the child. This suggests that, while the sample appears well balanced in terms of developmental outcomes, children in the intervention and comparison groups had significantly different home environments.

Table 1: Baseline Balance of Child-Level Outcomes and Covariates for Younger Sample

	Comparison	**Intervention**	**T-test of difference**
Variable	Mean/[SE]	Mean/[SE]	(Comparison)-(Intervention)
Overall CREDI	47.363 [0.178]	47.525 [0.187]	-0.162
Motor Domain	47.288 [0.216]	47.413 [0.215]	-0.125
Social Emotional Domain	46.836 [0.174]	47.132 [0.208]	-0.297
Cognitive Domain	47.306 [0.182]	47.568 [0.188]	-0.262
Language Domain	48.021 [0.150]	47.987 [0.150]	0.034
Child's age	11.596 [0.483]	11.697 [0.462]	-0.101
Child is female	0.506 [0.040]	0.493 [0.046]	0.013
N	***166***	***142***	
Clusters	***20***	***16***	

Note: Average values for comparison and intervention groups are presented above clustered standard errors at the VDC ward level in parentheses.
* = p < .05; ** = p < .01; *** = p < .001

Using the multivariate regression process demonstrated in Table 3, we conducted a three-step model-building process to assess the impact of the program. During this process, we attempted to predict the overall CREDI score as our primary outcome of interest. In the first model, we fit the relationship between endline overall CREDI scores and intervention status. In the second model, we introduced a control for baseline overall CREDI score. Finally, in our third model, we controlled for baseline overall CREDI score and two child-level covariates (child's age and sex).

Table 2: Baseline Balance of Caregiver-Child Interactions for Younger Sample

	Comparison	**Intervention**	**T-test of difference**
Variable	Mean/[SE]	Mean/[SE]	(Comparison)-(Intervention)
Talk to child	0.759 [0.050]	0.852 [0.039]	-0.093
Tell stories to child	0.120 [0.030]	0.106 [0.030]	0.015
Play simple games with child	0.518 [0.028]	0.697 [0.055]	-0.179**
Play with child with toys	0.512 [0.052]	0.634 [0.050]	-0.122
Play with child while feeding	0.687 [0.048]	0.754 [0.031]	-0.067
Sing to child	0.223 [0.039]	0.310 [0.040]	-0.087
Use picture book with child	0.133 [0.036]	0.268 [0.054]	-0.135*
Praise child	0.289 [0.027]	0.282 [0.038]	0.007
Hug child	0.795 [0.036]	0.817 [0.053]	-0.022
Total number of home learning activities	4.036	4.718	-0.682*
N Clusters	166 20	142 16	

Note: Average values for comparison and intervention groups are presented above clustered standard errors at the VDC ward level in parentheses.
* = p < .05; ** = p < .01; *** = p < .001

In all three models, we found that the coefficient for the treatment effect was insignificant and close to zero. Adding in baseline covariates allowed us to explain nearly 70 percent of the variance in endline scores and granted us considerable statistical power to detect an intervention effect. The CREDI-scaled scores were not immediately interpretable, so we instead considered the effect size.[9] The 95 percent confidence interval of the treatment effect on total CREDI score extended

9 Cohen's d is calculated by dividing the coefficient of the intervention variable by the baseline standard deviation of the outcome of the restricted nonattrited sample.

from -0.14 standard deviations to 0.11 standard deviations. As a result, we can state confidently that, as measured by CREDI, the intervention did not have meaningfully large positive or negative effects on children's developmental status.

Table 3: Taxonomy of Models Fitting Overall CREDI Score

	Model 1 (No controls)	**Model 2 (Baseline control)**	**Model 3 (Baseline + Child covariates)**
Intervention	0.00862 (0.205)	-0.0771 (0.172)	-0.0323 (0.158)
Baseline score		0.528*** (0.0183)	0.171* (0.0645)
Age (in months)			0.143*** (0.0244)
Child is female			0.0959 (0.0875)
Constant	51.03*** (0.160)	26.03*** (0.834)	41.23*** (2.760)
Observations	308	308	308
R-squared	0.000	0.619	0.663

Note: Standard errors clustered at the VDC ward level in parentheses.

* = p < .05; ** = p < .01; *** = p < .001

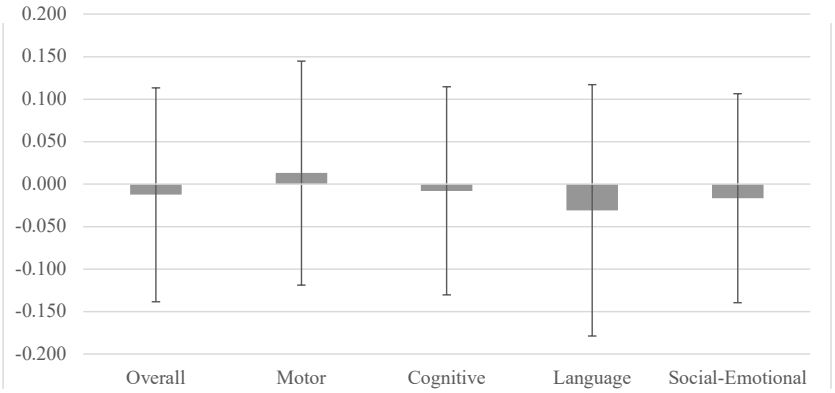
The final step in our analysis of the younger sample was to apply the third model to the four CREDI domains using our models from Table 4. We found results similar to the overall CREDI score, as shown in Figure 2. Children of caregivers in the intervention group scored similarly to children in the comparison group in the language, motor, social-emotional, and cognitive domains of CREDI, thus we can rule out effects larger than 0.15 or smaller than -0.2 standard deviations on all domains.

Table 4: Final Model Applied to CREDI Domains

	(1) Motor Domain	(2) Social-Emotional Domain	(3) Cognitive Domain	(4) Language Domain
Intervention	0.0396 (0.200)	-0.0440 (0.160)	-0.0199 (0.151)	-0.0654 (0.154)
Age (in months)	0.164*** (0.0237)	0.166*** (0.0253)	0.115*** (0.0194)	0.181*** (0.0220)
Child is female	0.126 (0.0942)	0.0509 (0.0966)	0.0462 (0.0828)	0.155 (0.127)
Motor Domain baseline	0.122* (0.0483)			
Social-Emotional Domain baseline		0.101 (0.0648)		
Cognitive Domain baseline score			0.108* (0.0522)	
Language Domain baseline score				0.215** (0.0715)
Constant	43.43*** (1.987)	44.05*** (2.740)	44.35*** (2.244)	38.89*** (3.182)
Observations	308	308	308	308
R-squared	0.633	0.648	0.556	0.648

Note: Standard errors clustered at the VDC ward level in parentheses.
* = p < .05; ** = p < .01; *** = p < .001

Figure 2: Effect Size (Cohen's d) Estimates of Intervention Effect on CREDI Domains (n=308)



Note: Error bars represent the 95 percent confidence interval of the intervention effect, clustered standard errors at the ward level.

We found similar null results when attempting to assess the program's effect on caregiver engagement. There were no differences in the total types of learning activities caregivers reported engaging in with their children at either baseline or endline.

Preschool Sample: 3-5 Years Old at Baseline

We took a similar analytical approach to analyzing the preschool sample and found substantially more encouraging results. As noted earlier, the observed attrition in the preschool sample was lower and nondifferential. As with the younger sample, we found that the comparison and intervention groups exhibited good balance in terms of children's sex, age, and developmental outcomes at baseline, as shown in Table 5. We do report in Table 6 that there were some slight differences in the caregiving practices of the preschool sample at baseline; namely, that caregivers in the intervention group were more likely than those in the comparison group to report playing with their child and teaching them new things; however, these differences were only marginally significant at the $p < 0.1$ level. The non-attrited preschool sample appeared well balanced between the intervention and comparison groups.

To assess the intervention's impact on the preschool sample, we followed the same process we took with the younger sample. The results of this process are detailed in Table 7. In our first model, we estimated a positive intervention effect of approximately 5.4 percentage points correct on the total IDELA score, but at $p = 0.082$, the coefficient was insignificant. Adding the baseline IDELA score did not substantively change our estimate of the intervention effect but it narrowed our standard error dramatically by explaining nearly 30 percent of the variance in endline IDELA scores. In this model, our intervention effect was estimated at 5.5 percentage points and was significant at the conventional level of significance ($p < 0.05$). Our final model controlled for baseline status, child's age, and child's sex, and it enabled us to further refine our estimate to 5.6 percentage points, significant at the $p < 0.01$ level. Extrapolating from this final model, we fit the estimated means at baseline and endline for children in the intervention and comparison groups, as shown in Figure 2.

As with the younger group, we took the final model and applied it to the four core domains of the IDELA assessment, as shown in Table 8. Figure 3 demonstrates that the intervention effect was large and positive for all of the core IDELA domains and the total IDELA score. However, the effect was only significant for the emergent numeracy and emergent literacy domains.

Table 5: Baseline Balance of Child-Level Outcomes and Covariates in Preschool Sample

	Comparison	Intervention	T-test of difference
Variable	Mean/[SE]	Mean/[SE]	(Comparison)-(Intervention)
Child is female	0.516	0.562	-0.046
	[0.037]	[0.051]	
Child's age	4.139	4.093	0.046
	[0.093]	[0.160]	
Motor Domain	0.147	0.138	0.009
	[0.031]	[0.025]	
Emergent Literacy Domain	0.107	0.103	0.005
	[0.014]	[0.013]	
Emergent Numeracy Domain	0.201	0.207	-0.007
	[0.017]	[0.015]	
Social-Emotional Domain	0.089	0.092	-0.003
	[0.009]	[0.011]	
Executive Function Domain	0.089	0.079	0.010
	[0.018]	[0.012]	
Approaches to Learning Domain	0.503	0.521	-0.018
	[0.034]	[0.027]	
IDELA Total	0.136	0.135	0.001
	[0.016]	[0.014]	
N	157	153	
Clusters	36	29	

Note: Average values for comparison and intervention groups are presented above clustered standard errors at the preschool level in parentheses.
* = p < .05; ** = p < .01; *** = p < .001

Table 6: Baseline Balance of Caregiver-Child Interactions for Preschool Sample

	Comparison	**Intervention**	**T-test of difference**
Variable	Mean/[SE]	Mean/[SE]	(Comparison)-(Intervention)
Read to child	0.503	0.601	-0.098
	[0.040]	[0.067]	
Told child stories	0.306	0.359	-0.054
	[0.035]	[0.051]	
Sing to child	0.338	0.386	-0.048
	[0.046]	[0.046]	
Talk child out	0.439	0.431	0.008
	[0.047]	[0.056]	
Play with child	0.210	0.333	-0.123
	[0.039]	[0.051]	
Draw with child	0.191	0.268	-0.077
	[0.043]	[0.049]	
Teach child new things	0.210	0.327	-0.117
	[0.039]	[0.057]	
Teach child letters	0.312	0.379	-0.067
	[0.049]	[0.034]	
Teach child numbers	0.197	0.261	-0.064
	[0.033]	[0.045]	
Hug child	0.726	0.843	-0.117
	[0.046]	[0.042]	
Total number of types of Home Learning Activities	3.433	4.190	-0.756
	[0.260]	[0.384]	
N	157	142	
Clusters	36	29	

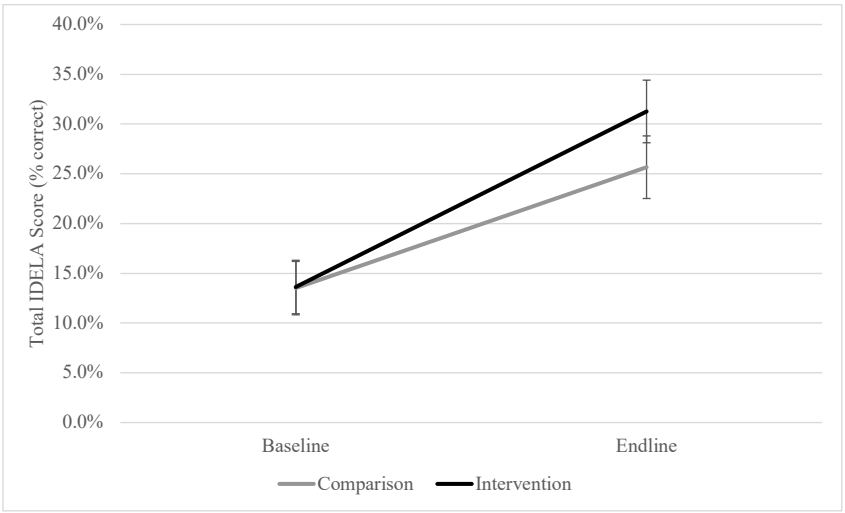
Note: Average values for comparison and intervention groups are presented above clustered standard errors at the VDC ward level in parentheses.
* = p < .05; ** = p < .01; *** = p < .001

Table 7: Taxonomy of models fitting Total IDELA score

Variable	Model 1 (No controls)	Model 2 (Baseline control)	Model 3 (Baseline + Child covariates)
Intervention	0.0545 (0.0305)	0.0551* (0.0211)	0.0560** (0.0199)
Baseline Score		0.769*** (0.0761)	0.696*** (0.0807)
Child's age			0.0304* (0.0123)
Child is female			0.0229 (0.0134)
Constant	0.257*** (0.0198)	0.153*** (0.0170)	-0.000585 (0.0577)
Observations	310	310	310
R-squared	0.031	0.316	0.348

Note: Unstandardized coefficients are presented above standard errors (in parentheses).
All models include clustered standard errors at the ECCD Center level.
* = p < .05; ** = p < .01; *** = p < .001

Figure 3: Fitted Baseline and Endline IDELA Scores in Intervention and Comparison Groups (N=310)



Note: Error bars represent the 95 percent confidence interval of the estimate with clustered standard errors at the ECD-center level.

The confidence interval on the total IDELA score and its core domains was substantially larger than that we found with the younger group. While the baseline-endline correlation was strong and significant for both CREDI and IDELA, at p = 0.786, the baseline-endline correlation for the CREDI score was much higher than for IDELA (p = 0.534). As such, we were able to refine our intervention effect estimates much more for CREDI than for IDELA. In fact, the plausible estimates for the impact of the intervention on the total IDELA score ranged from the rather small effect of 0.15 to the huge effect of 0.89. This is even more stark when examining the domain-level results. While all the point estimates were positive, the plausible range of effects on the emergent literacy domain was 0.04 to 1.07. Our most accurate estimate of the effect was for the emergent numeracy domain, where we are confident that the program generated an effect of 0.15 to 0.73 standard deviations. Our estimates of the program's impact are fairly imprecise in all cases.

We also examined the results of caregiver engagement with children in the preschool sample. As was the case with the younger sample, we found little evidence that the program had a positive impact on caregivers' engagement with children. There were no differences in the total types of learning activities caregivers reported engaging in with their children at either baseline or endline.

Table 8: Final Model Applied to IDELA Domains

	(1) Motor	**(2) Emergent Literacy**	**(3) Emergent Numeracy**	**(4) Social-Emotional**
Intervention	0.0723 (0.0372)	0.0649* (0.0301)	0.0592** (0.0194)	0.0304 (0.0152)
Child's age	0.0562** (0.0196)	0.0456** (0.0166)	0.0389** (0.0118)	0.0103 (0.0106)
Child is female	0.0615* (0.0287)	0.0178 (0.0203)	-0.00923 (0.0116)	0.0120 (0.0149)
Motor Domain baseline	0.562*** (0.0658)			
Emergent Literacy		0.570*** (0.0833)		
Emergent Numeracy baseline			0.414*** (0.0782)	
Social-Emotional baseline				0.389*** (0.101)

	(1) Motor	(2) Emergent Literacy	(3) Emergent Numeracy	(4) Social-Emotional
Constant	-0.0587 (0.101)	-0.0479 (0.0784)	0.0200 (0.0545)	0.0595 (0.0533)
Observations	310	310	310	310
R^2	0.236	0.222	0.291	0.111

Note: Unstandardized coefficients are presented above standard errors (in parentheses). Models include clustered standard errors at the ECCD Center level.
* = p < .05; ** = p < .01; *** = p < .001

DISCUSSION

Our two evaluations yielded different results. For the younger sample, we observed that the program had no effect on children's overall developmental outcomes, nor on children's motor, language, cognitive, and social-emotional abilities. For the preschool sample, we found that the intervention had a significant, if imprecisely estimated, impact on children's developmental outcomes, with the academic skills of emergent numeracy and emergent literacy showing the strongest gains. For both groups, we found little evidence that caregiver behaviors, and specifically their engagement in home learning activities, changed as a result of the intervention.

To understand the different results, we first considered the ecological levels each intervention targeted. The effort to build resilience through improvements in caregiver-child interactions at the family level appeared to be unsuccessful for both age groups. The intervention sought to equip caregivers with the skills needed to respond to and play with young children in a positive way, but it did not provide additional family-level resources, such as housing, livelihood support, social protection, or mental health and psychosocial services. Caregivers who had lost almost everything in the earthquake were living in temporary homes during the intervention, and they were struggling to meet their family's basic needs. Thus, they likely needed additional family-level resources in order to engage effectively with their children and provide a nurturing, stimulating, and predictable home environment. They also may have needed specific support to promote parent and caregiver mental health, which could have enabled them to act on the responsive caregiving lessons provided in the younger child intervention.

The attempt to build resilience by providing resources at the ECD-center level appeared to be more effective, although our evaluation does not allow us to disentangle which aspect of the intervention promoted this outcome most effectively. Providing children with a consistent routine in a play-based quality learning environment may have had a significant impact on children's early learning and developmental outcomes.

The program's service-delivery providers may also have played a role in the interventions' respective successes. The preschool group was served directly by ECD facilitators who were used to working with children, so the intervention was not a significant departure for them from their usual roles and responsibilities. By building on the ECD center facilitators' existing experience, capacity, and skills, they were able to build a quality early learning environment that improved children's resilience. Conversely, the skills introduced to the FCHVs may have been more challenging, as they likely had limited experience with responsive care and early stimulation. Using FCHVs was considered a more sustainable method of delivering responsive caregiving interventions at the family level, but their capacity and roles may not have been well aligned with the goals of the younger intervention, which possibly diluted the potential effects on caregiver-child interactions. Future programs for children ages 0-3 must consider the pros and cons of various service deliverers more carefully and select measures that improve both the content knowledge and facilitation skills of the delivery agents.

Younger Group Health Mother Group and Home Visits Intervention

We relied on FCHVs to incorporate proven means of responsive care and early stimulation into their home visits, and to teach caregivers ways to improve their caregiving practices in parenting group sessions, with the support of partner NGO social mobilizers. This program experienced a variety of challenges. On the one hand, to promote the program's sustainability, they had deliberately chosen to work through FCHVs who were already present and embedded in government health outreach mechanisms. This was similar to an approach used in Rwanda that relied on a combination of community volunteers and a salaried community family facilitator (Abimpaye et al. 2019). While attractive from a sustainability perspective, this approach created several challenges: FCHVs have numerous responsibilities that center on health and nutrition, so integrating a new and unfamiliar concept into their routine required additional time and effort.

Moreover, the program implementers reported that many FCHVs were illiterate and their facilitation skills were weak. In comparison, the highly successful implementation of the Building Brains program in Bhutan used highly trained district health officials as delivery agents (Seiden, Dowd, and Chetri 2019). Numerous challenges were also faced during the program rollout:

- Caregiver participation in the sessions was not continuous. Fathers, mothers, sisters, and other family members attended the sessions interchangeably and did not always share the lessons learned with other family members after each session. Monthly home visits could only compensate for that to a limited degree.

- There were few safe and suitable indoor places to hold the group learning sessions, due to the earthquake damage, so they had to be conducted in the open. Rain, wind, and high temperatures might have affected participation and retention.

- Parents were distracted by their children during the sessions and there was a lack of toys to keep the children engaged.

While early stimulation is a proven concept, there is a limited number of impact evaluations of ECD programs in emergency settings (Murphy, Yoshikawa, and Wuermli 2018). There also are large outstanding questions about how to generate the desired results and which intervention methods offer scalable and effective results (Baker-Henningham and López Bóo 2010). Home visitations conducted by dedicated paraprofessionals, as is done with the Jamaica Reach Up program, have been shown to improve children's long-term developmental outcomes and even their adult earning potential (Gertler et al. 2014). Interventions aimed at promoting early stimulation at a reduced cost have shown that the short-term gains generated by relatively inexpensive iterations of early stimulation programming can fade over time (Andrew et al. 2018). As the creators of the Reach Up program acknowledge, it is incredibly challenging to scale high-quality early stimulation interventions on a national scale and they come at a high cost (Government of Peru 2016). To build early stimulation and responsive caregiving skills, it is critical to find the correct balance between the intensity of the interventions, the minimum level and amount of exposure to key messages required, and the most effective touchpoints. The results of this program reinforce the importance of quality and consistency when it comes to early stimulation interventions.

Preschool Group ECD Center and Facilitator Intervention

The results for our preschool group are similar to other evaluations of ELM programming, both in terms of the magnitude of the effects generated and the domains in which ELM generated the largest and most significant effects. This evaluation followed a quasi-experimental design, but the 0.52 effect size on total IDELA score is similar to the effect size found in evaluations conducted in India (Bora et al. 2018; Seiden and Karnati 2019) and Ethiopia (Dowd et al. 2016; Pisani and Amente 2015) under experimental conditions. The observed effects also closely match the implementation of the early literacy and math program, which, as the name suggests, focuses on pre-academic skills. However, this ELM training lasted only two days because it was embedded in the larger foundational training, whereas the traditional stand-alone ELM training usually lasts four days.

Of interest (though insignificant) are the effects on other early learning and development domains. The gains children in the preschool group demonstrated in the social-emotional domain are of particular interest. This may point to the added benefit of integrating HEART into the curriculum as a way to provide children with psychosocial support and resources to build resilience, and of encouraging children to voice their feelings. Overall, we argue that our evaluation has demonstrated that bolstering ECD facilitators' ability to improve the quality of ECD centers can have a meaningful impact on children' outcomes, even in postdisaster and emergency settings.

Limitations

Quasi-experimental designs only generate credible causal estimates if the comparison group represents a reasonable estimate of the counterfactual. The largest potential limitation to our estimates of impact is unobserved bias in the characteristics of intervention and comparison children. While we assessed balance on outcomes at baseline and a few observable characteristics and found no differences between the groups, we cannot conclude that the comparison group was a perfect counterfactual. Our counterfactual was designed at the VDC level and attempted to create representative samples of children from VDCs that were similar in terms of geographic area, earthquake damage, urbanicity, and socioeconomic and demographic conditions. A stronger quasi-experimental design would have included a more refined process that matched individual intervention communities and ECD centers with comparison communities and ECD centers on a defined set of characteristics. Unfortunately, we did not have

the data to make this design improvement ahead of the project implementation. Our causal claims therefore rest on the credibility of our VDC selection process.

We also considered patterns of attrition. With the younger sample, we were able to conclude unambiguously that attrition may have biased our results. While attrition is often more prevalent in comparison groups, in our case the younger sample actually had a higher attrition rate in the intervention sample. We do not have a definitive answer as to why that occurred, but we suspect that the data collection method may have negatively affected the attrition rate in the intervention group. Sampling in the intervention areas relied on sampling from attendees at group sessions, which were not always attended consistently. In the comparison group, data collection was done exclusively at the household level, which resulted in an overall lower attrition level. Fortunately, the probability of attrition was not significantly predicted by any outcome or measured covariate. Nevertheless, the strongly differential attrition between intervention groups indicates a strong possibility of biased endline results and gives us substantially less confidence in the results from the younger group.

The preschool group's story of attrition was much more positive. The overall attrition in the analyzed dataset was low, did not differ by intervention group, and was well within acceptable thresholds. However, we were unable to verify with the original research consultant that no baseline cases were excluded from our dataset.[10] Given the excellent balance observed in the preschool sample, we are not overly concerned about this possibility, but we include it as a caveat for our findings with the preschool groups.

The measurement tools are another limitation of our results. CREDI and IDELA are both well-established instruments for measuring early learning and development, but they likely measure slightly different constructs. As such, the lack of findings in our younger sample could be due to the tool used rather than to the program's failure to have an effect on early learning and development. While such a finding is possible, we believe it is unlikely. First, while CREDI and IDELA measure slightly different constructs, there is a large degree of overlap; failing to detect an impact on one assessment tool without finding it on the other assessment is quite unlikely. A recent longitudinal study in the Philippines found that baseline CREDI scores were as predictive of endline IDELA scores

10 The authors repeatedly tried to recover completely raw data files from the research firm, but unfortunately this data had been discarded. The fast-paced nature of applied research and project-based evaluation in the context of postdisaster settings can unfortunately lead to less-than-ideal data storage and maintenance and is a limitation of research in these types of settings.

for older children as they were for endline CREDI scores for younger children (Seiden et al. 2018).

In general, finding an appropriate comparison group is a recurring challenge researchers face in the humanitarian context. The density of interventions is high and there are ethical considerations in withholding a program for the purposes of evaluation. This challenge was encountered in this program as well. For the younger sample, our monitoring system alerted us to programmatic spillover into the comparison group. Since the FCHV meetings followed the monthly staff meetings organized at government health posts (with participation of both targeted and nontargeted FCHV), FCHVs from the control sites learned about the Better Brains approach and replicated some of its activities in their own sessions with parents. Moreover, the fact that the partner NGO Tuki was implementing programs at both the comparison and the intervention sites could have affected some of our findings. The partner NGO staff working on the project shared some best practices with their colleagues, which also could have affected the comparison group's exposure to Better Brains content. In the rushed nature of emergency programming, it is difficult to select faultless comparison groups, and we do not believe that easy solutions to these challenges exist. Nevertheless, we feel that the benefits of attempting to rigorously evaluate programs in these contexts, even imperfectly, can generate useful lessons about the effects of programs and the conditions under which they work best.

CONCLUSION

We presented the results of two concurrently conducted impact evaluations of interventions seeking to improve ECD and resiliency in post-earthquake Nepal. We were able to find clear evidence that Save the Children's Quality Preschool Framework, which incorporates the foundational training for ECD facilitators, can provide resources for building resilience at the ECD-center and child levels and help mitigate the negative learning and developmental consequences anticipated in the wake of a disaster for children enrolled in preschool. However, we failed to find any evidence that the parenting programs for the 0-3 and 3-6 age groups, which attempted to improve resources for resilience at the family and child levels, were able to improve parental engagement or the developmental status of the youngest children suffering the long-term psychosocial harm caused by a natural disaster.

These findings suggest that the Quality Preschool Framework, coupled with the foundational training for ECD facilitators, is an appropriate approach to use to guide program design and implementation in emergency settings. However, we must continue to consider how to strengthen family-level resources for parenting programming in postdisaster settings and how to optimize the parenting program design. Programs should examine whether well-qualified health workers would be more effective delivery agents for the family-focused components. Future research also should examine whether providing more family-level resources to build resilience and help caregivers to meet their basic needs can unlock caregivers' potential to provide young children with safe, predictable, playful, and responsive homes in post-emergency settings.

REFERENCES

Abimpaye, Monique, Caroline Dusabe, Jean Providence Nzabonimpa, Richard Ashford, and Lauren Pisani. 2019. "Improving Parenting Practices and Development for Young Children in Rwanda: Results from a Randomized Control Trial." *International Journal of Behavioral Development* 44 (3): 205-15. https://doi.org/10.1177/0165025419861173.

Aboud, Frances E., Daisy R. Singla, Md. Imam Nahil, and Ivelina Borisova. 2013. "Effectiveness of a Parenting Program in Bangladesh to Address Early Childhood Health, Growth and Development." *Social Science & Medicine* 97 (November): 250-58. https://doi.org/10.1016/j.socscimed.2013.06.020.

Andrew, Alison, Orazio Attanasio, Emla Fitzsimons, Sally Grantham-McGregor, Costas Meghir, and Marta Rubio-Codina. 2018. "Impacts 2 Years after a Scalable Early Childhood Development Intervention to Increase Psychosocial Stimulation in the Home: A Follow-Up of a Cluster Randomised Controlled Trial in Colombia." *PLOS Medicine* 15 (4): e1002556. https://doi.org/10.1371/journal.pmed.1002556.

Baker-Henningham, Helen, and Florencia López Bóo. 2010. "Early Childhood Stimulation Interventions in Developing Countries: A Comprehensive Literature Review." Bonn: Institute for the Study of Labor (IZA). http://ftp.iza.org/dp5282.pdf.

Berger, Rony, and Marc Gelkopf. 2009. "School-Based Intervention for the Treatment of Tsunami-Related Distress in Children: A Quasi-Randomized Controlled Trial." *Psychotherapy and Psychosomatics* 78 (6): 364-71. https://doi.org/10.1159/000235976.

Bonanno, George A. 2004. "Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive after Extremely Aversive Events?" *American Psychologist* 59 (1): 20-28. https://doi.org/10.1037/0003-066X.59.1.20.

Bora, Punamdhita, Hanamanth Bajantri, Archana Raj, Prosenjit Roy, and Jonathan Seiden. 2018. "Partnering for Early Childhood in India: Impact Evaluation Report." Bangalore, India: Save the Children. https://resourcecentre.savethechildren.net/node/15868/pdf/save-india_endline-report_pvh-impact-evaluation-2018.pdf.

Borisova, Ivelina, Lauren Pisani, Amy Jo Dowd, and Hsiao-Chen Lin. 2017. "Effective Interventions to Strengthen Early Language and Literacy Skills in Low-Income Countries: Comparison of a Family-Focused Approach and a Pre-Primary Programme in Ethiopia." *Early Child Development and Care* 187 (3-4): 65-71. https://doi.org/10.1080/03004430.2016.1255607.

DiNicola, Vincenzo F. 1996. "Ethnocultural Aspects of PTSD and Related Disorders among Children and Adolescents." In *Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research, and Clinical Applications*, edited by Anthony J. Marsella, Matthew J. Friedman, Ellen T. Gerrity, and Raymond M. Scurfield, 389-414. Washington, DC: American Psychological Association. https://doi.org/10.1037/10555-015.

Dowd, Amy Jo, Ivelina Borisova, Ali Amente, and Alene Yenew. 2016. "Realizing Capabilities in Ethiopia: Maximizing Early Childhood Investment for Impact and Equity." *Journal of Human Development and Capabilities* 17 (4): 477-93. https://doi.org/10.1080/19452829.2016.1225702.

Gertler, Paul, James Heckman, Rodrigo Pinto, Arianna Zanolini, Cristel Vermeersch, Susan Walker, Susan M. Chang, and Sally Grantham-McGregor. 2014. "Labor Market Returns to an Early Childhood Stimulation Intervention in Jamaica." *Science* 344 (6187): 998-1001. https://doi.org/10.1126/science.1251178.

Government of Peru. 2016. "Resultados de la evaluación de impacto del Servicio de Acompañamiento a Familias del Programa Nacional Cuna Más." Lima: Government of Peru. https://www.mef.gob.pe/contenidos/presu_publ/ppr/eval_indep/informe_resultados_cuna_mas.pdf.

Hestyanti, Yohana Ratrin. 2006. "Children Survivors of the 2004 Tsunami in Aceh, Indonesia: A Study of Resiliency." *Annals of the New York Academy of Sciences* 1094 (1): 303-07. https://doi.org/10.1196/annals.1376.039.

IES WWC (Institute for Education Sciences What Works Clearinghouse). 2014. "Assessing Attrition Bias: Addendum." Washington, DC: IES WWC. https://ies.ed.gov/ncee/wwc/Docs/ReferenceResources/wwc_attrition_v3.0.pdf.

Jeong, Joshua, Dana Charles McCoy, Aisha K. Yousafzai, Carmel Salhi, and Günther Fink. 2016. "Paternal Stimulation and Early Child Development in Low- and Middle-Income Countries." *Pediatrics* 138 (4). https://doi.org/10.1542/peds.2016-1357.

Kandel, Nirmal, and Jaya Lamichhane. 2019. "Female Health Volunteers of Nepal: The Backbone of Health Care." *The Lancet* 393 (10171): e19-20. https://doi.org/10.1016/S0140-6736(19)30207-7.

Lieberman, Alicia F, and Patricia Van Horn. 2011. "Coping with Danger: The Stress-Trauma Continuum." In *Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment,* edited by Alicia F Lieberman and Patricia Van Horn, 35-64. New York: Guilford Press.

Lohani, Jeevan R., and Diwakar Basnet. 2018a. *Endline Report: Caregiver Reported Early Development Index (CREDI) to Assess Child Development (0-3 Years).* Kathmandu, Nepal: RIDA International.

Lohani, Jeevan R., and Diwakar Basnet. 2018b. *Endline Study: International Development and Early Learning Assessment (IDELA).* Kathmandu, Nepal: RIDA International. https://idela-network.org/resource/save-the-children-nepal-improves-student-outcomes-in-ecd-centers/.

Luthar, Suniya S., Dante Cicchetti, and Bronwyn Becker. 2000. "The Construct of Resilience: A Critical Evaluation and Guidelines for Future Work." *Child Development* 71 (3): 543-62. https://doi.org/10.1111/1467-8624.00164.

McCoy, Dana Charles, Jonathan Seiden, Marcus Waldman, and Günther Fink. 2021. "Measuring Early Childhood Development: Considerations and Evidence Regarding the Caregiver Reported Early Development Instruments." *Annals of the New York Academy of Sciences* (April): 3-10. https://doi.org/10.1111/nyas.14598.

McCoy, Dana Charles, Marcus Waldman, and Günther Fink. 2018. "Measuring Early Childhood Development at a Global Scale: Evidence from the Caregiver-Reported Early Development Instruments." *Early Childhood Research Quarterly* 45: 58-68. https://doi.org/10.1016/j.ecresq.2018.05.002.

Ministry of Education, Department of Education. 2016. *Child Centred Disaster Risk Reduction (CC-DRR) Consortium: DIPECHO VIII Promoting and Strengthening School Safety*. Position Paper. Sanothimi, Bhaktapur: Government of Nepal. https://nepal.savethechildren.net/sites/nepal.savethechildren.net/files/library/Position%20Paper%28Eng%29.pdf.

Ministry of Education, Department of Education, Monitoring & Management Section. 2016. *Status Report: 2015/016*. Sanothimi, Bhaktapur, Nepal: Government of Nepal. https://www.doe.gov.np/assets/uploads/files/cca724d2af543017ab39a85e0b20abdf.pdf.

Moving Minds Alliance. 2018. *ECD and Early Learning for Children in Crisis and Conflict*. Moving Minds Alliance. https://movingmindsalliance.org/wp-content/uploads/2019/03/ecd-and-early-learning-for-children-in-crisis-and-conflict.pdf.

Murphy, Katie Maeve, Hirokazu Yoshikawa, and Alice J. Wuermli. 2018. "Implementation Research for Early Childhood Development Programming in Humanitarian Contexts: ECD Implementation Research-Humanitarian Settings." *Annals of the New York Academy of Sciences* 1419 (1): 90-101. https://doi.org/10.1111/nyas.13691.

National Scientific Council on the Developing Child. 2005. *Excessive Stress Disrupts the Architecture of the Developing Brain*. Working Paper No. 3. Updated Edition. Cambridge, MA: Harvard University. https://developingchild.harvard.edu/resources/wp3/.

National Scientific Council on the Developing Child. 2015. *Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience.* Working Paper No. 13. Cambridge, MA: Harvard University. https://developingchild.harvard.edu/resources/supportive-relationships-and-active-skill-building-strengthen-the-foundations-of-resilience/.

Nepal Education Cluster. 2015. *Sindhupalchok School Structural Assessment Findings.* Sindhupalchok, Nepal: OCHA. https://reliefweb.int/report/nepal/nepal-sindhupalchok-school-structural-assessment-findings-july-2015.

Nikapota, Anula. 2006. "After the Tsunami: A Story from Sri Lanka." *International Review of Psychiatry* 18 (3): 275-79. https://doi.org/10.1080/09540260600658262.

Phiri, Peter, Jean Nkhonjera, Franis Mabeti, Kizito Kamiza, and Jonathan Seiden. 2016. *Malawi ELM & HEART Endline Analysis.* Lilongwe, Malawi: Save the Children. https://resourcecentre.savethechildren.net/library/malawi-elm-heart-endline-analysis.

Pisani, Lauren, and Ali Amente. 2015. *Ethiopia 2015 ELM Results.* Addis Ababa, Ethiopia: Save the Children.

Pisani, Lauren, Ivelina Borisova, and Amy Jo Dowd. 2018. "Developing and Validating the International Development and Early Learning Assessment (IDELA)." *International Journal of Educational Research* 91: 1-15. https://doi.org/10.1016/j.ijer.2018.06.007.

Pisani, Lauren, Romilla Karnati, and Sara Poehlman. 2017. *Building Brains: Early Stimulation for Children from Birth to Three.* Washington, DC: Save the Children. https://resourcecentre.savethechildren.net/node/13453/pdf/building_brains_brief.pdf.

Plan International. 2013. *Investing in the Youngest: Early Childhood Care and Development in Emergencies.* Surrey, UK: Plan Limited. https://inee.org/resources/investing-youngest-early-childhood-care-and-development-emergencies.

Plan International, Save the Children, UNICEF, World Vision, Government of Nepal, Central Child Welfare Board, and Government of Nepal, Ministry of Federal Affairs and Local Development. 2016. *One Year On, Children Express New Fears over Insecurity and Long Term Trauma Following Devastating Nepal*

Earthquakes. Nepal: ReliefWeb https://reliefweb.int/report/nepal/one-year-children-express-new-fears-over-insecurity-and-long-term-trauma-following.

Save the Children. n.d. *Healing and Education Through the Arts (HEART).* Fairfield, CT: Save the Children. https://www.savethechildren.org/us/what-we-do/protection/healing-and-education-through-the-arts.

Save the Children International. n.d. *Help Children in Nepal. London, UK: Save the Children.* https://www.savethechildren.org/us/where-we-work/nepal.

Seiden, Jonathan. 2018. "Adversity as a Dimension of Equity: Pitfalls and Practice." Presentation at 2018 Comparative International Education Society Conference, Mexico City, Mexico.

Seiden, Jonathan, Amy Jo Dowd, and Nar Chetri. 2019. *Care for Child Development Plus for 0-3 Children: Impact Evaluation Results.* Bhutan: Save the Children.

Seiden, Jonathan, Holly-Jane Howell, Whimcy Sagpang, and Georgia Ansell. 2018. *Philippines First Read Midline Report.* London: Save the Children.

Seiden, Jonathan, and Romilla Karnati. 2019. "Effects of a Center, Teacher, and Community Focused Intervention in Rural Bangalore Preschools." Panel discussion at 2019 Comparative International Education Society Conference, San Francisco, CA.

Sindupalchowk District Coordination Committee Office. 2018. Brief Introduction on development in Sindhupalchowk District. Chautara, Sindhupalchowk, Nepal: District Coordination Committee Office. https://dccsindhupalchowk.gov.np/.

Snyder, Richard C., Cheri Harris, John R. Anderson, Sharon A. Holleran, Lori M. Irving, and Sandra X. Sigmon. 1991. "The Will and the Ways: Development and Validation of an Individual-Differences Measure of Hope." *Journal of Personality and Social Psychology* 60 (4): 570-85.

Terranova, Andrew M., Paul Boxer, and Amanda Sheffield Morris. 2009. "Factors Influencing the Course of Posttraumatic Stress Following a Natural Disaster: Children's Reactions to Hurricane Katrina." *Journal of Applied Developmental Psychology* 30 (3): 344-55. https://doi.org/10.1016/j.appdev.2008.12.017.

UN Office for the Coordination of Humanitarian Affairs. 2015 *Nepal Earthquake District Profile: Sindupalchowk*. Relief Web. http://reliefweb.int/report/nepal/nepal-earthquake-district-profile-sindhupalchok-08052015.

UNICEF (United Nations Children's Fund). 2014. *Early Childhood Development in Emergencies: Integrated Programme*. New York: UNICEF. https://sites.unicef.org/earlychildhood/files/Programme_Guide_ECDiE.pdf.

Vernberg, Eric M., Annette M. La Greca, Wendy K. Silverman, and Mitchell J. Prinstein. 1996. "Prediction of Posttraumatic Stress Symptoms in Children after Hurricane Andrew." *Journal of Abnormal Psychology* 105 (2): 237-48. https://doi.org/10.1037/0021-843X.105.2.237.

Vijayakumar, Lakshmi, G. K. Kannan, and S. J. Daniel. 2006. "Mental Health Status in Children Exposed to Tsunami." *International Review of Psychiatry* 18 (6): 507-13. https://doi.org/10.1080/09540260601037581.

Waldman, Marcus, Dana Charles McCoy, Jonathan Seiden, Jorge Cuartas, CREDI Field Team, and Günther Fink. 2021. "Validation of Motor, Cognitive, Language, and Socio-Emotional Subscales Using the Caregiver Reported Early Development Instruments: An Application of Multidimensional Item Factor Analysis." *International Journal of Behavioral Development* 23 (1): 1-10. https://doi.org/10.1177/01650254211005560.

Wolmer, Leo, Nathaniel Laor, Ceyda Dedeoglu, Joanna Siev, and Yanki Yazgan. 2005. "Teacher-Mediated Intervention after Disaster: A Controlled Three-Year Follow-Up of Children's Functioning." *Journal of Child Psychology and Psychiatry* 46 (11): 1161-68. https://doi.org/10.1111/j.1469-7610.2005.00416.x.

World Health Organization. 2020. *Nurturing Care for Children Living in Humanitarian Settings*. Geneva: World Health Organization. https://nurturing-care.org/wp-content/uploads/2021/01/NC_Thematic_Brief_Humanitarian_Settings_WEB.pdf.

World Health Organization, World Bank Group, and UNICEF. 2018. *Nurturing Care Framework Toolkit*. Geneva: World Health Organization. https://nurturing-care.org/nurturing-care-framework-toolkit.

JOURNAL ON EDUCATION IN EMERGENCIES

Early Childhood Development in the Aftermath of the 2016 Wildfires in Alberta, Canada

Author(s): Julie L. Drolet, Caroline McDonald-Harker, Nasreen Lalani, Sarah McGreer, Matthew R.G. Brown, and Peter H. Silverstone

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 54-79

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62221

DOI: https://doi.org/10.33682/u3ar-wwzm

REFERENCES:

EARLY CHILDHOOD DEVELOPMENT IN THE AFTERMATH OF THE 2016 WILDFIRES IN ALBERTA, CANADA

Julie L. Drolet, Caroline McDonald-Harker, Nasreen Lalani, Sarah McGreer, Matthew R. G. Brown, and Peter H. Silverstone

ABSTRACT

The 2016 wildfires in Alberta, Canada, created numerous challenges for families with children under five years of age, due to the limited postdisaster access to early childhood development (ECD) programs, resources, and supports. In the immediate aftermath of the wildfires, families struggled to balance recovery activities with childcare responsibilities, which adversely affected their overall recovery. In this article, we discuss three main challenges experienced by families with young children after the wildfires: inadequate access to childcare services, a lack of availability and funding for ECD programs and resources, and limited long-term recovery support for families. Because of their early developmental stage, young children are especially vulnerable to the adverse effects of a disaster and dependent on their adult caregivers, thus it is essential to understand the unique challenges families face after a disaster. Children's prolonged exposure to the stress of a disaster environment is compounded when parents have limited access to crucial programs, resources, and supports during the most crucial periods of rebuilding and recovery. The findings we report in this article provide insights into the critical role disaster and emergency preparedness and planning play in ECD service delivery and infrastructure, and into the need for recovery efforts to "build back better." We advise all levels of government to consider ECD and the provision of child care to be essential services during natural disasters, crises, and pandemics. We further advise them to make the financial investment needed to ensure sustainable recovery operations, including infrastructure, provision of ECD services, and hiring of educators who can deliver high-quality, affordable early learning and child care in postdisaster environments.

Received March 2, 2020; revised June 19, 2020, and September 4, 2020; accepted March 17, 2021; electronically published June 2021.

Journal on Education in Emergencies, Vol. 7, No. 1

ISSN 2518-6833

INTRODUCTION

On May 1, 2016, a wildfire began in the Regional Municipality of Wood Buffalo (RMWB) in Alberta, Canada, southwest of the town of Fort McMurray. Extreme conditions caused numerous wildfires to burn out of control, and by May 4, the provincial government declared a state of emergency and issued a mandatory evacuation order for 88,000 residents (Government of Alberta 2016a, 2016b). The wildfires, and the resultant mass evacuation, were the largest natural disaster in Canadian history, with total damages estimated at Can$9.9 billion (Cryderman 2016). Voluntary re-entry into Fort McMurray began on June 1, 2016, and in 2021 the community rebuilding and recovery efforts are still ongoing.

There is an urgent need for a comprehensive early childhood development (ECD) and early learning response to the rapidly growing population of young children living in crisis and conflict situations across the globe (Bouchane 2018). Although ECD is widely recognized as crucial to the healthy growth and development of children ages 0-5, little research has examined ECD service delivery and infrastructure in the aftermath of a natural disaster, crisis, or pandemic, including tangible and fixed capital assets intended for public use or benefit. Bouchane (2018), who analyzed refugee and humanitarian response plans in the context of humanitarian emergencies, found that only 9 percent of plans include the essential elements of early learning. The world's most disadvantaged children, who are in greatest need of support for developing strong early learning foundations, often have no access to ECD programs (Save the Children 2017).

Climate-related disasters, including wildfires, have become more frequent and intense due to climate change; the number of events has tripled in the last 30 years (Oxfam 2020). Children and youth are particularly affected by such disasters because of their dependence on adults and their structural vulnerability to psychological and social factors related to their developmental stage (Brown et al. 2019).[1]

The project titled Health Effects of the 2016 Alberta Wildfire: Pediatric Resilience offers a timely assessment of the physical, psychological, and emotional health effects the wildfires have had on children and youth. It also provides a better understanding of the social, economic, cultural, personal, and health factors that contribute to positive mental health and resiliency in a postdisaster context

1 Structural vulnerability refers to an individual's or a population group's condition of being at risk for negative health outcomes through their interface with socioeconomic, political, and cultural/normative hierarchies (Bourgois et al. 2017).

(Brown et al. 2019). Drawing from the study data collected with community influencers—the individuals who deliver services and programs to children, youth, and families for a variety of organizations—we discuss in this article why ECD service delivery and infrastructure must be a component of disaster mitigation. We argue that inadequate access to ECD delivery, lack of funding for ECD programs and resources, and limited recovery support for children, youth, and families in the aftermath of the wildfires had a negative effect on the Fort McMurray community's overall recovery, including delayed rehabilitation and rebuilding. The study findings provide insight into the critical role disaster and emergency preparedness and planning provide for ECD service delivery and infrastructure, and for "building back better" after a disaster.

Disasters and ECD Programs

ECD programs support children's development and help protect them and their families; therefore, having access to these programs is especially critical in times of natural disaster or other emergency (Office of Child Care 2012). With the increased number of disasters occurring globally and in Canada due to climate change, children under age five are among the most vulnerable. During a disaster and the subsequent recovery efforts, early childhood educators can help children regain a sense of safety and address their emotional needs (Dicarlo et al. 2007). Moreover, young children are often in a childcare setting when an emergency occurs, which means they are separated from their parents or guardians (NACCRRA and Save the Children 2010). Childcare programs, including ECD, can provide children with a safe and secure environment during such separation, and they can help the children and their families manage trauma in the aftermath of a disaster.

Studies have shown that, when their safety or the safety of their caregivers is threatened, infants and young children may exhibit behavioral and physiological symptoms, such as difficulties with self-regulation, problems forming attachments, loss of previously acquired skills, or difficulty sleeping and eating (Zero to Six Collaborative Group 2010). Moreover, the increased stress on caregivers in disaster contexts has been shown to affect preschool children's cognitive outcomes (Gomez and Yoshikawa 2017). Research shows that providing postdisaster emotional support to families with children under age five is a factor in the children's psychosocial resilience (Deering 2000), thus the need for ECD providers who support children's caregivers is evident.

Experiencing a wildfire has been linked to psychological distress (Freedy et al. 1994), mental health difficulties (Freedy et al. 1992; Marshall et al. 2007), an overall decline in health and wellbeing (Paveglio et al. 2016), and a reduction in one's ability to cope (Langley 2000). This is particularly concerning, given that the ability to cope is an important factor in the postdisaster recovery process and can significantly impact long-term mental health outcomes (Langley 2000). In disaster situations, families often are displaced and thus face enormous physical, emotional, and psychosocial stress, which in turn can affect their children's development and growth (Masten and Osofsky 2010).

Children are often more adversely affected by a disaster than adults, due to the effects on their physical and psychological health and the disruption of their education (Proulx and Aboud 2019; Peek 2008). Despite awareness of these effects, critical gaps in the research on ECD response during disasters and emergencies remain, particularly on the impact of interventions and social services in the ECD sector (Burde et al. 2019). There also is a paucity of research on disaster risk reduction for preschool children.

State of ECD Services and Infrastructure in Fort McMurray before the Wildfires

Canada's federal and provincial governments have differing strategies for supporting ECD. The province of Alberta relies on a mix of public, for-profit, and not-for-profit providers for the organization, funding, and delivery of ECD services, which results in services of modest quality that are unevenly distributed and poorly connected at the local, regional, and provincial levels (Muttart Foundation 2016). The limited public funding for ECD across Canada and the provinces' jurisdiction over education and social services results in municipal governments having a limited role in decisions about the delivery of early childhood learning and care and without responsibility for the management of ECD services (Muttart Foundation 2016). The result is a patchwork of programs, services, and supports, including ECD, child care, before- and afterschool programs, family counseling, and other support services.

The RMWB is in a remote northern area of Alberta yet close to oil sands and gas industry facilities. Two-thirds of the population of the RMWB reside in Fort McMurray, a unique community of approximately 43,000 residents, many of whom are transient, due to the industry in the area. In 2015, the declining price of oil led to a dramatic bust in the sector's decade-long boom (Cake et al. 2018),

which created economic challenges in the Fort McMurray community that were exacerbated by the 2016 wildfires.

Fort McMurray's unique culture is characterized by long hours on the job, rotational shift work, and a high cost of living. Moreover, in 2016, 57 percent of children under age six and 55 percent under age three had working mothers (AECEA 2020a). Child care is thus an essential service for most Alberta families with young children, yet Fort McMurray has the most expensive childcare facilities in the province (Dorow et al. 2015). Although there was increasing awareness in the community of the value of high-quality care for young children and of the importance of specialized education and training to foster healthy ECD (Tough et al. 2013), Alberta's underfunded early learning and childcare system has been lacking appropriate spaces and workforce development since before the 2016 wildfires. Keyano College, which serves the northeastern region of the province and has a campus in Fort McMurray, offers an early learning and childcare certificate program; however, the program was suspended in 2015, due to low enrollment and a shortage of qualified early childhood educators in the region (Muttart Foundation 2019). Although the program was reinstated after the wildfires, the shortage of qualified educators continues.

Effects of the Wildfires

After the wildfires, schools in Fort McMurray played an important role in the recovery process by serving as community hubs and providing social and emotional support for children, youth, and parents (Kulig et al. 2017). Some schools, in partnership with nonprofit organizations such as the YMCA, offered ECD and early learning programs on site or in buildings adjacent to the schools (YMCA 2020). School staff members received professional development related to trauma-informed practice, grief and loss, skills for psychological recovery, and reactions to disaster (Kulig et al. 2017). A psychosocial coordinator was hired to support the resilience and wellbeing of children, youth, and families. The coordinator used a psychosocial pyramid-of-intervention approach to provide specialized supports for the few, targeted supports for many, and universal supports for all.[2]

2 The coordinator used a psychosocial approach adopted by Alberta Health Services, which recognized the importance of universal supports for all, such as information and communication, to specialized and targeted supports, such as specialized mental health interventions. It is a stepped-care approach. See https://www.albertahealthservices.ca/assets/healthinfo/mh/hi-mh-pfa-after-disaster-emergency-public.pdf.

Providing adequate services after the wildfires was sometimes difficult, as many community organizations, as well as health, education, and social service agencies, found it challenging to recruit and hire staff. The ECD sector also experienced a serious shortage of childcare workers (Thurton 2017), all of which affected the community's recovery process (Kulig et al. 2017).

"BUILDING BACK BETTER"

Environmental disasters, crises, and emergencies compound and highlight existing inequalities and disproportionately affect marginalized communities across the globe. The concepts of disaster preparedness, risk reduction, and recovery provide a lens for understanding ECD service delivery and infrastructure in the RMWB following the 2016 wildfires. The "building back better" (BBB) framework, which is often associated with disaster preparedness and recovery, promotes resilience and reduces vulnerability to future disasters (Fulton et al. 2020; Fulton and Drolet 2018).[3] Following the wildfires, the RMWB created a recovery task force to provide oversight of community-based recovery efforts. The task force officials brought together a variety of stakeholders to address the wide-ranging needs of individuals, communities, and organizations during the recovery. This effort was based on five pillars: people, economy, environment, rebuild, and mitigate (KPMG 2017); the people pillar supported the community's mental health and wellbeing using a psychosocial framework that included providing access to safe and effective education services (Kulig et al. 2017).

The BBB approach to postdisaster recovery reduces vulnerability to future disasters and builds community resilience, which is applicable to all sectors of society (Global Facility for Disaster Reduction and Recovery n.d.). In order to build capacity and promote disaster preparedness, risk reduction, and effective recovery efforts in the early learning and ECD sectors, the recovery framework must include opportunities for change and improvement.

Disaster Preparedness

Disaster preparedness includes the strategies, plans, and activities undertaken prior to a calamitous event to ensure an effective response. Preparedness includes developing an emergency response plan, establishing mutual assistance agreements between service providers, maintaining resource inventories and

3 The BBB framework has been adapted to the current COVID-19 pandemic response.

equipment, and conducting trainings on disaster response and recovery for all services (KPMG 2017). Preparedness in the ECD sector should include targeted interventions that prepare services and infrastructure to withstand and recover from disasters (Shores et al. 2009). In Canada, municipal governments play a key role in emergency management and are often the first to respond to disasters and emergencies in their communities. While the federal and provincial governments are involved in disaster and emergency planning, the operations that respond to emergencies are planned locally.

Disaster Risk Reduction

Disaster risk reduction and mitigation are important components of how a community understands disaster risks in all sectors of society. Canada is a signatory to the United Nations Sendai Framework for Disaster Risk Reduction, a voluntary, nonbinding 15-year agreement that recognizes that, while federal and provincial governments play a primary role in reducing disaster risk, responsibility should be shared by all sectors of society. The Sendai Framework emphasizes the need to have continuity in the operations that follow disasters, including providing psychosocial support and mental health services (United Nations 2015).

Disaster Recovery

Recovery refers to a municipality's strategies, plans, and actions taken to restore conditions to an acceptable level after a disaster, and to continuously improve prevention and mitigation measures to reduce future disaster risks. The RMWB aims to build back better by supporting community resilience and minimizing the impact of future disasters. In 2016, the RMWB developed the Wildfire Recovery Plan, which defines recovery as the "restoration, re-development, regeneration, rehabilitation, and improvement (adopting the 'build back better' principle) of facilities, livelihoods and living conditions of disaster-affected communities" (KPMG 2017, 6). The BBB principle reflects those of the Sendai Framework, including enabling communities to address underlying socioeconomic issues through a planned recovery approach and thus to enhance community resilience (Public Safety Canada 2019). In order to build back better in the ECD sector after a disaster, additional supports and resources are needed to deliver early learning and child care. This was particularly true in Fort McMurray when the wildfires recovery effort intersected with the COVID-19 pandemic and the provincial economic downturn.

METHODOLOGY

Our study adopted a qualitative approach focused on sharing knowledge with our community partners, including school districts, government departments, and community organizations. This enabled us to build our capacities collaboratively and informed our actions to address collective community concerns. The research team included academic and community-based researchers, knowledge end-users such as health services and education districts, health services and education district decisionmakers, and our community partners. In this article, which is based on qualitative interviews we conducted with 30 community influencers who deliver services and programs to children, youth, and families for a variety of organizations (Fulton et al. 2020; Drolet and Fulton 2018), we discuss our findings on the wildfires' effect on ECD service delivery and infrastructure.[4] The community influencers included direct service providers, ECD educators and managers, community decisionmakers, social workers, and human services practitioners. We conducted semi-structured, in-depth interviews to learn about the roles they played during the evacuation, re-entry, and recovery stages. Most of the participants provided services and programs to foster the community's postdisaster wellbeing and resilience, including ECD services and education.

We recruited the interview participants in Fort McMurray using a purposive snowball sampling approach. Our aim was to understand the perspectives and experiences of those directly engaged in the delivery of services and programs for children, youth, and families after the wildfires. To locate potential participants who met the study criteria, we conducted a scan of social service agencies, community organizations, healthcare services, and education structures, and accessed community directories. We obtained approval for the study from the University of Calgary Human Research Ethics Board and conducted the interviews from December 2018 to February 2019. Each participant received a $50 gift card and, to protect their anonymity, we have not shared any identifiable personal details. The participants, who provided rich descriptions of the postdisaster recovery context, were interviewed for 1-2 hours on average. The interviews focused on understanding each subject's perspectives and experiences, the availability and provision of services and programs postdisaster, and their understanding of child and youth mental health and resilience in the context of the wildfires.

4 Members of the study research team also administered a survey to 3,070 students in grades 7-12 to measure the psychological impact the wildfires had on children/youth (results are discussed in Brown et al. 2019), and completed 100 face-to-face qualitative interviews with school-age children/youth (ages 5-18) to examine the psychosocial factors that contribute to resilience.

We digitally audio-recorded the interviews with the participants' consent, and the researchers wrote memos about the important discussions and issues. The interview recordings and the memos were then transcribed for coding and analysis. Two members of the research team analyzed each interview transcript using open coding, axial coding, and selective coding to identify emerging themes, links, and associations. We extracted coded quotes for preliminary analysis, compared them within and between transcripts, and then grouped them according to key themes and subthemes. Two research assistants collected and analyzed our data separately using the procedures described above, and then integrated them for a final analysis. We used NVivo 11.0 to support our qualitative analysis of the interview data, and the researchers worked to reach a consensual interpretation.

FINDINGS

The analysis revealed gaps in the availability and provision of ECD services and facilities after the wildfires. The limited availability of and access to ECD programs and resources created numerous challenges for parents with children under age five, which left families struggling to balance recovery activities with their childcare responsibilities and affected their overall recovery. The interviews revealed three main challenges: inadequate access to childcare services, lack of funding for ECD programs and resources, and limited long-term recovery supports for children, youth, and families. Thus, we argue that disaster preparedness, risk reduction, and recovery plans must take into account the critical importance of ECD service delivery and infrastructure.

Inadequate Access to Childcare Services

One of the most significant challenges families faced following the fires was inadequate ECD services and infrastructure. Moreover, the displacement, upheaval, and increased responsibilities families faced during recovery altered and constrained their lives. Once they were allowed to return home after several weeks or even months, families were tasked with numerous time-consuming remediation responsibilities and activities. Because many childcare facilities were closed due to the damage caused by the wildfires, families had to start the rebuilding process with little or no access to child care. The childcare facilities not destroyed beyond repair were permitted to reopen, but only after extensive cleaning, repair, and multiple inspections and safety checks. Most of the participants discussed the serious difficulties the lack of child care created for families, which often delayed their return to the community. This was particularly challenging for parents

working for organizations and businesses deemed emergency or essential services, such as hospitals, banks, and grocery stores.

The COVID-19 pandemic has further demonstrated the importance of childcare provision during an emergency. Some provinces and territories have provided emergency childcare services for essential workers during the pandemic (Childcare Resource and Research Unit 2020).[5] One participant, who is a female early childhood educator, commented that child care was not considered an emergency or essential service in Fort McMurray after the fires, thus little support was provided to repair childcare facilities quickly. This left parents without child care, which delayed their return home:

> It was a little bit of a struggle in the beginning, as we were not recognized as an emergency service to open up for families; however, for families to work, they need child care. So, the banks and the grocery stores, they were all open before re-entry; however, parents couldn't return until child care was available. So, I was one of the first childcare employees to return to Fort McMurray, and I had to set up licensing, licensing inspection, fire inspections, health inspections.

All of the interview participants who worked in the ECD sector discussed the significant difficulties the lack of child care posed for many families after they returned to the community. Before they could begin repairing their damaged homes, parents had to meet with representatives from insurance companies, financial institutions, disaster recovery programs and services, and others. This was particularly challenging for parents with young children, as they had to take care of these time-consuming activities while also caring for their children. Other out-of-school programs and alternative childcare services were also not operational, another cause of a delayed return to the community. As one female educator asserted,

> our out-of-school program didn't open up . . . [despite] parents having to have babysitters . . . [in order] to spend a day with a lawyer or at a bank . . . you know? Those are things we don't think about. We have families to take care of and . . . have business to do, too.

5 Essential workers are those critical to preserving life, health, and basic societal functioning (Government of Canada 2020).

The lack of child care for both working and nonworking parents affected their ability to access public benefits and engage in efforts to rebuild the community. This was compounded by the fact that more children needed child care than there were spaces and providers available.

Most of the participants explained that many providers were not able to return to the ECD workforce, as they were busy rebuilding their own homes and caring for their own children. The lack of ECD services that families could rely on created multiple barriers during the rebuilding after the wildfires. A female educator stressed how critical child care was in helping individuals and communities recover after a disaster:

> It's that key piece where—I mean there's definitely day[care] homes where they have staff with the qualification to watch children, but when there's such a large amount of children [what happens?] It's one of the first step[s] . . . If they had child care, the rebuild would be a lot quicker.

Participants who delivered health, social, education, and community services and programs to families explained that many parents had to resign from paid employment in order to care for their children, which put added psychological and financial stress on families and affected children's wellbeing. A female participant stated that ensuring child care was in place before allowing people to return to the community after a disaster would go a long way in helping families' ability to recover:

> [Not having child care] adds to the pressure on the family because, you know, if someone's been working before and then can't work because they can't find proper child care, it puts strain on the family . . . If resources are put in place or the government make[s] it a little bit cheaper or subsidize[s] it, then it might be a lot easier on people.

Working parents in Fort McMurray experienced not only limited access to child care but also numerous financial constraints. The majority of participants reported that, while parents were able to be physically present with their children postdisaster, they were not always emotionally available, which affected their children's wellbeing. They observed that parents were often busy with the rebuilding and were therefore unable to be as involved in their children's lives

as they had been before the fires. A female educator expressed concern that parents' limited ability to provide socioemotional support for their children after the wildfires would have long-term adverse effects. She reflected on her ECD experiences with young children:

> If government can find a way to make it cheaper for parents to be able to support their kids, child care and all that might work better, you know? I think that's a big one, because most family [*sic*] are quite stressed when it comes to child care and supporting their kids.

Another educator added that "the people who are okay are okay. The people who are not okay are still not okay, in my opinion. There are still families who are struggling, you know, mentally, and we know that there are families who are struggling financially, [as] they are unable to pay for childcare fees." Families were affected by the wildfires in different ways. The socioeconomic impact reduced families' ability to afford childcare services, and the lack of child care and other supports likely delayed some families' recovery process.

Lack of Funding for ECD Programs and Resources

The lack of funding for ECD programs and resources in the Fort McMurray community after the wildfires made it difficult for the sector to meet the needs of children, both in the immediate remediation period and during the long-term recovery. Many organizations and facilities offering ECD programs had lost materials that needed to be replaced, such as toys, games, and learning materials, but they lacked the funds to buy them, let alone to rebuild damaged facilities. Consequently, many programs were not able to run effectively or to offer the services they had before the fire. One participant stated that having financial support for ECD programs and resources before the disaster would have reduced the time it took to rebuild, reopen, and once again offer the support children needed:

> More funding would help to get more people to get places back up and running again. For example, our programs couldn't reopen until every single toy and walls were washed. Every single thing in our program had to be gone through . . . A lot of our stuff had to be thrown out, stuffed toys and pillows, . . . and we had to sanitize . . . to get back to where we were. I volunteered my time to help get our program back up and running. [It would have

> helped] if we did have more funding, to have people who are willing to help and in the right mindset. It would have helped rebuild a lot quicker.

Another participant asserted that many of the organizations and facilities that offer ECD programs and services were not consulted about their specific funding needs, and that the short- and long-term needs of children were not considered:

> So [we] have funding restraints as well. I think, . . . because they're one of our major funders, they could have brought us to the table to discuss a little more how would it look moving forward if we were to change our funding stream. They more or less mandated it. And they looked at it from a numbers' perspective rather than from a person's perspective.

Funding to hire additional staff during the recovery period—counselors, mentors, family-school liaisons—also was limited. One participant described how extremely limited many early childhood programs and services were and noted that many families and children did not have access to the supports they needed, which had long-term effects:

> [It] is a great agency who works with the mentors that come into our building. They didn't have funding, we didn't have enough workers [or] mentors to come in and work with our kids, but the counselors had full lists plus [a] waitlist, the family school liaison workers had [a] waitlist and the mentors had [a] waitlist, and we still weren't reaching everyone. And that's to this day still very much the case . . . there is not enough of us . . . If we had the funding, [we] could easily put a couple of family therapists in our schools to help with the children and the families . . . We actually do not have anyone in town who does the family work.

Another participant noted that the problem of limited funding was further compounded by Fort McMurray's remote location, which made it nearly impossible to find people willing to come into the community to provide the supports children needed:

> So that's a huge piece of . . . the barrier . . . There is not enough money . . . to get more people in, and there is [*sic*] not enough professionals willing to come up here in[to] our community, so it's twofold. You know, like, if we had more grants and more funding to get more counselors, we would get them. But . . . trying to find them in other communities [and have them] willing to come into our community is another thing. So, we don't have the funding to get them, but we also don't have enough of a pool of people who are trained to . . . do the work. So that is definitely a barrier.

Interview participants discussed the need for programs and resources to address the diverse needs of struggling children. They recognized that funding was needed for ECD programs and services in order to meet the multiple and changing needs of children during the long-term recovery.

Limited Long-Term Recovery Supports for Families

In Alberta and other areas affected by environmental disasters, recovery funding was made available for up to three years. Most participants agreed that this limited funding for the long-term recovery was a significant challenge for children, parents, and early childhood educators. Participants explained that the psychosocial trauma caused by the disaster often appeared in children quite some time after the event. Because parents and other adults were often preoccupied with rebuilding efforts, they often did not immediately notice that their children needed support, or they believed that problems such as sleep disturbances, psychosomatic symptoms, or regressive behaviors would subside over time. A participant who worked in the social services sector described how, several years after the wildfire, the long-term trauma the disaster caused families was becoming more evident:

> I think we're just starting to really see the impact. I think the first two years we were so busy, and we put all these programs into effect and [focused on] do, do, do, to help, help, help, but now we are all living in it and we are going "Wow! The third year is actually really difficult."

Another participant who worked in mental health and wellness stated,

> 3½ years out and kids are still struggling . . . We are not the same community. We are a community with a lot of struggling

> families. Many of us, myself included, have bounced back. We're back to our normal routine, good food, exercise, and balanced holidays. [But] we [still] have a lot of famil[ies] struggling out there. It's hard work.

According to the majority of the participants, many parents and children were still struggling several years after the wildfires. Most expressed concern that, as disaster funding was reduced over time, they would no longer be able to help these parents and children. One participant explained that the programs and services her organization offered after the wildfires were not sustainable over the long term, due to a lack of financial support:

> Some of the challenges that we did see was, like, sustainable funding. So after the wildfire we had, . . . like, so much funding for rebuilding and . . . resources . . . Now the funding is . . . being depleted.

Another participant described the devastating impact the lack of long-term funding was having on the wider community, as service providers and practitioners were left to meet the postdisaster needs of children and families with few or no resources:

> It is a shame that the higher powers did not recognize when they put this funding in place for . . . only a short term, three years. You know, that's very unfortunate, because we're going to be crumbling in the next couple of years in ways that nobody probably is really realizing. And there's not going to be enough of us to pick up the pieces. So, that will be my takeaway messages.

The majority of participants discussed the importance of having accessible funding for disaster planning and mitigation efforts, such as developing and implementing emergency preparedness programs, evacuation plans, and additional physical infrastructure.

The lack of long-term recovery support for families has had serious consequences for both parents and children. Parents were often overwhelmed by the amount of work required for disaster remediation, rebuilding, and recovery, and the high level of stress they experienced affected their overall mental health and wellbeing:

> People [were] contemplating suicide, people [were] delaying adoption. There are certain people that their lives will never be the same. Do I think that people can move on and still have a good life? Of course, but I don't think full recovery is within the scope of a short-term future. It's been two years; it's a long time, but it's a short time considering what many went through.

Participants explained that long-term support was needed to foster positive mental health and resiliency in children during the recovery. As a practitioner participant stated, "The mental health support needs to continue here, as well as the understanding of behaviors, the anxiety, and the resiliency . . . in children." The limited access to mental health support has affected children, parents, and the wider community recovery process. A participant explained that a long-term recovery process requires long-term attention and support: "In a lot of ways we haven't fully recovered. If you walk in as an outsider, you would feel like it's a normal community. But if you know enough people here, you would know that not many have moved past [the disaster]."

One participant commented that disaster recovery is a challenge because the community will never be the same:

> People used to ask me, "Are we going to ever recover?" I said, "We'll never be the same. We might bounce back better. We might become better, but we'll never be the same." We call it the "new normal." I don't know if I like the term too much. It's going to be different . . . There are some things that have happened, people feel attached. They've all lived through a common experience. There are some thoughts that [the] community got stronger. There are some beautiful new houses built and people living in beautiful new houses, which is nice.

The limitations of short-term disaster recovery funding were perceived to be an obstacle to the community's recovery and rebuilding efforts. Participants recommended that additional financial support be provided to sustain services and programs in order to fully meet the needs of children and families.

DISCUSSION

The study findings provide insights into the critical role disaster and emergency preparedness and planning play in ensuring ECD service delivery and infrastructure during and after a disaster. Families' childcare needs after a disaster were an important finding, given the importance of ECD services in supporting the rebuilding and recovery process. After the wildfires, many families lost jobs and experienced financial challenges, which created new barriers to accessing affordable, high-quality child care. The evacuation of Fort McMurray resulted in the displacement or relocation of families to central and southern Alberta; some families migrated to other provinces in order to access social, economic, and cultural support. Moreover, because Fort McMurray attracted workers from across the country, the community faced unique challenges in providing psychosocial services postdisaster.

Displacement resulted in the loss of ECD services for some families, as physical structures and educational materials were damaged or destroyed, and all ECD centers closed. The wildfires also considerably affected the ECD workforce and the community that relied on them. Most childcare providers in Fort McMurray lost their jobs immediately after the evacuation, which resulted in a loss of income and livelihood for staff members and funding for programs. Many residents never returned to RMWB (Thurton 2019), including members of the ECD workforce. Participants described the lack of qualified ECD staff after the wildfires, which has continued to be a challenge during the long-term recovery. Similar findings on the need for targeted interventions and policy changes to prepare childcare facilities to withstand and recover from disasters were reported after Hurricane Katrina shut down New Orleans in 2005 (Shores et al. 2009). These are critical challenges for the ECD sector to consider so they can build back better in future postdisaster contexts.

The Sendai Framework for disaster risk reduction outlines the need to enhance disaster preparedness in order to provide an effective response and to build back better (United Nations 2015). Everyone has a role to play in building back better, including the ECD sector. The inadequate access to childcare services, the lack of funding for ECD programs and resources, and the limited recovery support for Fort McMurray's children, youth, and families have impeded individual and community recovery efforts. Disaster and emergency preparedness and planning must put greater emphasis on strategies to restore access to safe, accessible, and affordable ECD services and infrastructure and early learning programs in postdisaster contexts. Disasters can create opportunities for change and improvement and to disrupt inadequate policies and practices (Fernandez and Ahmed 2019). Taking

a BBB approach, which can create equity in the postdisaster context, can be interpreted in multiple ways, and it is incumbent upon the ECD sector to provide leadership in developing a collaborative, participatory process that engages the affected communities (Fernandez and Ahmed 2019). Disaster preparedness, response, and recovery are context specific, and the study findings reveal the unique considerations for ECD service delivery in Fort McMurray after the wildfires, such as environmental health issues; the effects of displacement; the physical, health, and emotional wellbeing of ECD staff, children, and families; and the importance of access to childcare services.

Recommendations for Policymakers

It is critical that municipal government policymakers consider ECD service delivery and infrastructure to be essential components of disaster response at the municipal level, including disaster preparedness, risk reduction, mitigation, and recovery. Communities affected by a disaster require long-term funding to ensure a full recovery. Emergency preparedness in the ECD sector can reduce the damage a disaster inflicts on young children. Moreover, adequate preparedness can enable ECD programs to recover quickly and restore a stable environment for young children, which has been shown to improve their psychosocial and emotional outcomes (Shores et al. 2009).

The COVID-19 pandemic has brought additional attention to the importance of ECD and education systems in times of crisis. A national survey conducted by the Muttart Foundation and the Canadian Child Care Federation (2020) found that childcare centers in Alberta suffered more layoffs during the first six weeks of the pandemic than those in other provinces and were significantly more exposed to the negative social and economic impact of the pandemic, due to the lack of provincial government financial support. Without access to early learning and childcare centers during the ongoing COVID-19 crisis, some parents have been unable to re-enter the workforce (Johnson 2020). This confirms that accessible quality child care is vital for essential service workers during a crisis or disaster, including first responders, nurses, grocery workers, and others. Furthermore, ECD services are needed so that infants and young children can get the care they need while their parents focus on rebuilding family and community life. The Alberta wildfires and the COVID-19 pandemic should make the importance of education in the early years clear to those engaged in preparedness and planning for situations of conflict and crisis (Bouchane 2018). It is imperative that the basic needs and rights of the youngest children are met in all situations, including during crisis, conflict, forced displacement, pandemics, and environmental disasters.

Access to quality ECD services and infrastructure was essential to Fort McMurray's families, children, and economy before COVID-19, and it will be critical in the post-COVID rebuilding period (AECEA 2020b). The challenge of providing ECD services has been magnified during the recent disaster and public health emergency in Alberta, and in all of Canada; all childcare services were closed to all but the children of essential workers during the COVID-19 lockdown, and the need for child care during recovery and reopening is finally being recognized (Press and Wright 2020). In Fort McMurray, as in many crisis-affected contexts globally, disaster recovery now intersects with the COVID-19 pandemic. Significant new investment is needed to stabilize the early learning and childcare sector in the town and across Alberta, and to build back better to ensure high-quality, affordable early learning and child care in an environment that has been dramatically changed by the pandemic. The findings of this study offer insights for policy and practice and highlight the need for accessible, affordable, high-quality child care, which must be treated as an essential service during and after a disaster, crisis, or pandemic. This is critical if communities are to meet the needs of children and families, to successfully reopen their economies, and to facilitate long-term recovery.

We make the following recommendations:

1. All levels of government must acknowledge the essential role of the early learning and childcare sectors, particularly in times of disaster, crisis, and pandemic. Financial investment is needed to prepare the ECD sector for the negative impact of disasters, crises, and pandemics.

2. Childcare centers need support in order to reopen and resume services postdisaster, which will facilitate individual and community recovery.

3. It is not sustainable for ECD centers to lay off staff during a disaster or public health emergency, given the additional time and resources required to recover and rebuild their organizational capacity.

4. Additional supports and resources are needed for ECD service delivery, infrastructure, and educators who can deliver high-quality, affordable early learning and child care in postdisaster environments.

5. Disaster and emergency management officials must plan for the provision of child care as a service that is vital and essential to the function of communities.

CONCLUSION

ECD and the provision of childcare services are vital to a community. This is particularly so in times of disaster, crisis, and public health emergency. The provision of ECD services in disaster-affected communities contributes to the continuity of care for children and families, minimizes the psychological impact of the disaster, and promotes resilience in children (Office of Child Care 2017). This study found that the lack of child care in Fort McMurray after the wildfires affected families' ability to engage in postdisaster recovery efforts and likely delayed the process for some. Improved disaster preparedness, disaster risk reduction, and disaster recovery planning are urgently needed in the ECD sector. The BBB principle should be applied to postdisaster ECD service delivery and infrastructure in order to reduce risks. Investment in ECD infrastructure and programming as an element of disaster risk reduction will facilitate recovery by allowing families to access relief assistance and recovery services. Additional financial support is needed during emergencies in order to sustain services and programs and continue to meet the needs of children and families. It is critical for the ECD sector to take the lead in developing a collaborative, participatory community process for disaster preparedness.

REFERENCES

AECEA (Association of Early Childhood Educators of Alberta). 2020a. *Getting It Right: Recommendations for Improving Alberta's Child Care Licensing Legislation*. Edmonton: AECEA. https://aecea.ca/sites/default/files/FINAL%20AECEA%20Position%20Paper%20on%20Legislative%20Change_0.pdf.

AECEA (Association of Early Childhood Educators of Alberta). 2020b. "Alberta's Child Care Funding Remedy Lacks Investments to Stabilize and Sustain the Sector as Province Begins Reopening from Lockdown." Edmonton: AECEA. https://aecea.ca/sites/default/files/200507%20Reopening%20press%20release_0.pdf.

Baxter, Joanne. 2019. "A Description of Post-Secondary Early Learning and Child Care Programs in Alberta with Strategies to Advance the Educational Preparation of Early Childhood Educators." Edmonton: Muttart Foundation. https://www.muttart.org/wp-content/uploads/2019/08/MTF-2019-Strategies-to-Advance-Educational-Preparation.pdf.

Bouchane, Kolleen. 2018. *Early Childhood Development and Early Learning for Children in Crisis and Conflict.* Paper commissioned for the 2019 Global Education Monitoring Report. Paris: UNESCO. https://nurturing-care.org/wp-content/uploads/2018/12/UNESCO.pdf.

Bourgois, Philippe, Seth M. Holmes, Kim Se, and James Quesada. 2017. "Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care." *Academic Medicine* 92 (3): 299-307. https://doi.org/10.1097/ACM.0000000000001294.

Brown, Matthew R. G., Vincent Agyapong, Andrew J. Greenshaw, Ivor Cribben, Pamela Brett-MacLean, Julie Drolet, Caroline McDonald-Harker et al. 2019. "Significant PTSD and Other Mental Health Effects Present 18 Months after the Fort McMurray Wildfire: Findings from 3,070 Grade 7-12 Students." *Frontiers in Psychiatry,* August 30, 2019. https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00623/full.

Burde, Dana, Heddy Lahmann, and Nathan Thompson. 2019. "Education in Emergencies: 'What Works' Revisited." *Education and Conflict Review* 2: 81-88. https://discovery.ucl.ac.uk/id/eprint/10081593/1/Burde_Article_14_Burde.pdf.

Cake, Susan, Emma Jackson, Eric Pineault, and Ian Hussey. 2018. *Boom, Bust, and Consolidation: Corporate Restructuring in the Alberta Oil Sands.* Edmonton: Parkland Institute. https://www.parklandinstitute.ca/boom_bust_and_consolidation.

Childcare Resource and Research Unit. 2020. *Emergency Child Care for Essential Workers.* Toronto: Childcare Canada. https://childcarecanada.org/resources/issue-files/child-care-and-covid-19-canada/emergency-child-care-essential-workers.

Cryderman, Kelly. 2016. "Fort McMurray Wildfires to Cost Insurers $3.6-billion." *The Globe and Mail,* July 7, 2016. https://www.theglobeandmail.com/report-on-business/fort-mcmurray-wildfire-damage-to-cost-36-billion-insurance-bureau/article30788517/.

Deering, Catherine Gray. 2000. "A Cognitive Developmental Approach to Understanding How Children Cope with Disasters." *Journal of Child and Adolescent Psychiatric Nursing* 13 (1): 7-16. https://doi.org/10.1111/j.1744-6171.2000.tb00070.x.

DiCarlo, Cynthia F., Diane C. Burts, Teresa K. Buchanan, Carol Aghayan, and Joan Benedict. 2007. "'Making Lemonade from Lemons': Early Childhood Teacher Educators' Programmatic Responses to Hurricanes Katrina and Rita." *Journal of Early Childhood Teacher Education* 28 (1): 61-68. https://doi.org/10.1080/10901020701224104.

Dorow, Sara, Marcella S. Cassiano, and Chad Doerksen. 2015. *Live-In Caregivers in Fort McMurray: A Socioeconomic Footprint.* Edmonton: On the Move Partnership. https://www.onthemovepartnership.ca/wp-content/uploads/2015/01/Live-in-Caregivers-in-Fort-McMurray-Report-Overview-Dorow-et-al-Jan-2015.pdf.

Drolet, Julie, and Amy E. Fulton. 2018. "Integrating Wellness and Self-Care in the Curriculum and Workplace: Perspectives of Community Influencers Engaged in Post-Flood Recovery in Alberta, Canada." *The International Journal of Learning: Annual Review* 25 (1): 1-11. https://doi.org/10.18848/1447-9494/CGP/v25i01/29-38.

Fernandez, Glenn, and Iftekhar Ahmed. 2019."'Build Back Better' Approach to Disaster Recovery: Research Trends since 2006." *Progress in Disaster Science* 1: 100-21. https://doi.org/10.1016/j.pdisas.2019.100003.

Freedy, John R., Heidi S. Resnick, and Dean G. Kilpatrick. 1992. "Conceptual Framework for Evaluating Disaster Impact: Implications for Clinical Intervention." In *Responding to Disaster: A Guide for Mental Health Professionals,* edited by Linda S. Austin, 3-23. Washington, DC: American Psychiatric Press.

Freedy, John R., Michael E. Saladin, Dean G. Kilpatrick, Heidi S. Resnick, and Benjamin E. Saunders. 1994. "Understanding Acute Psychological Distress Following Natural Disaster." *Journal of Traumatic Stress* 7 (2): 257-73. https://doi.org/10.1007/BF02102947.

Friendly, Martha. 2016. *Muttart Foundation: Childcare Resource and Research Unit*. https://www.muttart.org/wp-content/uploads/2017/02/Engaging-Alberta-Municipal-Level-Governments-122016.pdf.

Fulton, Amy E., and Julie Drolet. 2018. "Responding to Disaster-Related Loss and Grief: Recovering from the 2013 Flood in Southern Alberta, Canada." *Journal of Loss and Trauma* 23 (2): 140-58. https://doi.org/10.1080/15325024.2018.1423873.

Fulton, Amy E., Julie Drolet, Nasreen Lalani, and Erin Smith. 2020. "Prioritizing Psychosocial Services for Children, Youth and Families Postdisaster." *Disaster Prevention and Management* 29 (4): 591-607. https://doi.org/10.1108/DPM-09-2019-0310.

Global Facility for Disaster Reduction and Recovery. n.d. "Building Back Better in Post-Disaster Recovery Global Facility for Disaster Reduction and Recovery." Washington DC: World Bank. https://www.recoveryplatform.org/assets/tools_guidelines/GFDRR/Disaster%20Recovery%20Guidance%20Series-%20Building%20Back%20Better%20in%20Post-Disaster%20Recovery.pdf.

Gomez, Celia J., and Hirokazu Yoshikawa. 2017. "Earthquake Effects: Estimating the Relationship between Exposure to the 2010 Chilean Earthquake and Preschool Children's Early Cognitive and Executive Function Skills." *Early Childhood Research Quarterly* 38: 127-36. https://doi.org/10.1016/j.ecresq.2016.08.004.

Government of Alberta. 2016a. *Wildfire Update 1.* Edmonton: Government of Alberta. https://www.alberta.ca/release.cfm?xID=41701E7ECBE35-AD48-5793-1642C499FF0DE4CF.

Government of Alberta. 2016b. *Final Update 39: 2016 Wildfires.* Edmonton: Government of Alberta. http://www.alberta.ca/release.cfm?xID=41701E7ECBE35-AD48-5793-1642C499FF0DE4CF.

Government of Canada. 2020. *Preventing COVID-19 in the Workplace: Employers, Employees and Essential Service Workers.* Ottawa: Government of Canada. https://www.canada.ca/en/public-health/services/publications/diseases-conditions/preventing-covid-19-workplace-employers-employees-essential-service-workers.html.

Johnson, Lisa. 2020. "Fragile Child Care Sector in Alberta Hit Hard by COVID-19: National Survey." *Edmonton Journal.* https://edmontonjournal.com/news/politics/fragile-child-care-sector-in-alberta-hit-hard-by-covid-19-national-survey.

KPMG. 2017. *Regional Municipality of Wood Buffalo: Lessons Learned and Recommendations from the 2016 Horse River Wildfire.* Final Report. Amstelveen, Netherlands: KPMG International. https://www.rmwb.ca/en/community-services-and-social-support/resources/Documents Wildfire_Lessons_Learned.pdf.

Kulig, Judith, Kathy GermAnn, Naomi Parker, Valerie Salt, Doug Walker, and Cathie Scott. 2017. *Psychosocial Response and Recover Evaluation of the RMWB Wildfire 2016*. Final Report. Edmonton: PolicyWise for Children and Families. https://open.alberta.ca/dataset/cc0320fd-c107-48b5-a882-b62c4f9524ee/resource/3e7e2ac7-b038-49ac-925a-c74ef7d46f99/download/2017-08aug-29-rmwb-pss-final-report.pdf.

Langley, Audra Kae. 2000. "Coping Efforts and Efficacy, Acculturation, and Post-Traumatic symptomatology in Adolescents Following Wildfire: A Latent Variable Path Analysis." PhD diss., Virginia Tech. http://hdl.handle.net/10919/26473.

Marshall, Grant N., Terry L. Schell, Marc N. Elliott, Nadine R. Rayburn, and Lisa H. Jaycox. 2007. "Psychiatric Disorders among Adults Seeking Emergency Disaster Assistance after a Wildland-Urban Interface Fire." *Psychiatric Services* 58 (4): 509-14. https://doi.org/10.1176/appi.ps.58.4.509.

Masten, Ann S., and Joy D. Osofsky. 2010. "Disasters and Their Impact on Child Development: Introduction to the Special Section." *Child Development* 81 (4): 1029-39. https://doi.org/10.1111/j.1467-8624.2010.01452.x.

Muttart Foundation and Canadian Child Care Federation. 2020. *Early Learning and Child Care in Alberta: Results from a National Survey During the COVID-19 Pandemic*. Edmonton: Muttart Foundation. https://www.muttart.org/wp-content/uploads/2020/07/The-Pandemic-and-Early-Learning-and-Child-Care-in-Alberta-Final-July-20-1.pdf.

Office of Child Care. 2017. *How States and Territories Can Plan for Recovery*. Fairfax, VA: Office of Child Care. https://childcareta.acf.hhs.gov/sites/default/files/public/emergency_preparedness_response_and_recovery_planning_to_recover_0.pdf.

Office of Child Care, Administration for Children & Families. 2012. *Child Care Resources for Disasters and Emergencies*. Washington, DC: Office of Child Care, Administration for Children & Families. https://www.acf.hhs.gov/occ/resource/child-care-resources-for-disasters-and-emergencies.

Oxfam. 2020. *5 Natural Disasters That Beg for Climate Action*. https://www.oxfam.org/en/5-natural-disasters-beg-climate-action.

Paveglio, Travis, B., Chad Kooistra, Troy Hall, and Michael Pickering. 2016. "Understanding the Effect of Large Wildfires on Residents' Well-Being: What Factors Influence Wildfire Impact?" *Forest Science* 62 (1): 59-69. https://doi.org/10.5849/forsci.15-021.

Peek, Lori. 2008. "Children and Disasters: Understanding Vulnerability, Developing Capacities, and Promoting Resilience. An Introduction." *Children Youth and Environments* 18 (1): 1-29. https://www.jstor.org/stable/10.7721/chilyoutenvi.18.1.0001.

Press, Jordan, and Teresa Wright. 2020. "Feds Quietly Probe Expanded Role for Child Care in Post-Pandemic Recovery." *The Canadian Press,* May 18, 2020. https://www.ottawamatters.com/local-news/feds-quietly-probe-expanded-role-for-child-care-in-post-pandemic-recovery-2359034.

Proulx, Kerrie, and Frances Aboud. 2019. "Disaster Risk Reduction in Early Childhood Education: Effects on Preschool Quality and Child Outcomes." *International Journal of Educational Development* 66: 1-7. https://doi.org/10.1016/j.ijedudev.2019.01.007.

Public Safety Canada. 2019. *Emergency Management Strategy for Canada: Toward a Resilient 2030.* Ottawa: Public Safety Canada. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/mrgncy-mngmnt-strtgy/index-en.aspx.

Save the Children. 2017. *Windows into Early Learning and Development.* London: Save the Children International. https://idela-network.org/wp-content/uploads/2017/05/IDELA-REPORT-FINAL-4WEB-Cross-Country.pdf.

Shores, Elizabeth F., Cathy Grace, Erin Barbaro, Michelle Flenner, and Michael C. Barbaro. 2009. "Reducing Risks for Young Children: Indicators Research Can Guide Disaster Preparedness of the Early Childhood Sector." *Child Indicators Research* 2 (3): 293-301. https://doi.org/10.1007/s12187-009-9033-y.

Smith, Linda, Paula Davis, and Sheleen Dumas. 2010. *Protecting Children in Child Care During Emergencies.* Arlington, VA: National Association of Child Care Resources and Save the Children. http://www.ccc-nj.org/pdf/PROTECTING%20CHILDREN%20IN%20CHILD%20CARE%20DURING%20EMERGENCIES.pdf

Thurton, David. 2017. "Fort McMurray Faces Serious Shortage of Child-Care Workers." *CBC News*. January 12, 2017. https://www.cbc.ca/news/canada/edmonton/fort-mcmurray-early-child-care-worker-shortage-wildfire-1.3932745.

Thurton, David. 2019. "Fort McMurray Population Down Nearly 11 Percent Since Wildfire, Census Shows." *CBC News.* January 15, 2019. https://www.cbc.ca/news/canada/edmonton/fort-mcmurray-census-population-1.4978907.

Tough, Suzanne, Shivani Rikhy, Karen Benzies, Monica Vekved, Heather Kehler, and David W. Johnston. 2013. "Public Perceptions of Child Care in Alberta, Canada: Evidence for Policies and Practice from a Cross-Sectional Survey." *Journal Early Education and Development* 24 (4): 536-53. https://doi.org/10.1080/10409289.2012.689713.

United Nations. 2015. *Sendai Framework for Disaster Risk Reduction 2015-2030.* Geneva: UN Office for Disaster Risk Reduction. https://sustainabledevelopment.un.org/content/documents/2157sendaiframeworkfordrren.pdf.

YMCA. 2020. *YMCA Child Care.* Fort McMurray, Alberta: YMCA of Northern Alberta. https://northernalberta.ymca.ca/Regions/Wood-Buffalo/Fort-McMurray/YMCA-Eagle-Ridge-Child-Care.

Zero to Six Collaborative Group, National Child Traumatic Stress Network. (2010). *Early Childhood Trauma.* Durham, NC: National Center for Child Traumatic Stress. https://www.nctsn.org/resources/early-childhood-trauma.

JOURNAL ON EDUCATION IN EMERGENCIES

Home Visiting in the Middle East: Reflections on the Implementation of Reach Up and Learn

Author(s): Katelin Swing Wilton, Aimée Vachon, Katie Maeve Murphy, Ayat Al Aqra, Abdullah Ensour, Iman Ibrahim, Anas Tahhan, Kayla Hoyer, and Christine Powell

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 80-95

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62222

DOI: https://doi.org/10.33682/pzjw-p1nc

REFERENCES:

HOME VISITING IN THE MIDDLE EAST: REFLECTIONS ON THE IMPLEMENTATION OF REACH UP AND LEARN

Katelin Swing Wilton, Aimée Vachon, Katie Maeve Murphy, Ayat Al Aqra, Abdullah Ensour, Iman Ibrahim, Anas Tahhan, Kayla Hoyer, and Christine Powell

ABSTRACT

In this field note, we make a case for adapting Reach Up and Learn, an evidence-based home-visiting intervention, to the needs of refugees, internally displaced persons, and other vulnerable populations in the conflict-affected settings of Jordan, Lebanon, and northeastern Syria. We outline the implementation of the intervention in all three countries and share our observations, including successes and challenges, from the first two years (2016 and 2017) of this multiyear project. We also provide insights into the country-by-country evolution of the project. We compare and contrast the adaptation approaches in each country and highlight innovations based specifically on in-country feedback. We also touch on the measurement and costing approaches for the intervention, noting the ways the project is contributing to the limited body of evidence in this area. We offer specific recommendations for additional research to generate evidence on early childhood development in humanitarian programming, and we conclude with an overview of the next stage of the Reach Up and Learn project, which is part of a wider initiative to improve the developmental outcomes of children in the region who are affected by crisis and conflict.

INTRODUCTION

In 2018, more than 29 million babies were born in situations of conflict (UNICEF 2019). In situations of conflict and displacement, which are characterized by high levels of stress and insecurity, caregivers rarely receive support in providing nurturing care to their young children. Offered by the International Rescue

Received October 18, 2019; revised March 7, 2020; accepted April 15, 2020; electronically published June 2021.

Journal on Education in Emergencies, Vol. 7, No. 1

ISSN 2518-6833

Committee (IRC), the Reach Up and Learn program (henceforth, Reach Up) is a comprehensive home-visiting program for children ages 6 months to 3 years, and their caregivers. Designed to strengthen caregivers' capacity to provide enhanced play-based early learning opportunities for children, this program takes a novel approach to early childhood development (ECD) support by integrating ECD home visits into existing services within the humanitarian response.

In this note, after providing a brief background on the Syrian crisis and the need for ECD programming in the region, we offer an overview of Reach Up's programmatic approach and a description of the unique, iterative adaptation and implementation process that occurred in each of the three countries. We also provide key details about how the program evolved in the first two years of implementation. In the following sections, we discuss the lessons learned, present emerging results from the program in each country (see Figure 1), and make recommendations for future work.

Figure 1: Map of Syria, Lebanon, and Jordan Noting IRC's Reach Up Implementation Locations

Source: Sunghee Cho/IRC

THE SYRIAN CRISIS AND THE NEEDS OF CAREGIVERS OF YOUNG CHILDREN

Since 2011, the Syrian crisis has led to the mass displacement of nearly 11 million people, including over 6 million displaced persons within the country and more than five million Syrian refugees. Refugees and other displaced people typically live in camps, informal settlements, or peri-urban environments (UNHCR 2019).

The impact of the Syrian refugee crisis is notable for many reasons, but the impact on children is especially grave. Nearly half (45%) of all Syrian refugees are children age 17 or younger; as of September 2019, 15.7 percent of Syrian refugees were under 5 years old (UNHCR 2019). The adverse effects of war, violence, and/or displacement on young children, especially those under age three, have been well documented. Young children born into environments in which they have numerous adverse experiences, such as exposure to violence, chronic disease, or a lack of opportunities, are statistically more likely to have poor health outcomes and a level of wellbeing relative to the level of trauma they have endured (Felitti et al. 2019). With the lack of frequent responsive interactions with caregivers and the presence of stressors such as poverty and violence, children can develop a toxic stress response, which is a disruption of critical biological and neurological processes during the foundational stages of development. Toxic stress at an early age can have profound long-term consequences for children's development that increase their risk for poor physical and mental health outcomes, cognitive deficits, and, later, reduced earnings (Shonkoff et al. 2012).

There also is evidence of the significant impact war, violence, and/or displacement have on caregivers' wellbeing, specifically on their ability to provide responsive care for their children and engage in early learning activities. There are a number of factors and circumstances that adversely affect caregivers living in conflict settings, such as loss of community ties, financial hardship, mental and physical health problems, and environmental challenges. Fortunately, evidence shows that parenting programs can have a positive influence on caregiver practices and promote resilience in both caregivers and children living in conflict settings (Murphy, Yoshikawa, and Wuermli 2018).

The Nurturing Care for Early Childhood Development framework (WHO 2018) has identified the provision of holistic early learning services as an essential need for children under the age of three who have been affected by conflict. Parenting interventions such as Families Make the Difference, a group session for parents of children from birth to age eight, have proven effective (Puffer et al. 2015), but

few programs address the specific needs of children from birth to age three and their families, particularly in conflict settings. Only 27 humanitarian-response plans created by relevant United Nations agencies and country governments to respond to sudden-onset crises requiring international humanitarian assistance include ECD, and little evidence has been generated on effective programming; only four impact evaluations have been conducted of parenting interventions in humanitarian settings (Murphy et al. 2018; UNESCO 2018, 138-39). As a result, displaced families are left without critical support during the most pivotal period in their children's development.

REACH UP AND LEARN

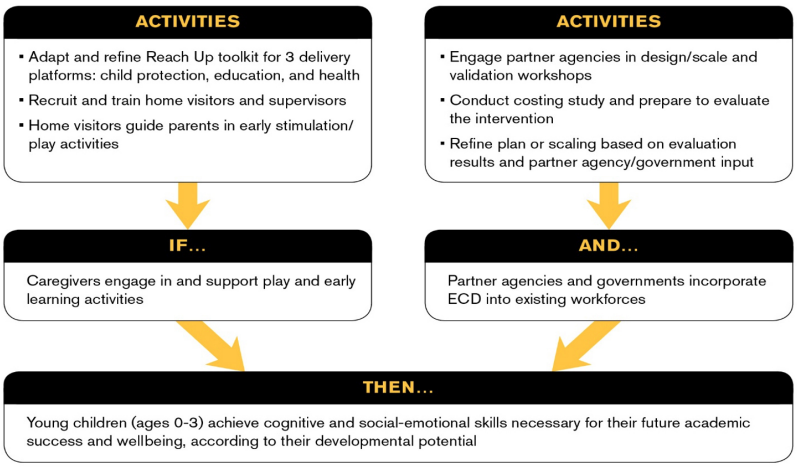
Reach Up is an early childhood home-visiting program designed to help caregivers support their children's healthy development. The program is based on an ECD intervention known as the Jamaican Home Visiting Program, created at the University of the West Indies. The studies conducted on the intervention in Jamaica documented the positive impact home visiting had on psychosocial support and cognitive stimulation for children ages 9 months to 24 months. While the studies recommended weekly home visits, they noted that visits every other week could also have a positive effect (Grantham-McGregor et al. 1991; Powell and Grantham-McGregor 1989). Later research included longitudinal follow-up studies, which documented the significant positive impact the program had on cognitive ability, mental health, and labor market returns (Gertler et al. 2014; Walker et al. 2011). Since its creation, Reach Up has been adapted and implemented in more than 13 countries.

The Reach Up toolkit provides a training manual for community members who want to become home visitors. The kit includes a structured play-based curriculum that prepares new home visitors to guide parents in doing early learning activities with their children. The program consists of weekly or biweekly home visits that last about one hour, in which the focus is on play and on building the caregiver's self-confidence. Playful early learning activities are introduced and scaffolded over a series of visits.

The home visitor demonstrates these activities in the caregiver's home, and then, while the caregiver practices them with their child, the home visitor offers support and praise. This "demonstrate, practice, praise" approach creates an environment in which both the caregiver and the child feel supported in their actions while being introduced to new learning opportunities. One major feature of this home-

visiting approach is the empowerment of the caregiver, which lays the groundwork for them to have a long-lasting impact on the whole family, as reflected in the program's theory of change (see Figure 2).

Figure 2: The Reach Up Theory of Change



Source: Katelin Wilton, Sunghee Cho/IRC

Despite the numerous adaptations of Reach Up that were implemented before this iteration for displaced communities in the Middle East, it had never been implemented as part of a humanitarian response. The current iteration benefits from earlier experience, but it was adapted specifically to address the unique needs of vulnerable children and caregivers in the Middle East. Given the IRC's extensive experience supporting parents and children in conflict-affected regions, the magnitude of the Syrian refugee crisis, and the dearth of ECD programming in emergency contexts, the Reach Up program was an ideal way to support parents in giving their children nurturing care.

Reach Up Phase One

Inception Research and Jordan Pilot

Beginning in 2016, the IRC conducted preliminary research in Jordan and Lebanon to identify how to address the needs of caregivers of young children in the wake of the Syrian refugee crisis. This work focused on understanding the interest in and availability of parenting support for Syrian caregivers living in displacement, the need to adapt evidence-based program models to promote uptake and reach scale, and

potential program costs. The findings showed not only that there were opportunities to support caregivers but that there was a demand for such programming among Syrian families. Specifically relevant to Reach Up were the findings showing that robust family-based social networks and the cultural tradition of hosting frequently meant that the community would welcome home visits.

As part of this research, a two-month pilot of Reach Up was conducted in December 2016 in the Azraq refugee camp in northern Jordan, where outreach volunteers were already making home visits to raise awareness about child-protection services. A short training was conducted before starting the pilot, during which eight volunteers visited sixteen families in order to determine the feasibility and acceptability of the model and what adaptations were needed to carry it out. A feedback questionnaire was distributed to all parents at the end of the pilot, on which they reported that their children "loved everything about the home visits." Parents also reported that, after participating in the program, they were more likely to praise their children (94%), talk to their children (81%), involve their children in household activities (68%), and play with their children (62%). Following the success of the pilot, Reach Up was expanded in the Azraq camp through the child-protection sector. A three-month pilot was then conducted in the Akkar and Bekaa governorates in Lebanon through the education sector, which built on existing relationships between families and staff that had been established through community-based preschool programs.

Training of Trainers and Program Adaptation

Members of the Reach Up and Learn team in Jamaica conducted a training of trainers for Reach Up in February 2017 to prepare for the program launch and to begin the process of adapting the program for the Syrian families. The adaptation focused on identifying delivery platforms within the IRC, planning to contextualize materials such as storybooks, and assessing the cultural relevance of the curriculum activities.

An initial key step was translating the curriculum into Arabic, the overarching language of the region. It was professionally translated into Modern Standard Arabic, reviewed by the Arabic Resource Collective for technical accuracy and regional dialect considerations, and, finally, adapted for tone and cultural relevance by IRC staff in the region.

IRC teams tested and confirmed that the adapted content was culturally relevant to both the Syrian refugees and the host communities, and to their living circumstances. The training manual went through several changes, including adding guidance on working with displaced populations in the region. This included working with large families who had multiple children in the home, a common occurrence among the Syrian population. To reflect the particular needs of the population, new content was added to the training to address caregiver wellbeing (stress management, coping strategies, and self-care messaging), safeguarding children, identifying signs of abuse (in particular violence against women or children), referring families to protective services, and using positive discipline.

The IRC worked with the Jamaican Reach Up team and Jordanian artists to adapt the pictures and storybooks used in the curriculum to the specific context. This included changing illustrations to feature locally relevant objects and environments. A key feature of Reach Up is toymaking, where home visitors use a detailed guide to make their own toys for the people they visit. The toymaking went through an exhaustive adaptation process, which involved identifying local materials for every activity in the curriculum. Local adaptations included making rattles from hair gel containers, trucks out of cardboard, and sheep dolls from cotton and cardboard. Local songs that were known and loved were added to each home-visit agenda.

Expansion into Northeastern Syria

In mid-2017, the IRC's northeastern Syria office reached out to the education technical unit about expanding the program through the child-protection sector. In late 2017, following a training for Syrian child-protection staff and additional adjustments to the curriculum and materials, a weekly visiting program was launched in several internally displaced person camps and in urban areas where displaced Syrians were living. In mid-2018, Reach Up expanded into Jordan, where it built on existing community health home-visiting services offered by the IRC. Working in close collaboration with the health sector, the program was expanded to the Mafraq governorate as an integrated ECD and community health home-visiting model. The home visits continued for one year, through June 2019, which ended the first phase of implementing Reach Up in the Middle East.

SUMMARY OF LESSONS LEARNED

Given the vastly different locations, number of people reached, and, in the case of northeastern Syria, the participants' varied backgrounds, the multicountry implementation of Reach Up produced numerous lessons.

Implementation

During the multicountry implementation of Reach Up, it became apparent that the curriculum and its delivery required further adaptation. For example, changes made to the storybooks reflected tentlike accommodations and apartment living, desert vegetation, and local animals and products. Since the program operates in peri-urban areas, tented settlements, and camp settings, it was a particular challenge to create the widely relevant visual content needed. However, the translations were well received, and the northeastern Syria program reported that the availability of translated materials eased their program start-up.

Challenges remained around making and using toys for the program. We learned that toymaking was more time-consuming for home visitors than we originally anticipated, so we had to allocate more time for them to prepare the toys for their visits. We also found that some materials were not as easy to collect as we had anticipated because recycling was not common in Jordan. In the Azraq camp, for example, distribution changes led to a shortage of the shampoo bottles they had used to make toy cars. We resolved this unexpected issue by encouraging IRC staff to participate in office recycling.

One of the most interesting lessons came from northeastern Syria, where the unique challenges of an insecure and low-literacy population led us to create an illustrated guide for parents, which depicted the home-visiting curriculum using almost no words. Originally conceived as a stopgap solution for replacing physical visits if unsafe conditions arose, we found that the visual format lent itself well to being a supplement for any Reach Up home visit, provided it could be printed at a low cost. The northeastern Syria team is piloting this product with community-led ECD committees.

Another adaptation was the use of a tablet-based software to deliver Reach Up in Jordan's health sector. Originally designed for community health volunteers, the tablet automatically alerted home visitors to the appropriate activity for a child, based on their registered age. The system collected a number of key data points, which allowed

for easier collection of program performance data. However, before we scale the use of tablets, we will need to resolve some lingering design challenges.

While several implementation challenges were unique to the specific contexts, some challenges occurred across all the programs in Jordan, Syria, and Lebanon, such as those related to training issues, staff retention, and supervision of home visits. The Reach Up training lasted ten days, after which trainees could conduct home visits, with periodic supervision. This time commitment was difficult for the trainers, who had many competing program management responsibilities. In several contexts, for example, due to work restrictions for refugees, home visitors were paid a stipend by the host government, rather than becoming staff members. This contributed to high staff turnover, which created a need for ongoing training. To combat the high turnover, Reach Up teams developed stand-by rosters of trained home visitors who were ready to be hired as needed. The biggest impact of staff turnover was a lack of fidelity to the Reach Up method and difficulty providing high-quality oversight. To help alleviate this challenge, the IRC created home-visitor learning circles, a peer-to-peer professional development model originally used with teachers. Supervisors hosted the learning circles monthly to help home visitors strengthen their practice, encourage them to share their challenges, and foster a sense of community. Learning circles have been implemented informally in Lebanon and are being rolled out in northeastern Syria and Jordan.

Another universal challenge was participant recruitment, though the core drivers were slightly different across contexts. In Lebanon and Jordan, an economic downturn heightened caregiver reports of financial stress, which led people to consider early learning a lower priority for their family than their financial challenges. Home visitors who made a persistent effort to overcome recruitment challenges by first engaging their neighbors in the program were able to build greater community rapport and to enroll participants who were initially doubtful.

Emerging Results

As of December 2019, the Reach Up program had reached more than 4,399 children and 4,025 caregivers in the three countries: the Jordan health teams served 1,725 children and 1,669 caregivers, the Lebanon team served 320 caregivers, and the northeastern Syria program served 1,748 children and 1,530 caregivers.

We used three assessments: the Caregiver Reported Early Childhood Development Instruments (CREDI) short form to measure child development, a caregiver questionnaire that asked about caregiver knowledge and the practices developed

by the IRC, and the supervisor checklist for assessing home visitors' performance, which the Reach Up team had developed as part of the toolkit. Data from Jordan and Lebanon are presented in Tables 1 and 2.

Table 1: CREDI Data from Jordan and Lebanon

	Lebanon, May-July 2018	Jordan, December 2018-July 2019
Total number of respondents	312	307
Percentage of respondents whose scores improved between baseline and endline	92	82
Average improvement in scores between baseline and endline	7	13

Source: IRC

Table 2: Specific Item Performance from Caregiver Questionnaire in Lebanon, May-July 2018

Techniques that you use with your child to support their learning and development			Children's books or picture books given to child at home in the past week		
Number of techniques	Percentage of respondents at baseline	Percentage of respondents at endline	Number of books	Percentage of respondents at baseline	Percentage of respondents at endline
0	26	0	0	87	12
1	11	8	1	7	47
2	12	30	2	3	24
3	51	62	3	2	17

Source: IRC

The Lebanon pilot showed overall improvement in child, caregiver, and home-visitor performance across all three measures. Caregiver practices improved significantly for a number of items, with notable spikes occurring at the lowest levels of engagement. For example, at baseline, only 26 percent of parents reported using techniques (e.g., reading books, singing songs) to support their child's development. By endline, 92 percent of parents reported using two or three techniques (the highest possible response being three), with no families reporting using none. Home-visitor performance also improved significantly during the pilot period, according to the Reach Up supervision checklist, with 87.5 percent of home visitors showing improvement between baseline and endline. Finally,

92 percent of the children showed improved CREDI scores between baseline and endline. The strong performance by both children and home visitors on their respective measures suggests a holistically sound model that is effectively addressing the needs of children and their families.

In Jordan, on the other hand, 82 percent of children showed improvement in their CREDI scores between baseline and endline, with an average improvement of 13 percent. While the overall improvement rate was lower than the pilot in Lebanon, average improvement was higher, up from the Lebanon pilot's 7 percent average improvement.

SUCCESS STORIES

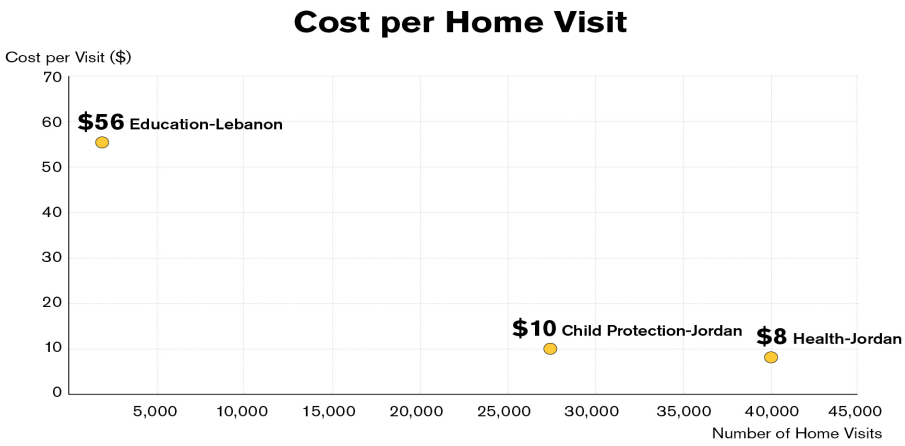
Anecdotal reports of the program's success came directly from both caregivers enrolled in the program and the home visitors who delivered it. Caregivers, both male and female, repeatedly reported delight and surprise when they saw how quickly their young children progressed in the program, commenting that their children had exceeded their expectations or their general understanding of young children's capacities. In northeastern Syria, where some families had been exposed to violence more recently, home visitors noted that many caregivers were shocked to see their young children begin to speak after receiving home visits. This success led to a high demand for the program in the area. Following the trainings and the time they spent visiting families, home visitors in all three contexts reported feeling fulfilled by their work. Upon conclusion of the Lebanon pilot, some home visitors went on to work as facilitators in early childhood education centers, noting anecdotally that children who had received the home visits entered the classroom more prepared to learn and socialize.

Costing

To reach the largest number of children with a limited budget, we assessed how the cost to deliver Reach Up varied among the three integrated models: education, child protection, and health. The models, which distributed the same content, cost from US$8 to US$56 (2019 dollars) per home visit (see Figure 3). The difference in cost was driven by the scale each team achieved rather than by any intrinsic feature of the programs within which Reach Up was integrated. We concluded

that the critical factor in choosing an efficient Reach Up delivery method is the scale in a given context; however, "scale" has many dimensions. Our health team was efficient, due to the large number of home visitors working on ECD and delivering health messages. The child-protection team was efficient, due to their visiting homes twice as often so they could spend more time on ECD. Having shown that both health and child protection can deliver Reach Up at a reasonable cost per home visit, future scale decisions will focus on the tradeoffs between the health team's geographic reach and the amount of time the child-protection team can dedicate to ECD.

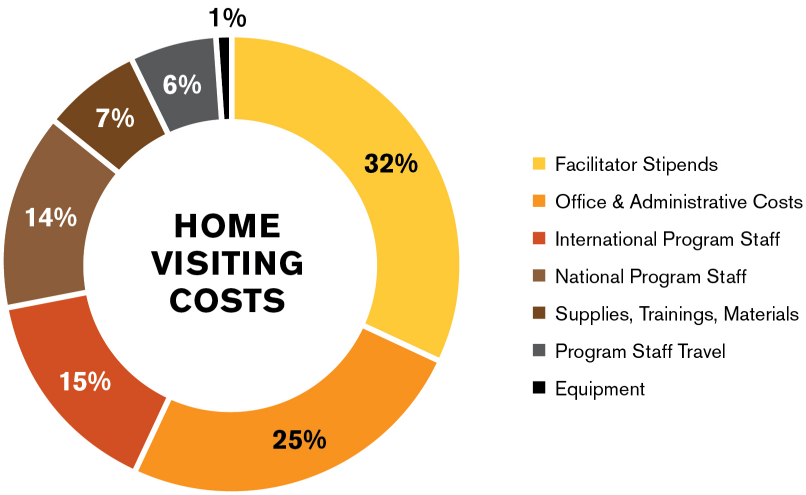
Figure 3: Cost per Home Visit across the Three Integrated Models



Source: IRC

While the human resource costs of home visiting may appear to be high relative to the local context (see Figure 4), such costs are associated with long-term returns on investment and gains made across multiple domains of human development (Gertler et al. 2014; Richter et al. 2017). The return on investment for early childhood care and education in Jordan, for example, is estimated at US$9-US$17 per every dollar invested (Fink et al. 2017). Federal governments in Latin America recently demonstrated the effective large scale-up of Reach Up adaptations, such as Cuna Mas in Peru.

Figure 4: Average Cost of the Three Integrated Home-Visiting Models



Source: IRC

REFLECTIONS AND RECOMMENDATIONS

In this field note, we have attempted to show both the value of and the problems encountered in implementing the Reach Up program to address the immense challenges of child and caregiver wellbeing presented by the Syrian refugee crisis. Through a multistage adaptation process, the program has grown and evolved to address the challenges faced by parents across this conflict-affected region. The results emerging from the first phase of programming have been encouraging. Ahlan Simsim, a partnership between Sesame Workshop and the IRC that launched in 2018, is bringing ECD programming to the Middle East, which will enable the IRC to forge local partnerships to scale Reach Up across the region. The new phase of programming will further explore and build on lessons learned.

The early work of this program suggests that Reach Up is a promising approach to ECD programming in humanitarian contexts. Recommendations for future iterations of this type of programming are as follows:

- Further innovation around training delivery is needed for ECD home visiting in humanitarian settings. Adaptations to shorten the training time should be tested, while also clarifying early on that the Reach Up training is longer and more comprehensive than the humanitarian actors may expect.

    - Trainings should be held on a regular basis to account for expected home-visitor turnover, due to the highly mobile nature of conflict-affected populations.

    - New training modalities should be piloted, such as training in phases or partial online training, to shorten program start-up.

- Home visitors should be equipped with up-to-date referral information so they can address caregivers' basic needs, particularly financial needs, by referring them to other services, particularly in contexts where caregivers are highly vulnerable.

- The early supervision and coaching of home visitors should reinforce the focus on changing caregivers' behavior. Since home visiting includes working directly with children, it can be confusing for home visitors to understand that supporting the caregiver should be a primary focus, but this challenge can be overcome through close supervision.

- The immersive nature of this model, with home visits lasting up to one hour, means that caseloads should be kept low—three to four visits per day—to reduce home visitors' fatigue and preserve the quality of their work.

- In the case of a multisectoral delivery approach, close collaboration with other sectors is vital to program success, as it will ensure that lessons are shared and that challenges can be addressed collaboratively. Learning circles can help facilitate this and orient the home visitors toward a shared vision of improving families' outcomes.

- The cost of home visiting should be analyzed regularly, and program managers should consider whether it is more advantageous to integrate with programs that have the greatest geographic reach, or with the more targeted or small-scale programs where the cost per family is greater.

Future evaluations will lead to additional learning about the impact of this program and inform what programming modalities are most cost-effective, scalable, and sustainable. The promising early stage results from the Lebanon pilot and the Jordan data collection, as well as positive feedback from families in all three countries, have laid the foundation for a planned impact evaluation that will measure the Jordan health sector's implementation of Reach Up. The evaluation will contribute important new findings to the limited body of evidence

on ECD in emergency settings that targets caregivers, infants, and toddlers. Such new evidence will be critical, not only to advocacy and funding efforts but to bringing the humanitarian community closer to its collective goal of improving child and caregiver outcomes in situations of conflict and crisis.

REFERENCES

Felitti, Vincent J., Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss, and James S. Marks. 2019. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study." *American Journal of Preventive Medicine* 14 (4): 245-58. https://doi.org/10.1016/S0749-3797(98)00017-8.

Fink, Günther, Dana C. McCoy, Hala I. Hatamleh, Helena Pylvainen, Alexandra Chen, and Ghazi Al-Assaf. 2017. "Economic Implications of Investing in Early Childhood Care & Education in Jordan." Working Paper No. 1. Amman, Jordan: Queen Rania Foundation.

Gertler, Paul, James Heckman, Rodrigo Pinto, Arianna Zanolini, Christel Vermeersch, Susan Walker, Susan M. Chang, and Sally Grantham-McGregor. 2014. "Labor Market Returns to an Early Childhood Stimulation Intervention in Jamaica." *Science* 344 (6187): 998-1001. https://doi.org/10.1126/science.1251178.

Grantham-McGregor, Sally M., Christine A. Powell, Susan P. Walker, and John H. Himes. 1991. "Nutritional Supplementation, Psychosocial Stimulation, and Mental Development of Stunted Children: The Jamaican Study."*The Lancet* (8758): 1-5. https://doi.org/10.1016/0140-6736(91)90001-6.

Murphy, Katie Maeve, Hirokazu Yoshikawa, and Alice J. Wuermli. 2018. "Implementation Research for Early Childhood Development Programming in Humanitarian contexts." *Annals of the New York Academy of Sciences* 1419 (1): 90-101. https://doi.org/10.1111/nyas.13691.

Powell, Christine, and Sally Grantham-McGregor. 1989. "Home Visiting of Varying Frequency and Child Development."*Pediatrics* (1): 157-64.

Puffer, Eve S., Eric P. Green, Rhea M. Chase, Amanda L. Sim, John Zayzay, Elsa Friis, Eduardo Garcia Rolland, and Laura Boone. 2015. "Parents Make the Difference: A Randomized-Controlled Trial of a Parenting Intervention in Liberia."*Global Mental Health* https://doi.org/10.1017/gmh.2015.12.

Richter, Laura M., Bernadette Daelmans, Joan Lombardi, Jody Heymann, Florencia Lopez Boo, Jere R. Behrman, Chunling Lu et al. 2017. "Investing in the Foundation of Sustainable Development: Pathways to Scale Up for Early Childhood Development." *The Lancet* 389 (10064): 103-18. https://doi.org/10.1016/S0140-6736(16)31698-1.

Shonkoff, Jack P., Andrew S. Garner, Benjamin S. Siegel, Mary I. Dobbins, Marian F. Earls, Laura McGuinn, John Pascoe et al. 2012. "The Lifelong Effects of Early Childhood Adversity and Toxic Stress." *Pediatrics* 129 (1): e232-46. https://doi.org/10.1542/peds.2011-2663.

UNESCO (UN Educational, Scientific, and Cultural Organization). 2018. *Global Education Monitoring Report 2019: Migration, Displacement, and Education—Building Bridges, not Walls.* Paris: UNESCO https://doi.org/10.18356/63d08c20-en.

UNHCR (UN High Commissioner for Refugees). 2019. "Operations Data Portal: Syria Regional Refugee Response." Online Data Resource.

UNICEF (UN Children's Fund). 2019, September 19. "29 Million Babies Born into Conflict in 2018." Press Release. https://www.unicef.org/press-releases/29-million-babies-born-conflict-2018.

Walker, Susan P., Susan. M. Chang, Marcos Vera-Hernández, and Sally Grantham-McGregor. 2011. "Early Childhood Stimulation Benefits Adult Competence and Reduces Violent Behavior." *Pediatrics* 127 (5): 849-57. https://doi.org/10.1542/peds.2010-2231.

WHO (World Health Organization). 2018. *Nurturing Care for Early Childhood Development: A Framework for Helping Children Survive and Thrive to Transform Health and Human Potential.* Geneva: WHO.

JOURNAL ON EDUCATION IN EMERGENCIES

Building Resilience and Mitigating the Impact of Toxic Stress in Young Children: A Model for Transforming Parenting and Male Caregiving in El Salvador

Author(s): Fabiola A. Lara

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 96-111

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62224

DOI: https://doi.org/10.33682/29xd-8cq5

REFERENCES:

BUILDING RESILIENCE AND MITIGATING THE IMPACT OF TOXIC STRESS IN YOUNG CHILDREN: A MODEL FOR TRANSFORMING PARENTING AND MALE CAREGIVING IN EL SALVADOR

Fabiola A. Lara

ABSTRACT

El Salvador is one of the most violent countries in the world, with one of the highest homicide rates among children and adolescents (UNODC 2019). Children's experiences have a profound impact on their development, and exposure to violence in their early years can lead to social, behavioral, learning, and emotional impairments. Caregivers play a critical role in shielding children from damaging experiences and in promoting their positive development (Shonkoff and Phillips 2000). This field note discusses program initiatives led by Save the Children that helped to mitigate the impact of violence on young children in three departments (states) in El Salvador. We developed what we call the Toxic Stress Mitigation Model that consists of three approaches: building resilience, promoting positive parenting, and providing transformative male caregiving in children's early years. Employing an integrated process comprising multiple sectors, including education, child protection, and health and nutrition, from September 2017 to September 2019 we implemented the three approaches in existing and newly formed preschool- and community-based delivery platforms for children ages 1-6 and their families. In this field note, I explore how the platforms engaged the children's primary and secondary caregivers, such as community health workers, volunteer group facilitators, and teachers, and examine the implications of these platforms for the field, and for early childhood and development policy more broadly. I specifically examine how these platforms ensure that programming and research go beyond child development and wellbeing in order to adequately address the wellbeing and other needs of both primary and secondary caregivers.

Received October 31, 2019; revised May 15, 2020; accepted March 17, 2021; electronically published June 2021.

Journal on Education in Emergencies, Vol. 7, No. 1

ISSN 2518-6833

VIOLENCE IN EL SALVADOR

El Salvador has one of the world's highest homicide rates. It is also one of the five countries with the highest homicide rates among children, four of which are in the Latin America and Caribbean region (Geoghegan 2019). Violence in El Salvador is driven by gangs and other criminal armed groups that are fighting for territorial control. They use violent methods to coerce individuals, including children, into gang activity and to extort money from residents of highly vulnerable municipalities across the country (Human Rights Watch 2019). Children in these areas experience poverty, forced displacement, natural disasters, sexual violence, and homicide in their homes, at school, and in their communities. Appallingly, at least one child is murdered every day in El Salvador (OHCHR 2018). Men in El Salvador, who are recognized as the main perpetrators of this violence, are driven by patriarchal attitudes and stereotypes (Menjivar 2014) that normalize violence against women. Half of the women ages 15 to 25 in El Salvador believe that men are inherently violent in nature, and because of this they endure their violent relationships (Ruiz and Sobrino 2018).

SAVE THE CHILDREN'S PROGRAMMING IN EL SALVADOR

Save the Children has been implementing early childhood care and development (ECCD) programming in El Salvador for more than ten years. During this time, we developed and tested the Essential Package, an integrated ECCD program for children ages 0-6. The program provides health and nutrition, education, and protection support and services in four of the country's 14 departments (states). It specifically targets children and their families who are living in highly vulnerable areas. Our ECCD programming in El Salvador works in conjunction with services offered by the ministries of health, protection, and education. Taking a community-based approach, the Essential Package program works directly with children and their families—the primary caregivers—and with their secondary caregivers—community health workers, volunteer group facilitators, teachers, etc. We work across the program's three key platforms: Family Circles (*círculos de familia*), Rotating Book Clubs (*rotación de libros*), and preschool classrooms (*parvularia*). Family Circles, which is focused on children ages 0-3 and their families, engages primary caregivers in a series of activities related to health, nutrition, and early childhood stimulation. The Rotating Book Clubs target preschool-age children (ages 4-6) who, due to their remote location, lack access to preprimary education. The clubs engage children and their primary caregivers

in literacy-based activities that cover topics such as health and nutrition, math, and art. The Essential Package is also implemented in preschool classrooms, primarily to support teachers by providing training and content support around topics similar to those covered by the Rotating Book Clubs.

In this field note, I describe how Save the Children developed and implemented its Toxic Stress Mitigation Model (hereafter the Model) in El Salvador from September 2017 to September 2019. The evidence-based Model was integrated into the Essential Package through its three platforms, described above. An additional platform, Active Fatherhood (*paternidad activa*), was established exclusively for male caregivers. Its primary aim is to mitigate the effects of violence—in particular toxic stress—on children ages 1-6. The Model aims to enhance children's early development by helping them develop the skills they need to process their experiences, which also prepares them to deal with future adversity. The Model also aims to give primary and secondary caregivers ways to manage their own stress and wellbeing while engaging in activities to enhance their relationships with their children. The Model is based on the premise that, if children have at least one stable, nurturing, supportive bond with an adult caregiver, the negative effects of their harmful experiences can be altered (National Scientific Council on the Developing Child 2015). Through this project, we reached more than 12,500 children in El Salvador and approximately 17,000 of their primary and secondary caregivers.

In this article, I first provide a contextual overview of the violence and other adversity children in El Salvador are exposed to. I then describe the three approaches of the Toxic Stress Mitigation Model—building resilience in young children, promoting positive discipline methods to primary and secondary caregivers, and transforming male caregivers' engagement in ECCD. Next, I offer an overview of our experience piloting the Model, including various stakeholders' perspectives. I close with lessons learned during implementation of the Model and reflections on future considerations for its application in ECCD policy and practice.

MITIGATING TOXIC STRESS IN YOUNG CHILDREN IN EL SALVADOR

There is strong consensus that experiencing toxic stress and being exposed to violence in the early years of life have a negative impact on children's physical, emotional, cognitive, and social development. The response to toxic stress,

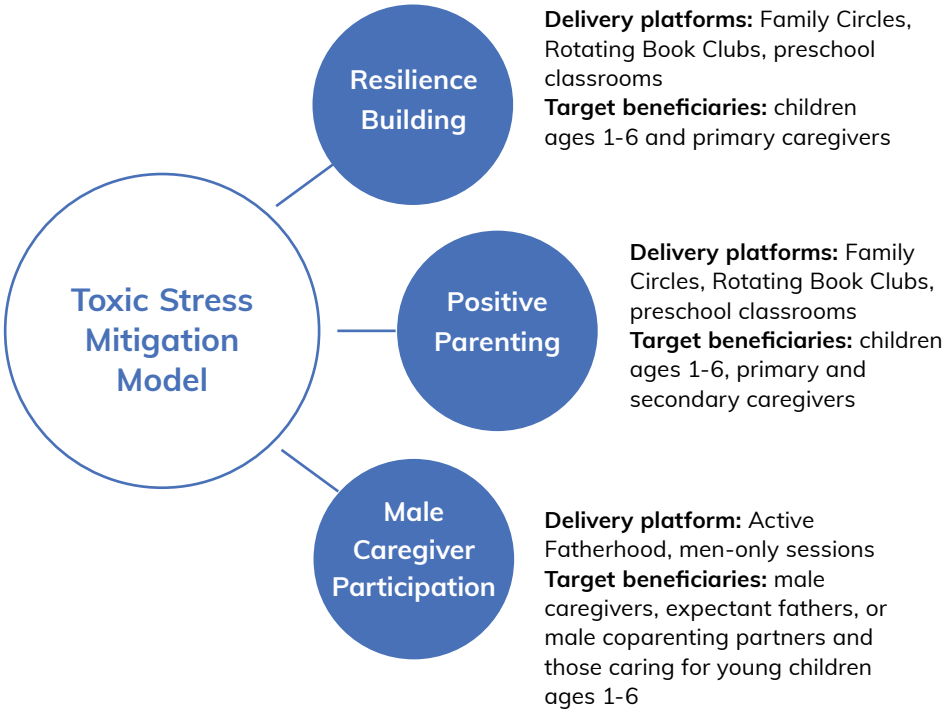
which differs from the response to normal stress, is a result of the continuous or prolonged activation of an individual's stress response system due to adverse experiences and the absence of protective relationships (Franke 2014). Having such adverse experiences in the postnatal period—particularly in the early childhood years, the peak time of brain development—negatively alters a person's neural circuitry and poses a threat to their health and wellbeing over the life course (Shonkoff and Garner 2012; Murphy and Bartlett 2019). Young children exposed to violence, natural disasters, and other adverse experiences need opportunities to build resilience, which can help to mitigate the negative developmental effects of such experiences (Guerra et al. 2012).

In the context of El Salvador, helping primary caregivers establish emotional attachments and bonding relationships with their children and enhancing their ability to provide nurturing and supportive care enables them to help their children build the resilience they need to break intergenerational cycles of adverse experiences (Woods-Jaeger et al. 2018). Positive relationships between children and their fathers or other male caregivers are especially critical for children's development, particularly in contexts where men are the main perpetrators of violence. Children with supportive male figures in their lives tend to be happier, more confident, eager to try new things, and to demonstrate empathy toward others (Pruett 2000; Allport et al. 2018). Men who are involved in their children's lives in meaningful ways and have nonviolent relationships with their children and coparenting partners are also less likely to engage in risky behavior, such as violent and criminal activities (Barker and Verani 2003; Charles et al. 2018).

Toxic Stress Mitigation Model

To support children and families in El Salvador who face adversity, Save the Children developed the Toxic Stress Mitigation Model to enhance its programming by focusing specifically on mitigating the effects toxic stress has on young children. The Model features three approaches that aim to build resilience skills in young children, promote positive parenting and discipline strategies among primary and secondary caregivers, and transform men's practices and norms during their participation in ECCD.

Figure 1: Toxic Stress Mitigation Model



Source: Fabiola A. Lara, Save the Children Senior Specialist, ECCD, 2020

Building Resilience in Young Children

The resilience-building approach uses two main components to help caregivers build their own and their child's resilience: a session guide for group meetings with primary caregivers, and an activity bank, which is a compendium of games and play-based activities that help young children build skills in the seven core competencies of resilience, as outlined by the American Academy of Pediatrics. A key aim of the session guide is to enhance primary caregivers' ability to serve as an anchor and provide positive emotional support for their children ages 1-6. This is particularly important for both children and caregivers who are experiencing various types of adversity. The sessions address the primary caregivers' self-care, managing actions and emotions when among children, bonding and playing with children, and providing a safe and secure environment for children.

The activity bank specifically targets children ages 4-6.[1] The play activities offered in the activity bank aim to build children's resilience in the seven core competencies—confidence, competence, connection, character, contribution, coping, and control (Ginsburg and Jablow 2015)—which we adapted for this age group. The activities, in which both caregivers and children participate, focus specifically on enhancing children's emotional awareness, and on their ability to mitigate the effects of crises by managing their emotions and stress response.

Positive Parenting and Discipline Strategies

The second approach, to encourage positive parenting, led to the development of a positive discipline manual that focuses on positive parenting training for primary caregivers and positive discipline strategies for secondary caregivers. The manual includes session content for the three platforms—Family Circles, Rotating Book Clubs, and preschool classrooms—that guides primary caregivers' nonviolent strategies for everyday interactions with children. It also provides information for secondary caregivers—community health promotors, volunteer group facilitators, and teachers—on how to respond to children's behavior without resorting to harsh discipline or violence, particularly in the classroom, and for volunteer staff working in sessions with caregivers where children are present.

Transformational Male-Caregiver Participation

The third approach, male-caregiver participation, focuses on transformational strategies that enable men to make meaningful changes in how they engage with their families and contribute to building a positive family environment, particularly in their children's early years. This approach led to the development of a manual on male caregivers that was used by facilitators working with men. The manual promotes male caregivers' high level of engagement with children, which in the Salvadorian context may include fathers, grandfathers, neighbors, uncles, and any other men who are caring for young children. It provides simple, actionable, and easy-to-understand information and key messages to help male caregivers become drivers of positive change in parenting practices and family structures. The manual also focuses on men's role in the positive development of the young children in their care, particularly as they take on expectant and coparenting roles in the pre- and postnatal periods and during their children's early years of development.

1 Typically developing children ages 4-6 can engage in both semi-independent and independent play-based activities, thus it is important to target both the children and their caregivers. However, children ages 1-3 cannot fully participate in play at this level, thus the focus is on their caregivers.

PILOTING THE TOXIC STRESS MITIGATION MODEL IN EL SALVADOR

We piloted the three approaches described above in three departments of El Salvador—Ahuachapán, Sonsonate, and San Miguel. We selected Ahuachapán and Sonsonate because Save the Children had existing programs in both. San Miguel was a new area of intervention for us, but we selected it for this project because it had characteristics similar to the other departments. All three departments are characterized by large rural populations—57 percent of the population in Ahuachapán lives in a rural area, 40 percent in Sonsonate, and 49 percent in San Miguel (Gobierno de El Salvador 2007). Both also have high levels of poverty and high rates of domestic and community violence, including sexual and physical assault, humiliating punishment (hitting, shaking, neglect, verbal abuse, etc.), and homicide. Communities in the three departments are also vulnerable to adverse natural events, such as volcanic eruptions, landslides, and floods.

Before offering technical training in these communities, Save the Children field officers held discussions and conducted interviews with volunteer staff and primary caregivers to encourage and support their participation in the development and adaptation of the Model. The trainings gave teachers, volunteers, and male facilitators of men-only group sessions an opportunity to discuss how to improve and revise the technical training materials immediately before they used them in the field. Once the technical materials were in use, the trainers had regular opportunities to give feedback on the materials with the field officers through SMS and group WhatsApp messages, and during observation visits.

Based on our landscape analysis conducted in the project design stage to identify target communities, we selected our participating children and families from low socioeconomic backgrounds (Save the Children 2017). The primary caregivers included mothers, fathers, grandparents, aunts, uncles, and other adults, many of whom were homemakers, subsistence farmers, or employed in the informal sector—all jobs that generated little or no income. Before implementing the project, the participating primary caregivers admitted to having little engagement in play-based, relationship-enhancing interactions with their children, and to a lack of understanding about how children develop. Thirty percent reported having resorted to negative discipline practices when their children misbehaved. Secondary caregivers, such as teachers, volunteers, and the male facilitators of men-only sessions, were engaged at different stages of the project. Secondary caregivers provided feedback on the final version of the technical materials for each of the three Model approaches, which they based on their own experiences and those

they had with children and families. The following feedback was collected from parents, teachers, school administrators, and volunteer staff during six community discussions, three one-on-one interviews, and several informal exchanges during site visits three months before the end of the two-year project cycle.

Building Resilience: Strengthening Children's Skills and Supporting Caregivers

School administrators, teachers, and volunteers from our different field sites expressed satisfaction with the resilience-building materials and described how the activities met the contextual challenges and needs of the children in their communities. For example, in an informal interview during a site visit in July 2019, one teacher described the behavioral changes in her students since she began using the materials:

> Since using the materials in my classroom, I have observed changes in the way that children respond to different, difficult situations. They are generally less timid, are more expressive when sharing what they feel, know how to point out what is wrong and how to reach out to me or other adults here at the school for help. Whether they themselves are in trouble or others, they know how to communicate to us that help is needed. (Teacher, Nahuizalco, July 25, 2019)

These comments demonstrate that, since this teacher began using the materials in her classroom, the children's behavior was changing. The children were gaining confidence in themselves and were better equipped to manage their own behavior and actions. Although the primary aim of the activities in the resilience-building approach is to promote primary caregivers' engagement with the children, at the time of this conversation the teacher was a new recruit and had not yet included primary caregivers in the activities. She expressed that, as she was just getting oriented with the curriculum and her classroom schedule in her new position, she was finding it challenging to request primary caregivers' attendance at resilience-building activities in advance. However, she noted that she planned to use the children's birthday celebrations as an opportunity to invite primary caregivers—in advance—to engage in resilience-building activities with their children.

Another important finding came from a school principal at a different school. Although he and his staff were using the resilience-building approach with the

children and parents, he said he felt the approach's target audience should be expanded to include the day-to-day realities that affected teachers' wellbeing:

> I really believe that the resilience-building approach is what the children and families in our communities have needed for a very long time. Children need to develop the skills that will allow them to overcome the bad experiences and events they witness regularly. After watching the children engage in the activities and seeing how their behavior has changed, my teachers have complained to me. They ask me why there is nothing like that offered for themselves. They say that children are responding to them so well and we can see the results and [the teachers] feel that they are missing out. And so you should know that my teachers are in great need of this as well. (School principal, San Miguel, July 23, 2019)

This principal's comments triggered greater reflection among our program staff and technical team on how much the teachers themselves and other adults who support children outside their immediate home environment need targeted support. Additional evidence showed a significant reduction in the number of primary caregivers in the treatment group who felt depressed or sad, which suggests that caregivers might be learning coping mechanisms through the caregiver session content and key messages from the resilience-building approach (Save the Children 2019). It is critical that future programming include approaches that offer support to more than the children and primary caregivers and that, given that their experience in this context mirrors that of the children and their families, teachers' resilience mechanisms and wellbeing also are addressed.

Positive Parenting and Discipline: Using Nonviolent Practices with Children

During each Family Circle and Rotating Book Club session, primary caregivers received key messaging on nonviolent strategies to use in their parenting practice, which is often linked with other topics, such as toxic stress and resilience. According to endline project data, the number of primary caregivers who reported using harsh parenting practices was significantly lower than at the start of the implementation, which might be attributed to the positive discipline messages or to the adult-child sessions and activities focused on bonding (Save the Children 2019).

During a site visit to observe a Family Circle in session, the volunteer group facilitator told us that the primary caregivers attending her sessions were responding well to the materials and, as a result, they were making positive changes in the way they responded to their children:

> This will tell you how the materials have changed the way that parents respond to their child "misbehaving." Do you see that mother right there [points to mother]? That mother would hit her one-year-old the minute that she would start "acting out." She would then look visibly stressed and anxious if the child cried more as soon as she hit her. Now you see her trying to console the child if she starts crying, for whatever reason. Notice how she is responding to the child in a calm manner and is attempting to find a toy that would please her. Now she is giving her a hug to see if that will soothe the child. (Volunteer, San Miguel, July 23, 2019)

This volunteer's remarks provided insight into the more positive, nurturing ways primary caregivers, in this case a mother, were engaging with their children, which they attributed to the session materials and content. The mothers' actions suggested that the content on nonviolent ways to discipline their children was relevant. The same volunteer noted that the primary caregivers initially found it difficult to change their responses to their children's behavior. She said a major challenge was that primary caregivers' actions and responses to their children were shaped by cultural assumptions that children misbehave in order to "test" adults and thus need to be "corrected." This often resulted in harsh punishment. Thus, we argue that it is essential to have a thorough understanding of the cultural and social norms and practices of the local community before designing approaches geared toward shaping and sustaining nonviolent parenting practices and discipline. A specific communication strategy may be needed to improve parents' adoption of these behavioral changes, and additional examination of the external influences on these practices and behaviors may be needed, particularly in conflict- or violence-affected contexts.

Transformational Male-Caregiver Participation: Enhancing the Role of Men

Male-caregiver participation was the last of the three approaches to be implemented. During a site visit to observe a group session of Active Fatherhood, a newly developed platform to enhance the implementation of this approach, male caregivers expressed their interest in understanding ways they can be more

involved in their children's lives. This session was facilitated by a grandfather who is raising his grandson and is a highly regarded figure in the community. One father attending the session commented:

> I really appreciate attending a session such as this one because no one has ever asked me how I feel about my child. I feel that my wife is asked more but I too have many feelings about my son. I do want to help him and that is why I chose to be here . . . so that I can understand what I can do beyond just providing basic necessities like clothes and food. I was not around when my older son was small so I want it to be different this time for my youngest. (Father, San Miguel, July 24, 2019)

Other men attending the session also noted that they feel it is generally more acceptable for women to be given guidance on how to support children. Some men had previous successful experiences attending group sessions through a substance abuse prevention intervention similar to Alcoholics Anonymous. The men said that, given their positive experience in a support group setting, they were eager to participate in groups that centered on enhancing their role as a father in their children's early years. One father who formerly had a substance abuse problem commented:

> I spend six months away from my family every year [during harvest season], from November to May, because of my job. With my oldest, who is now 18 years old, I was not there for him because of my addiction. But now I want to be there for my five-year-old daughter and I really regret the time that I have to be away from her and my family. These sessions help me understand what I can do when I am with her, while I am at home, to help make up for lost time. I want to be a better father. (Father, San Miguel, July 24, 2019)

This father and other male caregivers who had attended substance abuse prevention sessions noted that the new group setting resonated well with them. This feedback provided important information on ways to target fathers—for this project and for any future work in similar contexts, especially those where men have had prior experience in groups with a common aim.

Adapting Strategies to Increase Male-Caregiver Participation

When the male-caregiver participation approach was first piloted toward the end of the project cycle, it was integrated into the community-based platforms such as the Rotating Book Clubs and Family Circles, which were largely attended by women and their children. Key messaging geared toward men was integrated into the sessions in the hope that men's attendance would increase. While some men did participate in these platforms, the sessions were still attended largely by women. The men's participation eventually became sporadic, and their low attendance led to a shift in implementation strategy. This is when the men-only groups known as Active Fatherhood were established, and men who had attended the community-based Family Circles and Rotating Book Clubs sessions were assigned to be male mentor-leaders and facilitators. These men were trained to lead sessions with male caregivers in their community, during which they learned about toxic stress and their role at home as mitigators of toxic stress and violence. Through role-play with their peers, they practiced how to have healthy, positive interactions with their female partners, including during the pregnancy and postpartum periods. They also participated in hands-on activities that simulated games and learning activities geared toward children. Following the guidance in the manual, each man also had the opportunity to lead part of a session.

This new implementation strategy proved successful, which resulted in the establishment of the men-only sessions. These sessions were well attended, and each was designed to center on one key topic, primarily the importance of playing with children and providing emotional and physical support to the men's pregnant partners. New topics were developed for each group meeting, based on feedback from the male facilitators and local needs. The topics included addressing the toxic, gendered colloquialisms used toward women and young girls, the importance of fathers or other male figures in young children's lives, family planning and health, and breaking down traditional masculinity image issues in order to promote fathers as protectors and champions against violence. However, given that this shift in strategy took place toward the end of the project cycle, we were not able to capture detailed feedback, as we did with the two other approaches in the Model, resilience-building and positive parenting.

REFLECTIONS ON IMPLEMENTATION AND LESSONS LEARNED

While integrating the three approaches into existing or new platforms was mostly a positive experience, there were limitations. At the beginning of the project cycle,

we faced the challenge of sensitizing communities in the municipalities where Save the Children did not already have a presence. Since it took longer to formalize agreements in these new areas of intervention, there were delays in launching activities and collecting data.

Additionally, given the prevalence of violence in El Salvador, particularly in the areas where this project was implemented, families frequently migrated to other communities or to the United States, and there was high staff turnover. Some activities were paused while new staff members were being brought on board, which caused further delays, including the delayed implementation of the male-caregiver participation approach.

The data we collected, as well as feedback from community discussions, one-on-one interviews, and informal exchanges, suggest that the three approaches of the Model Save the Children developed and implemented to mitigate toxic stress—resilience-building, positive parenting, and transformative male caregiving—is filling a critical need for children and families in El Salvador who are experiencing economic adversity and violence. Although this specific project had the limitations described above, as well as data-collection challenges, caregivers in the communities continued to express their need to understand how their children are affected by adversity and how they can best support them in this challenging context.

It is also important to note that, while changing the sociopolitical context in which children live is difficult and the adversity they face is rooted in complex sources, the Model was focused on providing opportunities to buffer children and families from the hardships in their lives. Caregivers play a critical role in shielding children from adverse experiences, and in promoting the positive development that enables them to mitigate the damaging effects their circumstances have on their learning, physical and mental health, and behavior later in life (Shonkoff and Phillips 2000). Although the project that launched this work has ended, families in the communities that previously received program support continue to receive support on these issues from other sources. Communities that received support for these new initiatives only from Save the Children later received additional support before the project ended, such as technical training and guidance in planning workshops. They have since continued their caregiving activities with support from local government authorities and community leaders.

In our future programming, we would like to explore interventions that reduce caregiver stress, including offering support to secondary caregivers. We learned through this project that secondary caregivers, such as teachers, volunteers, and

other frontline workers, need as much support as primary caregivers for their own psychological wellbeing and health, and in order to support children to the best of their ability. There also is a need to examine the transformational change of male caregivers and how this affects their family environment and structure. Based on additional lessons learned from this project, it is clear that male caregivers can play a critical role in shaping family harmony and wellbeing, both of which depend on how men support their children and partner or coparent. The men who participated showed a keen interest in understanding how to play a more nurturing and emotionally supportive role; they expressed that women tend to be perceived as the sole caregivers of children and they want to contribute meaningfully in their caregiving roles. Having the opportunity to explore how male caregivers' behavior is transformed within a given time period would provide a deeper understanding of the impact the Model has on their families—and on the men.

The launch of the Model in the particular context of El Salvador provides an opportunity to address the specific needs of children in other areas of the country and globally, particularly in contexts affected by crisis, such as humanitarian settings. Since the early years of life are the most critical in establishing neural connections, building children's resilience in the face of adversity that could lead to forced displacement is key in helping them mitigate possible physical, mental, and emotional impairments. The Model calls for greater collaboration and coordination with other sectors and agents, such as social protection, health, and nutrition. Providing a version of the Model in humanitarian and emergency settings would enhance a cross-sectoral response. This also would enhance support for children's development and wellbeing in emergencies and strengthen interventions geared toward their primary and secondary caregivers on issues such as mental health and wellbeing, which may not be provided by ECCD programming and systems. The international community continues to focus its humanitarian response efforts primarily on designing interventions and rehabilitation initiatives to address children's experiences, rather than on the adults who care for and interact regularly with children. Future efforts need to address both primary and secondary caregiver wellbeing, not only to meet their needs but to effectively meet those of the children under their care.

REFERENCES

Allport, Brandon S., Sara Johnson, Anushka Aqil, Alain B. Labrique, Timothy Nelson, Angela Kc, Yoroghos Carabas, and Arik V. Marcell. 2018. "Promoting Father Involvement for Child and Family Health." *Academic Pediatrics* 18 (7): 746-53 https://doi.org/10.1016/j.acap.2018.03.011.

Barker, Gary, and Fabio Verani, eds. 2003. *Men's Participation as Fathers in the Latin American and Caribbean Region: A Critical Literature Review with Policy Considerations.* Washington, DC: World Bank.

Charles, Pajarita, Deborah Gorman-Smith, Michael Schoeny, Laura Sudec, Patrick Tolan, and David Henry. 2018. "Fathers' Criminal Behavior and Involvement with Children: The Moderating Role of Family Relationships." *Journal of the Society for Social Work and Research* 9 (1): 131-57.

Franke, Hillary A. 2014. "Toxic Stress: Effects, Prevention and Treatment." *Children* 1 (3): 390-402. https://doi.org/10.3390/children1030390.

Geoghegan, Tracy. 2019. *Changing Lives in Our Lifetime: Global Childhood Report.* Fairfield, CT, and London: Save the Children.

Ginsburg, Kenneth R., and Martha M. Jablow. 2015. *Building Resilience in Children and Teens: Giving Kids Roots and Wings* (3rd ed.). Elk Grove Village, IL: American Academy of Pediatrics.

Gobierno de El Salvador. 2007. *Censo de Poblacion y de Vivienda*. San Salvador: Ministerio de Economia y Direccion General de Estadistica y Censos. http://www.censos.gob.sv/censo/Default.aspx.

Guerra, Nancy G., Carly Dierkhisiing, Holly Foster, and Jeanne Brooks-Gunn. 2012. "The Impact of Violence on Children: The Current State of Research." *Early Childhood Matters* (119): 8-9.

Human Rights Watch. 2019. *El Salvador: Events of 2018*. https://www.hrw.org/world-report/2019/country-chapters/el-salvador.

Menjivar, Cecilia. 2014. *The Status of Women in Domestic Relationships in El Salvador.* Phoenix: Arizona State University.

Murphey, David, and Jessica D. Bartlett. 2019. *Childhood Adversity Screenings Are Just One Part of an Effective Policy Response to Childhood Trauma*. Bethesda, MD: Child Trends International. https://www.childtrends.org/publications/childhood-adversity-screenings-are-just-one-part-of-an-effective-policy-response-to-childhood-trauma.

National Scientific Council on the Developing Child. 2015. *Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience*. Working Paper No. 13. Cambridge, MA: National Scientific Council on the Developing Child. www.developingchild.harvard.edu.

OHCHR (United Nations Office of High Commissioner for Human Rights). 2018. *Committee on the Rights of the Child Reviews Report of El Salvador.* Geneva: OHCHR. https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23594&LangID=E.

Pruett, Kyle D. 2000. *Fatherneed: Why Father Care Is as Essential as Mother Care for Your Child.* New York: Free Press.

Ruiz, Damaris, and Belen Sobrino. 2018. *Breaking the Mould: Changing Belief Systems and Gender Norms to Eliminate Violence against Women* [PDF file]. Oxford: Oxfam International. https://oxfamilibrary.openrepository.com/.

Save the Children. 2017. *Baseline Report: Mitigating the Impact of Violence on Young Children in El Salvador.* Washington, DC: Save the Children US.

Save the Children. 2019. *Endline Report: Mitigating the Impact of Violence on Young Children in El Salvador.* Washington, DC: Save the Children US.

Shonkoff, Jack P., and Deborah A. Phillips. 2000. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Washington, DC: National Academies Press.

Shonkoff, Jack P., and Andrew S. Garner. 2012. *The Lifelong Effects of Early Childhood Adversity and Toxic Stress: A Technical Report.* Itasca, IL: American Academy of Pediatrics.

Woods-Jaeger, Briana A., Bridget Cho, Chris C. Sexton, Lauren Slagel, and Kathy Goggin. 2018. "Promoting Resilience: Breaking the Intergenerational Cycle of Adverse Childhood Experiences." *Health Education & Behavior* 45 (5): 772-80. https://doi.org/10.1177/1090198117752785.

UNODC (United Nations Office on Drugs and Crime). 2019. *Global Study on Homicide: Killing of Children and Young Adults* [PDF file]. Vienna: United Nations Office on Drugs and Crime. https://www.unodc.org/documents/data-and-analysis/gsh/Booklet_6new.pdf.

JOURNAL ON EDUCATION IN EMERGENCIES

Implementing a Humanitarian Needs Assessment Framework for Early Childhood Development: Informing Intervention Design for Displaced Rohingya Communities in Bangladesh

Author(s): Kim Foulds, Naureen Khan, Sneha Subramanian, and Ashraful Haque

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 112-132

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62225

DOI: https://doi.org/10.33682/1uqv-kn0f

REFERENCES:

IMPLEMENTING A HUMANITARIAN NEEDS ASSESSMENT FRAMEWORK FOR EARLY CHILDHOOD DEVELOPMENT: INFORMING INTERVENTION DESIGN FOR DISPLACED ROHINGYA COMMUNITIES IN BANGLADESH

Kim Foulds, Naureen Khan, Sneha Subramanian, and Ashraful Haque

ABSTRACT

Recent literature focused on education in conflict-affected settings firmly establishes the link between early childhood interventions, poverty reduction, and the effects of adverse childhood experiences, particularly for those exposed to violent conflict. A key factor of effective interventions targeting young children and their families, and thus the long-term sustainability of behavior change, is how those interventions are received by local populations. Despite the importance of understanding local perspectives, needs assessments are often deprioritized when the focus is on meeting the immediate need for safety, food, water, and shelter. In the absence of a needs assessment, programming is developed without understanding the key priorities and motivations of the communities served. Given that the average length of protracted refugee situations is now more than 20 years, early childhood development programming designed without local perspectives brings with it the possibility of long-term repercussions, little community buy-in, and, consequently, limited to no impact. Therefore, the long-term costs of not doing needs assessments in humanitarian contexts are likely to far exceed the initial investments in conducting such research. In acknowledgment of these opportunities and constraints, this article presents a framework for conducting a needs assessment

Received September 23, 2019; revised February 12, 2020, and April 23, 2020; accepted May 27, 2020; electronically published June 2021.

Journal on Education in Emergencies, Vol. 7, No. 1

ISSN 2518-6833

in a humanitarian setting, along with illustrative findings that underscore the value of seeking greater understanding of a community before designing early childhood development programming. Using a needs assessment to inform the design of an early childhood development intervention for displaced Rohingya communities living in Bangladesh, this article uses the design of that assessment to provide a framework for operationalizing needs assessments in humanitarian settings.

INTRODUCTION

Recent literature firmly establishes the link between early childhood interventions, reduced poverty, and the effects of adverse childhood experiences (Britto et al. 2016; Bouchane et al. 2018; El-Haj et al. 2018; Murphy, Yoshikawa, and Wuermli 2018; Shonkoff et al. 2012; Young 2007; Gertler et al. 2013). While there is ample evidence showing that returns on investments in early childhood development (ECD) programs exceed those associated with other educational investments (Richter et al. 2016; Young 2007; Gertler et al. 2013), there is a dearth of implementation studies and high-quality evidence to inform interventions in conflict-ridden and emergency contexts (Murphy et al. 2018).

A key factor of effective interventions targeting young children and their families, and thus the long-term sustainability of behavior change, is how those interventions are received by local populations (Dionne 2012). Education interventions often sit at a crossroads between the international donors who drive global priorities and the needs of local communities (Jeffrey and Jeffrey 1998; Dionne 2012; Foulds 2016). Despite the significance of these intersecting perspectives, there is ongoing concern that local attitudes and preferences may be inadequately researched and considered when implementing interventions that are designed and/or supported by external actors (Mohanty 2003; Benavot and Braslavsky 2007; Dionne 2012; Foulds 2013).

These gaps in reciprocal understanding about the nurturing care and education of young children are even more pronounced in humanitarian settings, where the priority is on meeting the immediate need for safety, food, water, and shelter. Recent data on humanitarian funding for education indicates that only 2.25 percent of humanitarian aid finances education, and just a fraction of that goes to ECD (UNOCHA 2019).[1] Moreover, that 2.25 percent met only 59 percent of all education funding requirements.

1 Of the US$17.45 billion funded, US $392 million went to education.

More broadly, development aid to ECD increased between 2002 and 2016, from 1.7 percent to 3.8 percent. However, the majority of all ECD funding went to health and nutrition interventions; only 1 percent went to preprimary education, a decline in the relative share of funding (Zubairi and Rose 2018). When funds are limited, funders and/or grantees tend to be less willing to carry out needs assessments and more likely to spend scarce resources on visible delivery services.

In the absence of funding or the time to conduct a needs assessment that collects primary data from target communities, programming is likely to be developed without understanding the key priorities and motivations of the communities served. Given that the average length of protracted refugee situations is now an estimated 26 years (UNHCR 2017), we argue that programming designed without the input of local perspectives could have long-term repercussions, little community buy-in, and, consequently, limited to no impact. Therefore, the long-term costs of not doing needs assessments in humanitarian contexts likely far exceed the initial investment in conducting such research.

In acknowledgment of these opportunities and constraints, this article presents a framework for conducting a needs assessment in emergency situations and illustrative findings from a study conducted with displaced Rohingya families. Both the framework and the findings underscore the value of conducting such research in a humanitarian setting before designing an intervention. While the needs assessment described here was used to develop a set of interventions to facilitate play-based learning for children affected by crisis and displacement and was specifically tailored to the local context, the framework can be adapted to a variety of humanitarian settings and curricular areas.

STEPS FOR IMPLEMENTING THE NEEDS ASSESSMENT FRAMEWORK

An operational framework is required to implement an effective needs assessment, as it ensures that the research will be aligned with programmatic needs and existing knowledge gaps. The framework must include a focus on ethics approval and the piloting of measures to ensure that the instruments reflect the targeted communities. While there is a standard definition of a general needs assessment,

there is not a standardized process to conduct one.[2] Thus, we adopted the following process:

1. Develop research questions and supporting survey tools to address knowledge gaps, in collaboration with project partners
2. Identify an in-country research partner with strong ties to the target communities
   a. Work with research partner to refine instruments and develop sampling plan
   b. Secure ethics approval of research design through Institutional Review Board
   c. Pilot and finalize instruments in keeping with pilot findings
3. Implement a full-scale needs assessment
   a. Analyze data in keeping with research plan and develop report narrative
   a. Present findings to project partners to inform development of intervention plan

The framework provided here supports a rigorous research design and the application of that design. This framework is supported by the principle that, the more rigorous the needs assessment, the more reliable the data. While a rapid response is the top priority in meeting the immediate needs of displaced populations, taking a rigorous approach to designing and implementing a needs assessment ensures that the time and funding allocated will provide a greater return on investment over the lifetime of the intervention. To support the application of this framework, the following sections of this article detail these steps and their operationalization. The next section provides background on the recent wave of displacement among the Rohingya, followed by a section detailing the steps of the needs assessment outlined above, then the illustrative findings, and, finally, a conclusion that reinforces the value of this approach in a humanitarian setting.

2 A needs assessment is defined as a data-collection exercise, usually conducted at a single point in time, to gain an understanding of the protection issues, availability of resources, sources of problems, and their impact on the affected population (Project Information Management 2017; UNHCR 2017).

BACKGROUND ON RECENT DISPLACEMENT AMONG THE ROHINGYA

Before August 2017, the majority of the estimated one million Rohingya in Myanmar resided in Rakhine State (Figure 1), where they accounted for nearly one-third of the population (Albert and Maizland 2020). In Myanmar, the Rohingya have been subjected to state-sponsored religious and ethnic persecution, physical and sexual abuse, and forced labor (Kingston 2015). Seeking refuge after fleeing a campaign of physical violence and terror sparked by the Myanmar military's launch of "clearance operations" against the Rohingya people, the 2017 exodus of Rohingya from Myanmar unfolded as one of the fastest-growing refugee crises in history. An estimated 641,000 Rohingya refugees fled into Bangladesh in August and September 2017 alone, adding to the 278,000 Rohingya refugees already living in Cox's Bazar who were part of the two previous waves of refugees who had fled Rakhine State since 1978 (Médecins Sans Frontières 2018; UNDP 2019). As of April 2019, there were 908,878 Rohingya in need of assistance in Bangladesh (UNICEF 2019).

Figure 1: Map of Bangladesh and Myanmar

Source: Asrar (2017)

Bangladesh has denied the Rohingya formal legal status, so they are not legally recognized as refugees and do not have access to the full spectrum of services and benefits available to refugees (Merritt 2017; UNDP 2019). Though the UN

system has been able to mobilize humanitarian aid, the Rohingya have no formal protection under any state or international organization and thus are in a "state of acute vulnerability" (Médecins Sans Frontières 2018).

The challenges of displacement the Rohingya children face are extensive. Only 43 percent of girls and boys ages 3-5 reported attending a learning center since arriving in Bangladesh (Education Cluster 2018). A recent assessment of the mental health and psychosocial needs of displaced Rohingya living in Cox's Bazar found that 30 percent to 40 percent of Rohingya children frequently experience difficulty sleeping, feelings of sadness and tension, and somatic complaints such as headaches, sore muscles, and back pain (International Organization for Migration 2018).[3]

While there are data available that detail their challenges in accessing education services, Rohingya communities are underresearched, particularly around their education-specific needs (Education Cluster 2018; IPA 2018; Merritt 2017). A 2018 study of Rohingya caregivers found that most parents want their children to receive the equivalent of a grade 10 education or to become *Qur'an-e-Hafiz*—which means they have memorized the entire Qur'an (IPA 2018).

METHODOLOGY

In Collaboration with Project Partners, Develop Research Questions and Supporting Survey Tools to Address Knowledge Gaps

An effective needs assessment fills a gap in the existing knowledge base for the target communities. This supports the funding organization's immediate programmatic needs and the work of other organizations providing programming to the same communities. The gap in the literature around Rohingya communities is extensive and, given the aforementioned limits on conducting needs assessments in humanitarian settings, our research set out to conduct a needs assessment that would inform the design and implementation of an early childhood education intervention targeting Rohingya children and their families. We anticipated that it would fill current gaps in understanding and support the creation of an enhanced knowledge base specific to the ECD needs of the Rohingya communities in Cox's Bazar.

3 For the 2018 International Organization for Migration study (n=327), children were respondents 7-16 years old, youth were 17-25 years old, and adults were 30-55 years old. Somatic symptom disorder is characterized by an extreme focus on physical symptoms, such as pain or fatigue, that causes major emotional distress and problems functioning. Those experiencing somatic symptom disorder may experience significant emotional and physical distress (Mayo Clinic n.d.).

Aware of the importance of considering the needs and perspectives of the target communities in an intervention design, our research focused on collecting data in the communities surrounding the Rohingya camp in Cox's Bazar, and in the camp itself. The following research questions led the design and sampling of this assessment:

- What are Rohingya and host community caregivers' educational priorities for their children 3-6 years old?
- What are the educational priorities for children 3-6 years old among the practitioners serving children in displaced Rohingya communities and the host community?
- What are the parenting needs of Rohingya and host community caregivers of children 3-6 years old?
- What is the perception of the value of play in children's development among Rohingya and host community caregivers and practitioners?
- What are the existing play habits of displaced Rohingya and host community children and their families?
- What roles do song, storytelling, and dance play in these families' lives?
- What professional needs and challenges face the people working directly with children in displaced Rohingya communities and the host community?

In addition to asking questions to promote better understanding of the educational priorities for young Rohingya children, the study focused on play norms and cultural expression. Research has shown that playful learning helps foster young children's development and lays the foundation for them to become creative, engaged, lifelong learners—which identifies play as an integral component of ECD (Brooker and Woodhead 2013; Kelly-Vance and Ryalls 2008).

Guided by our questions and using previous needs assessments conducted by Sesame Workshop to inform intervention programming (Foulds and Bucuvalas 2019; Kohn et al. 2020), Sesame Workshop drafted the assessment instruments in collaboration with BRAC, LEGO Foundation, and New York University's Global

TIES for Children.[4] These project partners provided feedback so we could incorporate on-the-ground experience and refine our questions to ensure collaborative alignment.

For this study, we applied a mixed methods design that incorporated both qualitative and quantitative data-collection methods. Data-collection instruments included a demographic questionnaire and interview protocols for both caregivers of children 3-6 years old and practitioners working with young children. Interview protocols included closed- and open-ended questions that were analyzed using quantitative and qualitative methods. Most questions were open-ended, and scale/ranking questions were added to inform our analysis.

Identify an In-Country Research Partner with Strong Ties to Target Communities

Community support and buy-in are key to the development of research instruments and the quality of the data collected. A research partner who has an existing relationship with the target community can provide important insights to inform the research design. Furthermore, due to these existing relationships with the community, respondents will be more likely to support the research during data collection, thus improving the quality of the responses provided.

Innovations for Poverty Action (IPA), in partnership with Yale University, is currently conducting the Cox's Bazar Longitudinal Cohort Study, which is the largest population-based cohort study to date of families in refugee camps.[5] Through this study, which started in 2019 with a sample of 5,000 Rohingya and host community households, IPA has well-established ties and access to displaced Rohingya communities in Cox's Bazar.[6]

While needs assessments are not the primary focus of IPA, Sesame Workshop's interest in developing an ECD curriculum framework for Rohingya refugees living in Cox's Bazar through the rigorous testing of video and print content was appealing to the organization. Programming designed with the local perspective in mind could bring a host of benefits to an incredibly vulnerable population. IPA was responsible for managing the research process, including translation of instruments, enumerator recruitment and training, data collection and translation, and report write-up.

4 Sesame Workshop is the nonprofit behind *Sesame Street*. The lead author works at Sesame Workshop.

5 The principal investigator is Professor Mushfiq Mobarak, Department of Economics, Yale University. Three of the authors worked at IPA at the time of the study; one has since left.

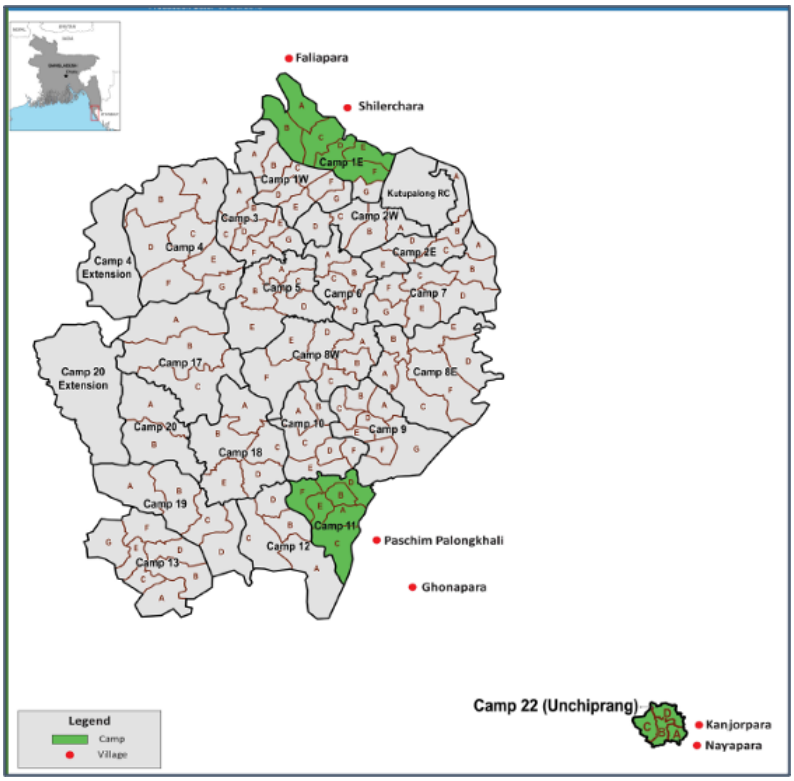
6 For evidence of this, please see IPA (2018) and Khan (2019).

Refine Instruments and Develop Sampling Plan

Relying on their understanding of the target community and experience conducting research with Rohingya families in Cox's Bazar, Sesame Workshop shared its draft instruments with IPA for a review and refinement that would enhance the final set of pilot instruments.

Guided by Sesame Workshop's interest in a diverse sample, IPA developed a sampling plan that used 3 out of 34 Rohingya camps for the survey. IPA first stratified the camps across the Ukhia and Teknaf *upazilas* into three groups based on size and location, then randomly selected one camp from each group.[7] The host community sites included respondents from neighboring villages. Figure 2 provides a spatial context for the sampling sites. The green markings represent camp sampling sites, while the red markings represent host community sampling sites.

Figure 2: Map of Sampling Sites



Source: IPA (2019)

7 *Upazilas* are administrative regions in Bangladesh.

Secure Institutional Review Board Approval and Conduct Enumerator Training

As with any human-subject research, securing Institutional Review Board (IRB) approval and training enumerators ensures that every effort is being made to prevent the research from doing harm. These steps are especially important in humanitarian settings, particularly when working with a community like the Rohingya, who have few national and international protections in place.

With the instruments developed and the sampling plan finalized, and in keeping with their internal process, IPA secured IRB approval for the project and ensured that adequate information about the survey procedure was provided to the participants.[8]

IPA translated both surveys from English into Bangla and conducted an enumerator training. The enumerators, hired locally from the Chittagong and Cox's Bazar districts, interviewed the Rohingya community in the Rohingya language.

Pilot and Finalize Instruments

Piloting instruments to make sure that respondents understand the questions and that the enumerators are explaining the study adequately ensures that the target communities are directly represented in the research design. IPA piloted all the instruments with 24 respondents, 16 caregivers, and 8 practitioners. This exercise provided valuable feedback on the structure of the questionnaire, on general issues related to the question format, and on the respondents' level of comprehension. IPA incorporated all feedback into the final assessment design.

Based on data on the Rohingya language collected from local enumerators during the pilot process for this study, IPA provided a list of Rohingya words that differ from the Cox's Bazar local dialect to help the enumerators when conducting their interviews.

8 Reflecting its commitment to conduct high-quality, ethical research, IPA founded the IPA IRB in 2007. IPA's IRB enables it to consider ethical issues across all IPA projects, and to ensure respect for and protection of the human subjects participating in IPA research. The time taken to receive IPA IRB approval depends on the type of research, the level of risk to participants, and on-time submission of all documents requiring review. We did not face any significant time lag from the IPA IRB process while setting up for this project.

Implement a Full-Scale Needs Assessment and Analyze Data in Keeping with the Research Plan

During the data-collection process, female enumerators interviewed female caregivers and male enumerators interviewed male caregivers, but enumerators were not matched with practitioners based on gender. IPA administered interviews using CAPI devices and recorded all of them on password-protected tablets.[9] Interviews with caregivers averaged 64 minutes, those with practitioners averaged 55 minutes.

IPA first transcribed the interviews from audio to text. To ensure quality, they re-transcribed 10 percent of all interviews and compared the two versions to ensure that the transcription was consistent. The audio was also transcribed into Bangla on handwritten documents. IPA then translated the handwritten documents from Bangla into English, and again re-transcribed 10 percent of the interviews. Following the coding and data analysis, IPA shared the findings with Sesame Workshop. The following section provides an illustrative sample of those findings.

ADDRESSING THE CHALLENGES WE FACED

We faced a number of challenges in designing and implementing this framework.

Collaboration across multiple partners: We wanted to ensure that all partners had the opportunity to inform and review the research instruments and sampling plans. We knew that representing the needs and perspectives of multiple partners could pose a number of challenges. To address this, we provided consistent communication and biweekly updates via working group conference calls and follow-up email discussions. We also used collaborative software when designing our instruments.

Permission to access camps: In humanitarian contexts, gaining access to displaced populations is typically a challenge, due to concerns for their safety. To get permission to administer the surveys for the needs assessment, IPA submitted information about the research and its usefulness for the refugees to the relevant local authorities. Clear communication in simple terms and consistent follow-ups helped reduce the time it took to get authorization to work in the camps.

9 CAPI stands for computer-assisted personal interviewing.

Instrument structure: The instruments we used included a mix of open-ended and closed questions, which are analytically different but both important when collecting a range of data. While some responses were identified in open-ended questions, others were selected only when posed directly to respondents. This raised concerns about social desirability bias. When conducting research to inform intervention design, it is important to address social desirability bias to ensure that the needs assessment findings accurately reveal existing perceptions, values, and behaviors so that the intervention design is not guided by skewed results. Our comprehensive coding scheme helped alleviate the impact of this analytical difference, and relevant sections were amply highlighted when we presented the results. For example, in the section on caregivers' perceptions of the role of play in children's learning, findings from a Likert scale questionnaire indicate that the majority of caregivers strongly agreed that play is important in children's learning. With open-ended questions, however, few caregivers talked about the role of play in learning. This discrepancy suggests that social desirability bias may have played a role in caregivers' responses when statements were posed to them directly. Without a comprehensive coding scheme, such bias could inaccurately depict a stronger understanding of the role of play in children's learning than actually occurs in the communities.

Interview structure: While our original design included individual interviews with caregivers and practitioners, we learned that it is common in this context for people to do things together. It would have been difficult for us to collect data through individual interviews, as the process might have been considered suspicious if enumerators had insisted that only one person be present. To account for this, enumerators focused on asking questions of the primary respondent, in the presence of a group. Because an individual's responses may differ between an individual and a group setting, social desirability bias could alter a participant's responses if there is a higher likelihood that others will hear and repeat those responses.

NEEDS ASSESSMENTS DATA: SELECT SAMPLE DEMOGRAPHICS

Of the 321 respondents who participated in this study, 238 were caregivers and 83 were practitioners (Figure 3). The practitioners represented many local and international organizations.

Figure 3: Respondent Sample Breakdown

n=321	Camp	Host Community
Caregiver	160 (81% women)	78 (85% women)
Practitioner	53 (68% women)	30 (67% women)
Total	**213**	**108**

Source: IPA (2019)

Among the caregiver respondents, 83 percent were married women with an average age of 31. Their education levels were limited; 41 percent had attended a madrassa, and 31 percent had completed some primary school as their highest level of schooling.

The caregivers in this study had an average of four children under eighteen, with an average age of seven. Though all the parents and other caregivers recruited had children ages 3-6, IPA randomly selected one of their children in this age range and asked questions about the "target child" during the interviews. While the sample of the selected children focused on those ages 3-6, the sample skewed to children ages 5-6.

Most practitioners were women (67%) and their average age was 24. Nearly half of the practitioners had a university or postgraduate degree and another 39 percent had completed secondary school. Thirty-one percent of practitioners were Rohingya; 64 percent of them served Rohingya refugee communities, and one-third served the host community.

The majority of the practitioners served a wide range of grades, from kindergarten to grade 6 or higher, 74 percent worked as teachers, and most were fairly new to their current position, 53 percent having worked there less than a year.

Select Needs Assessment Findings: Educational Priorities for Caregivers and Practitioners

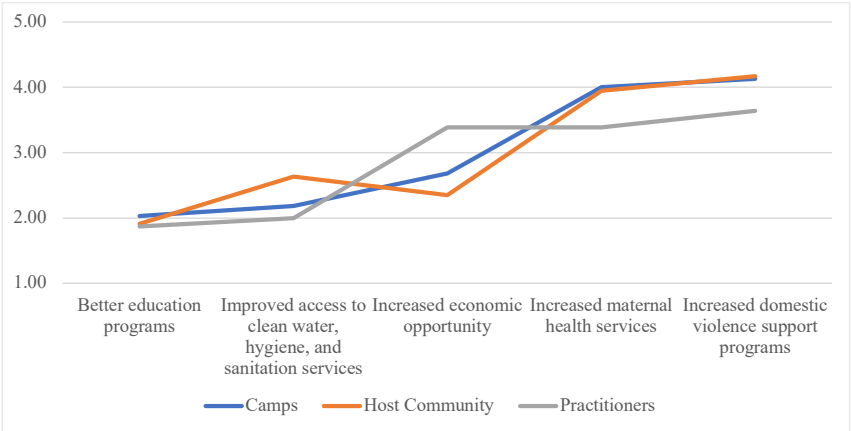
In both the camps and the host communities, parents' perceptions of the importance of education for their children and their community emerged when respondents were asked to put a relative value on education as one option among five social interventions, which enumerators ascertained by reading them the following script:

> Now, I would like to ask you your opinion on programs in this area. People have said they would like programs to improve their lives here in this area. Some programs that could improve

> life would be: improved access to clean water, hygiene, sanitation services; increased maternal health services; increased domestic violence support programming; better education programs; and increased economic opportunity. Thinking about families who live nearby and what is most important to them, how would you rank these five programs? There is no right or wrong answer; I just want to know what you think.[10]

The responses showed that caregivers and practitioners were in agreement that the most important intervention was to provide better education programming (Figure 4). The intervention all caregivers and practitioners in the camps ranked second most important was improved access to clean water and hygienic sanitation services—a finding aligned with earlier work that explored knowledge, attitudes, and behaviors around health and hygiene (IPA 2018).

Figure 4: Ranking Program Interventions



Source: IPA (2019)

To better understand respondents' priorities for children's development, enumerators read them the following script:

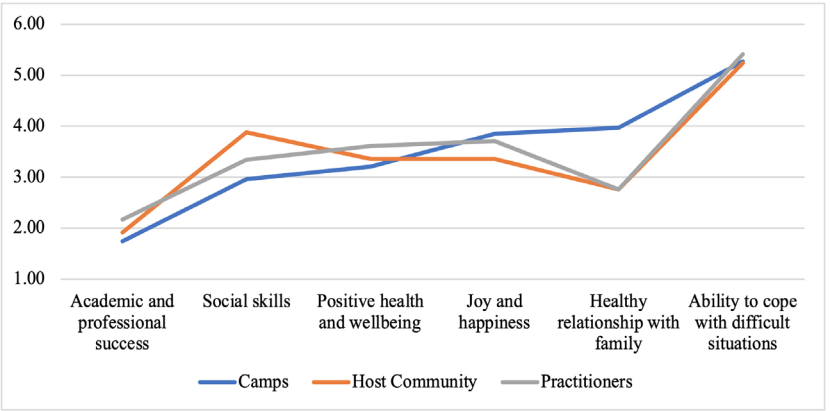
> Now, thinking more specifically about children who live nearby and what is most important for them and their development, how would you rank these priorities? Academic and professional success; positive health and wellbeing; social skills; joy and

10 This question was adapted from Dionne's 2012 work on rural Malawians' prioritization of public policy interventions.

happiness; healthy relationship with family; ability to cope with difficult situations.[11]

Based on mean scores, children's academic and professional success was the clear priority for all respondents (Figure 5).

Figure 5: Ranking Priorities for Children's Development



Source: IPA (2019)

Social concepts were also a priority for all respondents, including healthy relationships with family, social skills, and good health and wellbeing. Despite the high prevalence of children and adults who self-reported feelings of sadness, anxiety, fear, and grief, the ability to cope with difficult situations was the lowest priority among all groups.

Select Needs Assessment Findings: Caregivers' and Practitioners' Educational Content Priorities for Rohingya Children

When exploring what caregivers and practitioners prioritized for children in terms of education and academic success, respondents' priorities showed greater variability. When caregivers in the camps were asked to identify the most important things children should learn in school to prepare them for the future, 73 percent named Islamic education. Practitioners in the camps focused on general education (68%), learning English (24%), and learning Burmese (16%).

The importance of Islamic education for the families of young children also revealed itself when cultural transmission and social etiquette were discussed

11 This question was also adapted from Dionne's 2012 work on rural Malawians' prioritization of public policy interventions.

with caregivers. When asked to describe their culture and how they teach their children about it, caregivers focused on teaching about religious culture, norms, and values, as well as social etiquette and rules to live by. When asked to discuss the particulars of Rohingya social etiquette and rules, religion was clearly cited as a driving force in the cultural fabric of Rohingya norms. Girls had to follow additional social norms, including rules for going out of the house and for interacting with people outside the immediate family, and *purdah*.[12]

Because cultural norms are often transmitted through art, during the interviews respondents also shared stories, legends, poems, and songs commonly used in their communities. These too underscored the importance of Islam, as 76 percent of all caregivers mentioned reciting poems and singing to their children at home, including *ghazals, surahs,* and *qawwali.*[13]

CONCLUSION

While funders often do not prioritize early childhood education in emergency settings, the returns on investment for ECD interventions are well-established across the globe. Because funding is limited, the evidence supporting effective implementation is also limited. One key facet of designing an effective ECD intervention is to first conduct a needs assessment. This can be challenging in a humanitarian crisis, when the focus is on providing for immediate needs. However, the framework and illustrative findings presented here demonstrate the inherent value of conducting a humanitarian needs assessments to inform the design of ECD interventions, which can be relevant, respectful, supportive, representative, and, most importantly, effective (Bouchane et al. 2018). While conducting a needs assessment in a humanitarian context may delay implementation and add to program costs, the need for such informed intervention design is growing, given the increasing length of population displacements and the likely need for long-term service provision.

Using a rigorous needs assessment design, as detailed in the framework provided here, gives implementers the opportunity to systematically collect essential data and insights to inform the design of effective, sustainable, localized ECD interventions. As shown in this article, without implementing this approach, we

12 *Purdah* is the practice of requiring girls and women to remain within the family home until marriage once menstruation has started.

13 *Ghazal* is a poem, often about both the pain of loss or separation and the beauty of love despite that pain; *surah* is a chapter of the Qur'an; *qawwali* is a type of Sufi devotional music.

would not have known how Rohingya caregivers prioritize children's development priorities, particularly the relatively low priority they put on children's ability to cope with difficult situations. This indicates a clear opportunity for an adult-facing intervention to support caregivers' understanding of the link between resilience, mitigation of adverse childhood experiences, and children's healthy long-term development.

Early childhood education in humanitarian contexts is often not prioritized by humanitarian donors, as it is not seen as a lifesaving need, in contrast to health, food, water, and sanitation. The illustrative findings presented here showcase the priority Rohingya caregivers place on educational access for their young children, which demonstrates the importance of funding early education opportunities in such contexts. A needs assessment further identifies what existing norms those opportunities should consider. Using the people's existing educational priorities and motivations as a springboard to ensure community buy-in and the adoption of new educational concepts is critically important for long-term success. Because both positive and negative experiences in early childhood influence the formation of critical pathways and processes, ensuring that children and their parents feel listened to and represented in an intervention is fundamental to children's long-term cognitive, social, emotional, and physical development.

ACKNOWLEDGMENTS

The research was supported by funding from LEGO Foundation as part of the Play to Learn program with Sesame Workshop, BRAC, and the International Rescue Committee. We would like to thank Dr. Elisabeth King for her useful comments and Dr. Bulbul Ashraf Siddiqi for helping set up the data-analysis framework. We would also like to thank the *JEiE* editorial team and anonymous reviewers for their valuable feedback, which helped us to improve the quality of the article.

REFERENCES

Abu El-Haj, Thea Renda, Garene Kaloustian, Sally Wesley Bonet, and Samira Chatila. 2018. "Fifi the Punishing Cat and Other Civic Lessons from a Lebanese Public Kindergarten School." *Journal on Education in Emergencies* 4 (1): 13-44 https://doi.org/10.17609/xnpr-ce74.

Albert, Eleanor, and Lindsay Maizland. 2020. *The Rohingya Crisis.* New York: Council on Foreign Relations.

Asrar, Shakeeb. 2017. *Rohingya Crisis Explained in Maps.* Al Jazeera, October 28.

Benavot, Aaron, and Cecilia Braslavsky. 2007. *School Knowledge in Comparative and Historical Perspective: Changing Curricula in Primary and Secondary Education.* Dordrecht: Springer. https://doi.org/10.1007/978-1-4020-5736-6.

Bouchane, Kolleen, Hiro Yoshikawa, Katie Maeve Murphy, and Joan Lombardi. 2018. *Early Childhood Development and Early Learning for Children in Crisis and Conflict.* Background paper for the 2019 "Global Education Monitoring Report." Paris: UNESCO https://unesdoc.unesco.org/ark:/48223/pf0000266072.

Britto, Pia, Stephen Lyes, Kerri Proulx, Aisha Yousafzai, Stephen Matthews et al. 2016. "Nurturing Care: Promoting Early Childhood Development." *The Lancet* 389 (10064): 91-102 https://doi.org/10.1016/s0140-6736(16)31390-3.

Brooker, Liz, and Martin Woodhead. 2013. *The Right to Play (Early Childhood in Focus).* Milton Keynes, UK: The Open University. http://oro.open.ac.uk/38679/.

Dionne, Kim Yi. 2012. "Local Demand for a Global Intervention: Policy Priorities in the Time of AIDS." *World Development* 40 (12): 2468-77. Education Cluster. 2018 https://doi.org/10.1016/j.worlddev.2012.05.016.

Joint Education Needs Assessment: Rohingya Refugee in Cox's Bazar. Cox's Bazar, Bangladesh: UNICEF, Save the Children, and Education Cluster https://reliefweb.int/report/bangladesh/joint-education-needs-assessment-rohingya-refugee-cox-s-bazar-june-2018.

Foulds, Kim. 2013. "The Continua of Identities in Postcolonial Curricula: Kenyan Students' Perceptions of Gender in School Textbooks." *International Journal of Educational Development* 33 (2): 163-72 https://doi.org/10.1016/j.ijedudev.2012.03.005.

Foulds, Kim. 2016. "The Somali Question: Protracted Conflict, National Narratives, and Curricular Politics in Kenya." In *History Can Bite: History Education in Divided and Post-War Societies,* edited by Denise Bentrovato, Karina Korostelina and Martina Schulze, 45-60. Göttingen: V&R Unipress https://doi.org/10.14220/9783737006088.45.

Foulds, Kim, and Abby Bucuvalas. 2019. "Playing Every Day on *Sesame Street:* Global Learnings from a Play-Based Pilot Intervention in India, Mexico, and South Africa." *American Journal of Play* 12 (1): 17-36. https://files.eric.ed.gov/fulltext/EJ1238557.pdf.

Gertler, Paul, James Heckman, Rodrigo Pinto, Arianna Zanolini, Christel Vermeersch, Susan Walker, Susan M. Chang, and Sally Grantham-McGregor. 2013. *Labor Market Returns to Early Childhood Stimulation: A 20-Year Followup to an Experimental Intervention in Jamaica*. NBER Working Paper 19185. Cambridge: NBER https://doi.org/10.3386/w19185.

International Organization for Migration. 2018. *Assessment of Mental Health and Psychosocial Needs of Displaced Refugees Roginghya in Cox's Bazar.* Cox's Bazar, Bangladesh: International Organization of Migration.

IPA (Innovations for Poverty Action). 2018. *Current Level of Knowledge, Attitudes, Practices, and Behaviours (KAPB) of the Rohingya Refugees and Host Community in Cox's Bazar: A Report on Findings from the Baseline Survey.* Dhaka: IPA. https://reliefweb.int/report/bangladesh/current-level-knowledge-attitudes-practices-and-behaviours-kapb-rohingya-refugees.

IPA (Innovations for Poverty Action). 2019. *Humanitarian Needs Assessment of Rohingya Camps & Host Communities.* Report prepared for Sesame Workshop. Dhaka: IPA.

Jeffrey, Patricia, and Robert Jeffrey. 1998. "Silver Bullet or Passing Fancy? Girls' Schooling and Population Policy." In *Feminist Visions of Development: Gender Analysis and Policy,* edited by Cecile Pearson and Ruth Jackson, 239-58. London: Routledge https://doi.org/10.4324/9780203980460-17.

Kelly-Vance, Lisa, and Brigette Oliver Ryalls. 2008. "Best Practices in Play Assessment and Intervention." In *Best Practices in School Psychology V,* edited by Alex Thomas and Jeff Grimes, 54-60. Bethesda, MD: National Association of School Psychologists.

Khan, Asraul. 2019. *The Impact of Large-Scale Forced Displacement on Rohingya Refugees and Host Communities in Cox's Bazar, Bangladesh*. Dhaka: Innovations for Poverty Action.

Kingston, Lindsey. 2015. "Protecting the World's Most Persecuted: The Responsibility to Protect and Burma's Rohingya Minority." *The International Journal of Human Rights* 19 (8): 1163-75 https://doi.org/10.1080/13642987.2015.1082831.

Kohn, Shanna, Kim Foulds, Katie Maeve Murphy, and Charlotte Cole. 2020. "Creating a *Sesame Street* for the Syrian Response Region: How Media Can Help Address the Social and Emotional Needs of Children Affected by Conflict." *Young Children* 75 (1): 32-41. https://search.proquest.com/openview/b98905081a01d03f5c05527ccb6b1446/1?pq-origsite=gscholar&cbl=27755.

Mayo Clinic. n.d. *Somatic Symptom Disorder.* Rochester, MN: Mayo Clinic.

Médecins Sans Frontières. 2018. *One Year On, Rohingya Refugees Live in Dire Camps, Facing an Uncertain Future and Legal Limbo.* Cox's Bazar, Bangladesh: Médecins Sans Frontières.

Merritt, Chiara. 2017. *Protection in Protracted Refugee Situations: The Case of Rohingya Refugees in Bangladesh.* BIGD Working Paper Series. Dhaka: BRAC University.

Mohanty, Chandra Talpade. 2003. *Feminism without Borders: Decolonizing Theory, Practicing Solidarity.* Durham, NC: Duke University Press.

Murphy, Katie Maeve, Hiro Yoshikawa, and Alice Wuermli. 2018. "Implementation Research for Early Childhood Development Programming in Humanitarian Contexts." *Annals of the New York Academy of Sciences* 1419 (1): 90-101. Project Information Management. 2018. *PIM Matrix.* Geneva: ICT 4 Peace. https://doi.org/10.1111/nyas.13691

Richter, Linda M., Bernadette Daelmans, Joan Lombardi, Jody Heymann, Florencia Lopez Boo, Jere R. Behrman et al. 2016. "Investing in the Foundation of Sustainable Development: Pathways to Scale Up for Early Childhood Development." *The Lancet* 389 (10064): 103-18 https://doi.org/10.1016/s0140-6736(16)31698-1.

Shonkoff, Jack, Linda Richter, Jacques van der Gaag, and Zulfiqar A. Bhutta. 2012. "An Integrated Scientific Framework for Child Survival and Early Childhood Development." *Pediatrics* 129 (2): 1-13 https://doi.org/10.1542/peds.2011-0366.

UNDP (UN Development Programme). 2019. *Impacts of the Rohingya Refugee Influx on Host Communities*. Dhaka: United Nations Development Programme, Bangladesh Country Office https://doi.org/10.1111/nyas.13691.

UNHCR (UN High Commissioner for Refugees). 2017. *Contribution to the Fifteenth Coordination Meeting on International Migration.* Geneva: UNHCR.

UNHCR (UN High Commissioner for Refugees). 2017. *Needs Assessment Handbook.* Geneva: UNHCR.

UNICEF (UN Children's Fund). 2019. *Bangladesh Humanitarian Situation Report No. 49 (Rohingya Influx).* Dhaka: UNICEF.

UNOCHA (UN Office for the Coordination of Humanitarian Affairs). 2019. *Financial Tracking System.* New York: UNOCHA.

Young, Mary E. 2007. "The ECD Agenda: Closing the Gap." In *Early Child Development from Measurement to Action: Priority for Growth and Equity,* edited by Mary E. Young and Linda M. Richardson, 1-16. Washington, DC: World Bank. https://web.oas.org/childhood/EN/Lists/Recursos%20%20Bibliografia/Attachments/16/14.pdf.

Zubairi, Asma, and Pauline Rose. 2018. *Just Beginning: Addressing Inequality in Donor Funding for Early Childhood Development.* Donor scorecard. London: Theirworld.

JOURNAL ON EDUCATION IN EMERGENCIES

BRAC Humanitarian Play Lab Model: Promoting Healing, Learning, and Development for Displaced Rohingya Children

Author(s): Erum Mariam, Jahanara Ahmad, Sarwat Sarah Sarwar

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 133-149

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62226

DOI: https://doi.org/10.33682/u72g-v5me

REFERENCES:

The *Journal on Education in Emergencies (JEiE)* publishes groundbreaking and outstanding scholarly and practitioner work on education in emergencies (EiE), defined broadly as quality learning opportunities for all ages in situations of crisis, including early childhood development, primary, secondary, non-formal, technical, vocation, higher and adult education.

BRAC HUMANITARIAN PLAY LAB MODEL: PROMOTING HEALING, LEARNING, AND DEVELOPMENT FOR DISPLACED ROHINGYA CHILDREN

Erum Mariam, Jahanara Ahmad, and Sarwat Sarah Sarwar

ABSTRACT

In August 2017, almost a million Rohingya people fled to Bangladesh to escape violence and persecution in Myanmar; 55 percent of them were children. BRAC, one of the largest nongovernmental organizations in the world, operates an initiative called the Humanitarian Play Lab model for children ages 0-6 in the Rohingya refugee camps in Bangladesh. The intervention combines play-based learning with psychosocial support from paracounselors to promote positive developmental outcomes for children in crisis settings. Designed using a community-based participatory approach that promotes a sense of pride and belonging among those living in a displaced community, the play model strongly emphasizes the importance indigenous cultural practices play in healing and learning. This field note, in which we describe the key features of the play model, covers the period of implementation from its start in October 2017 up to December 2019. Our intended audience includes policymakers, practitioners, and other advocates for early childhood development and play who are working to promote child development and wellbeing in humanitarian settings. We offer this description as a case study of how providing play-based learning to children in emergency situations may help mitigate the detrimental long-term effects of displacement and trauma.

Received October 15, 2019; revised February 18, 2020, and August 17, 2020; accepted May 10, 2021; electronically published June 2021.

Journal on Education in Emergencies, Vol. 7, No. 1

ISSN 2518-6833

BRAC'S HUMANITARIAN PLAY LAB MODEL WITH DISPLACED ROHINGYA CHILDREN

The duration of population displacements is increasing around the globe: UNHCR (2017) data estimate that protracted refugee situations now last an average of 26 years. At the end of 2018, some 15.9 million refugees across the globe were living in situations of protracted displacement (UNHCR 2018). This means that the short-term responses that dominate humanitarian aid are wildly insufficient. Efforts must focus instead on sustainable solutions that bridge the humanitarian/development divide to fuel long-term recovery. At present, less than 3 percent of the global humanitarian aid budget is dedicated to education, and a mere fraction of that benefits young children (UNESCO 2015).

One of the biggest refugee crises in recent years has been the displacement of the Rohingya people from Myanmar to Bangladesh. The Rohingya, who numbered around one million in Myanmar at the start of 2017, are one of many ethnic minorities in the country. Rohingya Muslims represent the largest percentage of Muslims in Myanmar, the majority of them living in Rakhine State. However, the government of Myanmar, a predominantly Buddhist country, denies the Rohingya citizenship and even excluded them from the country's 2014 census. In the last few years before the current crisis, thousands of Rohingya fled from Myanmar to escape communal violence or alleged abuse at the hands of Myanmar's security forces (BBC 2020).

In August 2017, a widescale exodus took place—almost a million Rohingya fled to Cox's Bazar, Bangladesh, to escape persecution and violence in Myanmar. The vast majority of the displaced Rohingya people currently living in Bangladesh are women and children; more than 40 percent are under age 12 (UNHCR n.d.). Uprooted from their homes, this marginalized population has faced trauma and violence, and many of them are now showing signs of psychological distress.

Since 2015, BRAC, one of the world's largest nongovernmental organizations, has implemented its Play Lab model, an early childhood program that uses a play-based curriculum, in Bangladesh, Uganda, and Tanzania. The Play Lab curriculum integrates learning and developmental outcomes set by the government of each country with play activities that are tailored to the cultural context. Learning through play is the primary goal, as research shows that play-based activities are an optimal way to help children learn, to promote the development of their language, social, and emotional skills, and to foster their creativity and imagination (Hirsh-Pasek and Golinkoff 2008; Pyle and Danniels 2017). The Play Lab model, which

is implemented in community centers and in government primary schools, is designed to ensure that the most vulnerable children and families have access to quality early childhood development services and education. The beneficiaries are children who live in low-income communities. Young women from the community are hired and trained as facilitators, or Play Leaders, of the activities. The design of the spaces where the program is implemented is a key focus of the model. Parents and community members collaborate with the Play Leaders to build toys and decorations using low-cost, recycled materials.

BRAC's Humanitarian Play Lab (HPL) model, a play-based program for children living in emergency settings, has adapted the theoretical underpinnings of the Play Lab model to the humanitarian context of the Rohingya refugee community in Cox's Bazar—currently the largest refugee settlement in the world. The aim of the HPL model is to promote positive developmental outcomes for children in crisis settings and to help them build resilience in order to overcome the trauma they have faced. This model is underpinned by the assumption that using activities taken from their own culture will give children who have been uprooted from their homes a sense of pride and belonging, which in turn will help them heal. This assumption is based on BRAC's observations and experiences of implementing the HPL model in the field. The HPL model integrates playful learning with child protection, psychosocial support, and links to critical services. It incorporates relevant cultural traditions into its work and engages with both the Rohingya and the host communities. The HPL curriculum includes approaches and play activities based on the Rohingya culture, which were drawn from a continuous series of observations, interviews, and focus group discussions with the Rohingya community. Young Rohingya women serve as facilitators: those working with the model for children ages 2-6 are known as Play Leaders, those with the model for children ages 0-2 as Mother Volunteers. The model is implemented in child friendly spaces (CFS) and operates within the Child Protection Sub-Sector.[1]

The HPL model, which is easily adaptable, adopts the best cultural practices of communities living in humanitarian settings. This makes it both accessible and scalable in different environmental and social contexts. The model demonstrates how organizations and stakeholders can work together to ensure that the content

1 The Child Protection Sub-Sector is a coordinating body that brings together both national and international agencies to organize activities and interventions related to child-protection issues in the camps. It functions as part of the Protection Sector Working Group. Organizations in the Child Protection Sub-Sector include Save the Children, BRAC, Terre des Hommes, and others, with UNICEF being the lead organization. It aims to prevent and respond to abuse, neglect, exploitation, and violence against Rohingya children and host community children affected by conflict. CFS are one of UNICEF's key child-protection interventions; they provide safe spaces where children in crisis situations can access recreation and learning activities.

is relevant to the cultural context and, in turn, generate a sense of ownership among community members. As of December 2019, BRAC was running 304 CFS in the camps in Cox's Bazar and reaching around 41,000 Rohingya children ages 0-6. Since December 2018, BRAC has been working in partnership with Sesame Workshop, the International Rescue Committee, New York University's Global TIES for Children, and the LEGO Foundation as part of the Play to Learn project to scale-up the model and cocreate additional elements to integrate into the HPL intervention.

This paper proceeds as follows. We first describe BRAC's response during the initial days of the Rohingya crisis. We then describe how the play-based model was developed using Rohingya cultural practices and how the model is differentiated for various age groups. Next, we summarize how BRAC uses paracounselors to integrate psychosocial support into the model, how Rohingya cultural elements are integrated into the design of the spaces where the model is implemented, and how monitoring data are used to improve implementation. We conclude with a short discussion of the challenges we faced, and of lessons learned that other organizations can apply.

DEVELOPMENT AND ADAPTATION OF THE MODEL FOR THE ROHINGYA COMMUNITY IN COX'S BAZAR

Early Days in the Humanitarian Camps

Within a couple of weeks of the influx of Rohingya into Bangladesh in mid-September 2017, several BRAC staff members visited Cox's Bazar to observe the situation and assess the ongoing crisis. What they observed was a scene of great confusion. People were clustered on the side of the road, as many of them did not know where to go or what to do. The BRAC staff members spent a few days talking to people from the Rohingya community. Psychologists employed by BRAC shared their observations, which showcased several cases of children with vacant eyes, children who were very violent and aggressive, and others who were extremely quiet and withdrawn. Preliminary observations in the camps noted that the children talked of revenge and violence, and their artwork initially expressed violent themes, including images of guns, bloodshed, and bombs. Providing psychosocial support to children and their families was deemed crucial.

The Child Protection Sub-Sector, which was well organized in the early days of the crisis, provided an easy entry point for BRAC to work with children and implement its play-based model. From the beginning, BRAC had the goal of scalability and replicability in mind. It had a good presence in all sectors across all the camps—education, shelter, health, etc.—which simplified on-the-ground coordination across sectors in the camps and enabled BRAC to scale-up its interventions quickly.

UNICEF provides a standard guideline for CFS (UNICEF 2018), which BRAC adapted to the needs of the Rohingya community. Initial observations showed that, although toys and books were provided, most of the children had no idea what to do with them. Many of the children were withdrawn and would sit in a corner, unable or unwilling to talk or interact. It was clear to BRAC staff members that some elements of psychosocial support and child stimulation would need to be added to the usual CFS practices. When BRAC started to operate its own CFS in 2017, its goals included providing safe spaces for children, nurturing their spontaneity and promoting their holistic development, and giving them a sense of belonging by preserving elements of their culture.

Adapting the CFS Concept

BRAC was originally running seven CFS in collaboration with UNICEF, which trained the BRAC employees on standard CFS procedures. BRAC added elements of child development, child engagement, and social-emotional learning to the curriculum. Several small CFS were created throughout the camps to enhance access for all the children. Fixed rather than mobile facilities were built to make it easier to keep track of the children attending the CFS, who were required to stay for at least two hours—a child-protection measure. The children were divided into age cohorts of 2-4 years and 4-6 years, again to make it easier to track their attendance. An initial curriculum for the play-based model was developed toward the end of 2017.

Other educational opportunities for children in the camps included learning centers run by UNICEF and other organizations, which provided nonformal basic education. The classes offered included English, math, Burmese, science, and life skills. BRAC's play model was unique in this landscape, in that it provided learning opportunities for children younger than six through play activities rooted in the Rohingya culture.

Integrating Culture with Play and Developing the Curriculum

The learning framework at the heart of the HPL curriculum was developed in conjunction with various international consultants who were experts in curriculum design and play-based pedagogy. It is based on the Early Learning Developmental Standards set by the Bangladesh government, which define developmental outcomes for different age groups (Bhatta et al. 2020). The learning framework focuses on four broad areas of development—physical, social and emotional, language and communication, and cognitive. Each of these developmental domains has defined outcomes for the different age cohorts.

Since 2017, BRAC's curriculum team has been collecting and documenting elements of the Rohingya culture, including *kabbiyas* (folk rhymes), *kissas* (stories), art motifs, and various physical activities, around which they design the curriculum. Initial surveys and focus group discussions conducted in the camps revealed that traditions and cultural norms such as collectivism, as well as intergenerational practices, stories, and rhymes, play a strong role in the everyday lives of the community members. The following elements of the Rohingya culture emerged through conversations with community members, by playing with children and asking them what they liked, and observing community members' practices:

- The *kabbiyas* of the Rohingya people, which are often folk rhymes passed on orally from generation to generation, play an essential role in the lives of the children. Chanting the *kabbiyas* brings the children together, and the joy on their faces as they chant is clear to see. Parents and other adults chant the rhymes alongside the children, and the community members describe the effect as cathartic.

- The *kissas* of the Rohingya people root them to their culture, create a feeling of harmony among the children, and forge strong bonds between children and their parents. These stories are often animal fables or folk tales centering on kings and queens, princes and princesses.

- Traditional games and physical activities bring out the children's spontaneity and joyfulness. The games are usually detailed, each with its own set of rules. Initial observations show that the games are gendered; boys demonstrate skill in activities such as the "Elephant Game," where they climb on top of each other to form an elephant, and the girls play "*Iching Biching*," a game with very intricate footwork. However, all the games display a remarkably

wide array of skills, dexterity, and endurance that BRAC had not observed in children in the Bangladeshi community.

- Art is very important to the Rohingya community. Given a piece of paper and some crayons, children as young as two or three years old will sit down and patiently draw patterns that are often complex. Community members report that creating these floral patterns and motifs that are so specific to their culture gives these displaced children the feeling that home is never far away.

Activities that are taken from the Rohingya culture are modified to achieve the outcomes set out in the learning framework, and each activity in each session has associated learning outcomes. A curriculum manual has been developed in which all the steps of the activities are illustrated, which enables the Play Leaders, many of whom have a low literacy level, to understand them easily. The Play Leaders are introduced to the activities through a series of training sessions and field observations. The curriculum team also receives feedback from facilitators, field staff, and consultants who are experts in pedagogy and play-based learning, which leads to further refining of the activities.

In the early days of the model implementation, the two Play Leaders who facilitated each session in the CFS were from the host communities surrounding the camps, including Cox's Bazaar, Teknaf, and Ukhia. That later changed so that one Play Leader came from the host community and the other from the Rohingya community. Then, in 2019, BRAC program staff observed that women from the Rohingya community who were trained in play-based learning and psychosocial support functioned very well as Play Leaders. BRAC thus decided that both Play Leaders would be Rohingya women, which would give the children more positive role models from their own community. It also made it easier to facilitate activities taken from the Rohingya culture.

BRAC also wanted to empower young Rohingya women from the refugee community, and staff members found that engaging them as Play Leaders helped create a sense of ownership of the model among community members. The Play Leaders, who generally have a minimum level of primary or early secondary education, are given an initial five day long basic training, followed by monthly refresher trainings. The content of these training sessions is decided by the curriculum team and tailored to issues the Play Leaders report encountering as they do their job. The Play Leaders are supervised by Project Assistants who give them on-the-spot mentoring and coaching as needed.

The Humanitarian Play Lab Model for Different Age Groups

The HPL includes a center-based model for children ages 2-6, a home-based model for children ages 2-4, and a home-based group model for children ages 0-2 and their mothers.

The Center-Based Model for Children Ages 2-6

Two shifts of two-hours each are run in the CFS, also called HPL centers. One focuses on children ages 2-4 and the other on children ages 4-6. The curriculum for the age 4-6 cohort is focused on traditional academic outcomes that are achieved through play-based activities. For example, Burmese alphabets are taught during *kabbiyas* and through art activities; numbers are taught through physical play activities and rhymes; concepts of big-small, tall-short, and patterns are taught through art and physical play, and so on. On average, 40 children per shift are supervised by two Play Leaders. The routine for a shift starts with one 10-minute welcome session, followed by four sessions of 25 minutes each. The sessions focus on *kabbiyas* and *kissas*, physical play activities, free play, and art. The shift concludes with a 10-minute goodbye session. Each activity has specific learning objectives based on the learning framework; hygiene and safety messages and exercises for emotional self-regulation are also included in the HPL curriculum. The HPL centers are informally referred to as *Kelle Peyo Nera,* meaning Happy Play Space—a name given by the Rohingya community

The Home-Based Model for Children Ages 2-4

BRAC also operates a home-based model for the ages 2-4 cohort, which is similar to the center-based model for children ages 2-6. In 2019, BRAC piloted sessions for children ages 2-4 in 50 home-based pockets, a pocket being a predefined catchment area surrounding an HPL center. The aim was to increase the number of children reached. While the curriculum for the home-based model is similar to that used in the HPL centers, the activities have been modified for smaller spaces and fewer children. In the home-based model, one Play Leader supervises 14-15 children.

The Home-Based Group Model for Children Ages 0-2 and Their Mothers

There also is a home-based group model for children ages 0-2 and their mothers. The informal name for these group sessions is *Ajju Khana,* or Place of Hope, which was chosen by the Rohingya mothers. Introduced in May 2018, this home-

based group model focuses on alleviating symptoms of maternal depression and on teaching the mothers how to interact with and nurture their children. Paracounselors facilitate this model with the help of Mother Volunteers from the Rohingya community. As of December 2019, one thousand home-based pockets were operational.

Group sessions are run out of one mother's home. Research shows that maternal wellbeing is important to children's developmental outcomes, especially young children (Singla, Kumbakumba, and Aboud 2015; Alvarez et al. 2017). Therefore, the age 0-2 group model strongly emphasizes maternal mental health and attachment to their children, and thus helps prevent cases of intergenerational trauma. Sessions are run with 11-14 Rohingya mother-child dyads and meet once a week. The paracounselors conduct one home visit with future mothers in their last trimester of pregnancy to prepare them for the birth and to talk about maternal mental health. When the baby is between 0 and 45 days old, a paracounselor conducts another home visit to check on the mother and give her tips on taking care of her newborn. Mothers and children join the group sessions when the baby is more than 45 days old.

A typical group session has four components. An opening greeting section is followed by a section on maternal mental health. Concepts related to psychosocial support such as positive thinking and anger management are introduced in this session through discussion and activities. This is followed by a section on infant stimulation. Activities introduced in the infant stimulation sessions are designed in consultation with the community and are modified for children of different ages. The last section focuses on concluding the session and saying goodbye. During these sessions, the paracounselors identify mothers who might need additional psychosocial support and then visit them in their homes to provide that support in conjunction with psychologists.

Providing Psychosocial Support through Paracounselors

Mental health and psychosocial wellbeing are critical components of the HPL model. Conversations with and observations of Rohingya children have shown that a vast majority of them suffer from severe trauma, stress, anger, etc. Mothers of these children also suffer from trauma, stress, anxiety, depression, etc. The HPL model thus connects beneficiaries to psychosocial counseling through a four-tier referral pathway.

The BRAC paracounselors are an integral part of BRAC's four-tier psychosocial referral pathway and they were instrumental in integrating mental health support into the HPL model. The paracounselors are frontline staff members who are trained to provide psychosocial support to children and their family members under the supervision of psychologists. Each paracounselor is assigned a specific HPL center, where they attend to the mental health needs of the children in attendance. They also conduct home visits in a predefined catchment area surrounding their center and facilitate basic training for the Play Leaders in the skills required to provide psychosocial support, build rapport with beneficiaries, and observe and identify clients.

The paracounselors make a daily report to the psychologists about new cases of children who may be suffering from psychosocial distress. The psychologists then determine if any cases require therapeutic services and guide the paracounselors in deciding what techniques and methods to use next. The psychologists also can refer children to psychiatrists and other experts for further support. The paracounselors are also responsible for referring individuals to other necessary services and groups, such as health-care facilities, BRAC's Human Rights and Legal Service group, the CFS manager, etc.

The paracounselors are young women from the host community who speak a dialect similar to the Rohingya language. BRAC selected women from the host community for a number of reasons: they generally had a higher level of education than Rohingya women, and the organization believed that, to provide adequate psychosocial support, the paracounselors themselves needed to be free of trauma. The Rohingya women had experienced significant trauma, and BRAC felt that it would not be effective to ask them to provide psychosocial support to others while dealing with their own mental health issues. Moreover, because of the cultural stigma surrounding mental health issues in the Rohingya community, BRAC thought it would be easier for Rohingya people to confide in outsiders they did not have to see or interact with regularly.

The referral pathway works as follows:

1. Play Leaders are trained to provide psychosocial support. They deliver programs in the HPL centers and build rapport with children and their families during play sessions. Utilizing their training, Play Leaders identify children who might need psychosocial support and refer them to the paracounselors.

2. Paracounselors conduct routine visits to HPL centers and private homes to provide psychosocial support to those in need. They also advise and support the Play Leaders, provide psychosocial counseling support to children and mothers, and offer parenting sessions to mothers of children ages 0-2. Paracounselors report to assigned counseling psychologists.

3. Counseling psychologists supervise the paracounselors, provide therapeutic support for the more complex cases, and provide training for both Play Leaders and paracounselors.

4. Experts are national and international psychologists and psychotherapists who work in the fields of clinical psychology, counseling psychology, education, maternal wellbeing, child development, play, and child observation. They supervise the psychologists, develop capacity-building initiatives, and create content, frameworks, and evaluation tools for play-based healing and psychosocial wellbeing for use in the HPL model. They also provide support in making clinical assessments of the referred cases and sometimes refer cases for psychiatric treatment.

During regular play sessions in the HPL centers, Play Leaders observe children for signs of withdrawal and aggression. The identified cases are referred to the paracounselors, who provide psychosocial assistance to these children and, if necessary, to their family members through home visits and sessions in the HPL center. The Play Leaders also identify children who have been separated from their parents (they reside in different camps) or are unaccompanied (they crossed the Myanmar-Bangladesh border without a parent or guardian), and refer the list to the paracounselors.

During home visits, the paracounselors identify individuals who display one or more of the following signs:

- Disrupted eating
- Disrupted sleeping
- Withdrawal
- Aggression
- Inability to do their daily activities

- Intrusive thoughts and nightmares
- Suicidal ideation

In 2017 and 2018, paracounselors went door-to-door to provide support, in consultation with psychologists, to anyone they felt needed psychosocial assistance. As their client group became more defined over time, they started to focus more on children and their family members. The paracounselors and psychologists have received extensive training from consultants and experts from various national and international organizations on using psychosocial support skills, such as active listening, displaying empathy, maintaining confidentiality, maintaining an unbiased attitude, and refraining from personal judgment. The psychologists and paracounselors are also trained in different therapeutic techniques that range from play therapy to psychological first aid to recognizing signs of trauma. This training is ongoing.

Designing Spaces Where the Model Is Implemented Based on Rohingya Culture

The initial HPL centers built in September-October 2017 were rudimentary—just canvas tents tied to four bamboo posts stuck into the ground. In early 2018, those at risk of damage from landslides or flooding were relocated. The roofs of some centers built on hills were tied down to prevent them from being blown away in strong winds. All the centers were repaired and reinforced with stronger building materials.

Besides making sure the CFS were structurally sound, BRAC began to focus on their design and feel. In June 2018, BRAC organized focus groups, which were facilitated by architects it employed, to discuss the common housing patterns and traditional décor found in the Rohingya culture. Beginning in September 2018, BRAC tested the process of using traditional Rohingya elements to decorate the CFS. Architects and community members worked together to incorporate *shamiyanas,* the traditional tapestries of the Rohingya community, and *alpanas,* or traditional designs painted on walls. This process was refined for implementation on a larger scale in December 2018, when the community designed about 300 CFS with the help of the Play Leaders and managers, following detailed guidelines from the architects. Because physical play is important for the Rohingya children, the architects made sure the play centers had open, unrestricted interiors, as big outdoor play spaces often were not available in the camps.

In late March 2019, BRAC decided that the Rohingya community should take charge of the whole design and building process, with architects on site to observe and guide them. The organization held a workshop for Rohingya children, their families, and community members that included architects who were experts in the community-led participatory design process and in play-space design. Starting in April 2019, under the supervision of these architects, the Rohingya community designed, developed, and implemented its new play spaces. Eighteen indoor play spaces and two outdoor play spaces were constructed and implemented in May and June 2019. The architects took inspiration from traditional Rohingya building practices to create spaces in which the Rohingya people would feel at home.

Monitoring and Research

Monitoring data used to assess the day-to-day activities of the HPL implementation began to be collected regularly in late 2018. The data, such as children's attendance records, how facilitators implemented the curriculum, etc., are used to improve the program implementation.

The monitoring tools include observation checklists to measure the quality of interactions between the Play Leaders and the children, the environmental quality, and how faithful the program implementation is to its stated objectives. Monitoring officers collect these data regularly and share them with program staff, who use them to inform program revisions.

BRAC is currently working with consultants and experts to improve the quality of the monitoring data collected. Children, mothers in the age 0-2 home-based model, and program staff such as Play Leaders all have high attendance records—an indication that these participants find value in the program. Focus group discussions with mothers, facilitators, and community members also indicate that the program is having a positive impact. The reasons for this are many. First, BRAC has been able to engage successfully with the community to ensure that the intervention is tailored to their needs and is culturally contextualized. The program provides a stimulating environment for children to engage in play-based learning and receive psychosocial support. The program also provides a safe space for mothers to process and heal from their traumas and learn about child stimulation. The program is also focused on women's empowerment, which it demonstrates by hiring young Rohingya women as facilitators and giving them extensive training to build their capacity. BRAC has worked to identify several globally accepted monitoring and evaluation tools and adapt them to the Rohingya context. A couple of internal research studies carried out by BRAC James P. Grant

School of Public Health, BRAC University and BRAC Institute of Governance and Development, BRAC University in 2019 show the positive impact the HPL intervention is having on children; the studies have not yet been published. Global TIES for Children at New York University will be evaluating the HPL model over the next few years, including a rigorous study of how the play model affects children's developmental outcomes.

CONCLUSION: LESSONS LEARNED AND MOVING AHEAD

The HPL model developed in the Rohingya refugee camps of Bangladesh combines the science of play with psychosocial support. The aim is to build resilience in children who are living in fragile settings and provide them with a safe, nurturing environment where they can engage in age-appropriate, stimulating, culturally relevant activities. The model, which is based on a participatory approach, includes elements of the Rohingya culture, such as play activities. This is done to give the children a sense of belonging; facilitators are chosen from the Rohingya community for the same reason. The spaces where the model is implemented are designed using elements from the Rohingya culture. BRAC staff members hold material development workshops at which facilitators, mothers and other family members, and community members use low-cost recycled materials to create toys and decorations for the centers. This ensures that the intervention is relevant to the refugees' home culture and gives them a sense of ownership.

BRAC's bottom-up approach, which is grounded in a deep understanding of the Rohingya context, was key to the model's development. Because of extensive, detailed planning and strong technical expertise, coupled with being flexible and willing to adapt to changing circumstances in the camps, the organization successfully scaled-up its programs in a short amount of time with only limited resources. The model has been adapted to reflect research results and will continue to be adapted as necessary as BRAC gains a deeper understanding of the Rohingya culture. BRAC is partnering with Sesame Workshop and others to cocreate several new elements that will be integrated into the program in the future, such as storybooks and parenting education. Sesame Workshop is also creating video content for use in the program.

By implementing the HPL model, BRAC has learned several lessons that may be applicable to other organizations. First, any learning intervention for young children in a humanitarian setting should also focus on their psychosocial wellbeing. It is also important to understand the needs of the beneficiaries and to include them in the design of any intervention meant to serve them. It is

important to get started with the implementation of a model without waiting for the perfect design, since the design will change in keeping with the experience of implementing it in the field. BRAC started the HPL model in late 2017, and it has since gone through several major iterations based on observations, feedback, and lessons from on-the-ground experience. In the humanitarian context, it is particularly important to work in any sector that provides an easy entry point—for BRAC's HPL model, this was the Child Protection Sub-Sector. This experience has also informed BRAC's implementation of the Play Lab model in noncrisis settings. We have come to realize how crucial providing psychosocial support is when promoting child development and positive parenting in all contexts, not just in conflict and crisis settings. Thus, we have strengthened the mechanisms for providing psychosocial support to children and caregivers in our Play Lab model.

BRAC faced several challenges while implementing the model, including a lack of space in the camps. Here the organization had an advantage because it was working in all sectors and had a presence in the camps since the early days. Another challenge was to focus continuously on disaster preparedness, because the area where the camps are located is prone to heavy rains, floods, and mudslides for several months each year. Many Play Leaders have low literacy levels and little initial capacity to facilitate effectively, thus they need a lot of training and support, and the curriculum must be largely picture based to accommodate their limitations. Although the Rohingya community has many unique play activities, the concept of learning through play was new for many Rohingya adults. BRAC initially faced strong resistance from the community about women working as facilitators, but because the model was developed using a participatory approach, which included consultations and conversations with community members, this resistance was slowly overcome.

Despite the many challenges, this model holds great promise for adaptation to other humanitarian contexts. Engaging in play-based activities with responsive caregivers can help mitigate the long-term detrimental effects displacement and trauma have on children and help them gain the skills they need to thrive. The model provides practitioners and policymakers with a case study of how to design a play-based intervention for young children in a humanitarian setting in cooperation with members of the displaced community. Its principles can be adapted to humanitarian settings around the world.

REFERENCES

Alvarez, Shanna L., Samantha Meltzer-Brody, Marcia Mandel, and Linda Beeber. 2015. "Maternal Depression and Early Intervention: A Call for an Integration of Services." *Infants and Young Children* 28 (1): 72-87. https://www.doi.org/10.1097/IYC.0000000000000024.

BBC. 2020. "Myanmar Rohingya: What You Need to Know about the Crisis." BBC, January 23, 2020. https://www.bbc.com/news/world-asia-41566561.

Bhatta, Saurav Dev, Tashmina Rahman, Md. Naibur Rahman, Uttam Sharma, and Lindsay Adams. 2020. *The Landscape of Early Childhood Education in Bangladesh.* World Bank Report Number: AUS0001357. Washington, DC: World Bank. http://documents1.worldbank.org/curated/en/720311583471084983/pdf/The-Landscape-of-Early-Childhood-Education-in-Bangladesh.pdf.

Hirsh-Pasek, Kathy, and Roberta Michnick Golinkoff. 2008. "Why Play = Learning." In *Encyclopedia on Early Childhood Development,* edited by Richard E. Tremblay, Michel Boivin, and Ray DeV. Peters. https://www.child-encyclopedia.com/play/according-experts/why-play-learning.

Pyle, Angela, and Erica Danniels. 2017. "A Continuum of Play-Based Learning: The Role of the Teacher in Play-Based Pedagogy and the Fear of Hijacking Play." *Early Education and Development* 28 (3): 274-89. https://doi.org/10.1080/10409289.2016.1220771.

Singla, Daisy R., Elias Kumbakumba, and Frances E. Aboud. 2015. "Effects of a Parenting Intervention to Address Maternal Psychological Wellbeing and Child Development and Growth in Rural Uganda: A Community-Based, Cluster-Randomised Trial." *The Lancet Global Health* 3(8): 458-69. https://doi.org/10.1016/S2214-109X(15)00099-6.

UNESCO (United Nations Educational, Scientific and Cultural Organization). 2015. "Humanitarian Aid for Education: Why It Matters and Why More Is Needed." UNESCO Key Messages: Policy Paper 21. Paris: UNESCO. https://en.unesco.org/gem-report/humanitarian-aid-education-why-it-matters-and-why-more-needed.

UNHCR (United Nations High Commissioner for Refugees). n.d. *Rohingya Emergency.* Geneva: UNHCR. https://www.unhcr.org/rohingya-emergency.html.

UNHCR (United Nations High Commissioner for Refugees). 2017. *Global Trends: Forced Displacements in 2017.* Geneva: UNHCR. https://www.unhcr.org/5b27be547.pdf.

UNHCR (United Nations High Commissioner for Refugees). 2018. *Global Trends: Forced Displacement in 2018.* Geneva: UNHCR. https://www.unhcr.org/globaltrends2018/.

UNICEF (United Nations International Children's Emergency Fund). 2018. *A Practical Guide to Developing Child Friendly Spaces.* New York: UNICEF. https://www.humanitarianresponse.info/en/operations/afghanistan/document/practical-guide-developing-child-friendly-spaces-unicef.

JOURNAL ON EDUCATION IN EMERGENCIES

Accessible Strategies to Support Children's Mental Health and Wellbeing in Emergencies: Experience from the Rohingya Refugee Camp

Author(s): Samier Mansur

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 150-163

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62227

DOI: https://doi.org/10.33682/1cba-5m06

REFERENCES:

Mansur, Samier. 2021. "Accessible Strategies to Support Children's Mental Health and Wellbeing in Emergencies: Experience from the Rohingya Refugee Camp." *Journal on Education in Emergencies* 7 (1): 150-163. https://doi.org/10.33682/1cba-5m06.

ACCESSIBLE STRATEGIES TO SUPPORT CHILDREN'S MENTAL HEALTH AND WELLBEING IN EMERGENCIES: EXPERIENCE FROM THE ROHINGYA REFUGEE CAMP

Samier Mansur

ABSTRACT

More than half a billion children globewide currently live in conflict or crisis contexts (UNICEF 2016), including more than 30 million displaced and refugee children (UNICEF 2020). The extreme and often prolonged adversity suffered in these environments can have lifelong physical, psychological, and socioeconomic consequences for children, and thus for society, and can affect an entire generation. Despite these dire consequences, less than 0.14 percent of global humanitarian financial aid is allocated to child mental health (Save the Children 2019). Frontline aid workers and parents and guardians often lack access to early childhood development training, and to the resources needed to meaningfully address the unique challenges faced by children living in crisis and conflict environments, including their mental health and wellbeing. To meet these critical knowledge and resource gaps, No Limit Generation, a nonprofit organization based in Washington, DC, developed a video training platform to equip frontline aid workers, parents, and guardians across the globe to support the wellbeing of vulnerable children. No Limit Generation then conducted a monthlong pilot study in the Rohingya refugee camps in Bangladesh to test this technology-driven training approach. In this field note, we describe our program design and pilot findings, which we consider a possible strategy for delivering sustainable and scalable early childhood development training and resources to workers on the front lines. Our hope is that this innovative work will help young children around the world heal, grow, and thrive, and ultimately achieve their full potential.

Received January 6, 2020; revised May 18, 2020, and July 2, 2020; accepted July 22, 2020; electronically published June 2021.

Journal on Education in Emergencies, Vol. 7, No. 1

ISSN 2518-6833

INTRODUCTION

Fifty Rohingya girls and boys from Myanmar sat packed under the shade of a makeshift tent, unsure how to respond to the question I asked them: "What do you want to be when you grow up?" It dawned on me in that moment that no one had asked them this question since they arrived in their new surroundings. Indeed, perhaps no one had ever asked them this question.

One year earlier, these children's lives were violently uprooted. Their homes and villages were burned down, their fathers were executed and their mothers gang-raped by soldiers at gunpoint, and their siblings were flung into burning huts. As Rohingya refugees fled into Bangladesh, humanitarian agencies were overwhelmed by what they called a children's crisis, as more than 60 percent of the nearly one million Rohingya refugees were children (Alexander 2017). With refugee displacement around the world currently lasting an average of 25 years ("Contribution to the Fifteenth" 2017), these Rohingya children are likely to reach adulthood in the camps.

When they first arrived in the camps, it quickly became clear what these children had endured. Clutching crayons in their tiny hands, they expressed on paper what they were battling within, using green for army uniforms, orange for fire, black for machine guns, brown for lifeless bodies, and red for blood. I had never seen crayons used in this way until that day. I was in the tent with the children because it was a part of a child-friendly space (CFS) I founded in partnership with the JAAGO Foundation, a local Bangladeshi organization dedicated to the education and welfare of underserved children, whose name means "WAKE UP!" in Bengali. JAAGO Foundation provides schooling for children in the slums and remote parts of the country who historically have fallen outside the jurisdiction of government schools. We named this place the Safe Haven and designed it as a space of protection, learning, and healing for 500 Rohingya refugee children ages 4 to 15 who were survivors of genocide.

My task as a founder and initial trustee of Safe Haven was to ensure that local aid workers and facility coordinators received the necessary mental health training to play a healing role in the children's lives. During this process, I made the startling observation that aid workers, parents, and caregivers (the adults who

play the most influential role in a child's life) on the front lines of conflict and crisis zones do not have adequate access to training or the resources they need to help children—especially the youngest—work through the unique challenges to their mental health and wellbeing.

I sought to learn more about early childhood development (ECD) training approaches and the accessibility gap by conducting a series of interviews and focus groups with members of leading humanitarian agencies and local nongovernmental organizations (NGOs). Thus I learned the true extent of the problem—or, indeed, the open secret that this challenge is not unique to the Rohingya refugee camps but a systemic global challenge with far-reaching consequences. Fortunately, we now have an opportunity to address it in a meaningful way.

After founding Safe Haven, I launched No Limit Generation (NLG), a global platform to provide aid workers, ECD professionals, educators, parents, and youth-serving professionals the critical training and resources they need to address child wellbeing. NLG partnered with JAAGO Foundation and global humanitarian organizations to implement training programs. NLG works with leading professionals to create engaging video training curricula designed to help local and international organizations respond more effectively to the mental health and ECD needs of children, both broadly and specifically, and to address the most pressing issues faced by children. NLG's pilot launched in May 2019, and its open-access platform has had promising results with frontline aid workers, parents, and caregivers. Based on the pilot results (detailed below), the NLG platform has helped its partner organizations in the Rohingya refugee camps in Bangladesh develop literacy in child wellbeing and mental health. To date, the platform has been accessed in 100 countries by approximately 15,000 frontline professionals, parents, and other caregivers.

This field note, a contribution to the field of ECD in emergencies in which I share my team's research, experience, and insights, provides a snapshot of my key takeaways from our work on the ground from my perspective as the organization's founder. I describe NLG's innovative approach to training practitioners and how it emerged from field research that included interviews and focus group discussions with frontline humanitarian agencies and local NGOs working in the Rohingya refugee camps in Bangladesh. I also offer practical insights for practitioners who support ECD in emergency contexts, including the untapped potential of using technology to provide staff training, the effectiveness of a human-centered communications approach to enhance training outcomes, and key challenges to consider for future programming.

IMPACT OF SEVERE AND PROLONGED STRESS

The world is currently experiencing the highest number of people on the move since World War II (Esthimer 2014). Given the increased number of children living in conflict-affected areas and the growing number of grave violations committed against them, the UN now acknowledges that mental health challenges for vulnerable and conflict-affected populations are much higher than previously thought; estimates are that 22 percent or more of these individuals have a mental health condition (Charlson et al. 2019; Hamdan-Mansour et al. 2017). With new conflict and migration drivers displacing an average of 37,000 people from their homes each day, scalable solutions are urgently needed to address one of the least funded areas of humanitarian intervention: young children's wellbeing and protection. At present, less than 1 percent of global humanitarian aid goes to the protection of children's mental health (Save the Children 2019), even though 30.4 percent of refugee children suffer from post-traumatic stress disorder, 26.8 percent from anxiety, and 21.4 percent from a state of grief (Betancourt et al. 2012).

Enduring traumatic experiences and living in an environment of extreme or prolonged adversity causes severe stress that can dramatically affect the quality and trajectory of children's lives. Recent studies of adverse childhood experiences—defined as physical and emotional abuse, neglect, and household dysfunction experienced before age 18—have demonstrated that, while not every child has the same reaction to adversity, increased exposure to adverse events can have lifelong consequences for children's mental, physical, and social development (Monnat and Chandler 2015). Prolonged stress can impair brain development, which causes developmental delays and regression of developmental milestones (von Werhthern et al. 2018), and children affected by adversity also are at increased risk of developing physical health impairments and diseases, such as cancer, diabetes, and ischemia (Alvarez et al. 2018).

Children living under high-stress conditions are vulnerable to the early onset of mental health challenges, including anxiety, depression, post-traumatic stress disorder, self-harm and suicidal ideation, and extreme emotional fluctuations. They also may engage in high-risk, delinquent, or risk-seeking behaviors. These vulnerabilities often expose a child to further abuse, substance misuse, or neglect (WHO 2020), which can result in subsequent developmental challenges, diminished personal and social skills, and functional limitations that compromise learning, work opportunities, and future earnings. These results not only compromise the individual's quality of life, they also increase public health and social costs and can stunt economic growth and development, both nationally and globally

(Richter et al. 2019). Finally, the consequences of persistent, untreated stress or trauma can be passed down from one generation to the next through epigenetic alterations, which are changes in gene expression (Ramo-Fernández et al. 2015; Dominguez-Salas et al. 2012).

Despite facing such adversity, many children remain adaptive, resilient, and full of potential. The Inter-Agency Standing Committee *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* state that the majority of children in emergency contexts need a stable environment (IASC 2007). Indeed, having strong attachments and responsive care from the beginning of life helps to create a buffer against the impact of toxic stress (Center on the Developing Child n.d.). Nevertheless, many children in crisis contexts are deprived of these buffers.

Total humanitarian funding for children's mental health and psychosocial support from 2015 to 2017 was a mere 0.14 percent of all development assistance (Save the Children 2019). To put this number into perspective, the humanitarian response currently allocates 14 US cents of every US$100 for children's mental health. Below I describe NLG's efforts to promote better understanding of the gaps in ECD training and resources on the front lines.

INSUFFICIENT SUPPORT AND CRISIS OF CARE

In 2018 and 2019, NLG conducted thirty-two interviews and three focus groups with child health professionals from leading humanitarian agencies, and with frontline aid workers from local NGOs, temporary learning centers, and CFSs in the Rohingya refugee camps in Bangladesh. Five members of the NLG team and eight members of NLG partner organizations were involved in this research. Our purpose was to identify the limitations of existing training approaches, determine the accessibility of mental health training and ECD resources in areas of crisis and conflict, and develop needs-based solutions to address gaps we found in training and resources.

Our research identified several challenges. First, there is insufficient local capacity to meet the growing demand for ECD. For instance, there is a shortage of qualified child health professionals on the front lines of the global crises, and most parents, caregivers, and frontline aid workers who work with children in vulnerable environments are not specialists. They usually have little or no experience addressing children's mental or physical health, or protection, and high turnover among field staff exacerbates this challenge.

Second, the existing ECD training was often difficult to access. The barriers aid workers cited most often were the cost of travel, a lack of time off to attend trainings, the inconvenient distance of some trainings, the need for funds to attend, and the length of some trainings or their infrequency. The training they were able to access was often led by non locals, which made the content difficult to comprehend due to language differences, lack of cultural relevance, or the complexity of the curriculum. Lack of follow-up training due to the high cost or to travel and safety restrictions further contributed to workers' poor retention and limited impact on the lives of children. Finally, we found that barriers to ECD training for parents and caregivers centered primarily on time and financial pressures. Parents and caregivers often did not attend, even when training was free, due to the priority they put on earning wages or attending to essential errands to support their families' needs.

NLG'S ACCESSIBLE AND SCALABLE MODEL

NLG's needs assessment revealed that frontline aid workers, parents, and caregivers in the Rohingya refugee camps do not have adequate training or the resources they need to address the unique challenges faced by their children. To help fill this gap, we launched a global online training platform designed to give caregivers the critical guidance they need to stabilize, protect, and heal vulnerable children and restore their wellbeing. NLG's platform is built on the idea that frontline aid workers, parents, and caregivers can help children develop resilience and even reverse the negative impact of toxic stress or trauma. Guidance provided includes the following:

1. Create safe, structured, and inclusive environments for children to play in every day. The availability of safe, predictable, and inclusive environments where children can play and interact with others is healing for those who may have lost the social safety nets they once had.

2. Engage children through informed, trustworthy, and supportive adults. When adult caregivers are informed and engaged as trusted role models, their presence plays a critical role in a child's healthy development (National Scientific Council on the Developing Child 2020).

3. Believe in children's potential to heal and live a fulfilled life. When adult caregivers see a child as strong, resilient, and adaptive, the child no longer views themself as "broken" or in need of "fixing." When caregivers believe in a child's limitless potential, the child has a broader vision of the possibilities available to them in life.

The NLG platform supports existing global interventions and training programs with an open-access digital library of information on child wellbeing, which is informed by mental health and psychosocial support standards and adheres to the six core principles outlined in the IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* ECD and child health professionals are invited to use the platform, based on their previous experience and proven impact in the field. NLG works with these professionals to create a curriculum, which is then presented to the professionals, caregivers, and youth-serving professionals via the training platform website through an engaging short video series; it is also available online at www.nolimitgen.org.

The platform training content is integrative, trauma informed, and evidence based. The ECD training videos for frontline staff in the Rohingya refugee camps are translated, adapted to the local culture, and dubbed into the local Rohingya language. They are designed to be either self-led or led by an instructor in a group setting. Integral to the effectiveness of the NLG content is its unique human-centered communications approach, which was developed with feedback from frontline aid workers, parents, and caregivers to ensure that it is

- clear, engaging, and actionable;
- easy to access through online and offline modes;
- useful for frontline aid workers, parents, and caregivers of all education levels;
- evidence based, culturally informed, and relevant; and
- connective—in other words, emotionally engaging through everyday language, storytelling, and approachable experts on both a cognitive and an emotional level.

Accessibility and localization are the central components of the human-centered communications approach. Consistent with how end-users and other beneficiaries currently access media content, training materials should be easily accessible online (web and mobile phone) and offline (offline mobile phone and thumb drives). NLG suggests that, to be consistent with the realities in the field, the content should be delivered in a way that is comprehensible to all levels of literacy, and to all education and professional backgrounds.

Localization helps to ensure that the NLG training content is accurate, culturally informed, and culturally relevant. NLG works with Translators without Borders to develop localized glossaries of key terms, translate scripts into local languages, and adapt scripts to fit local customs and culture, and then dubs content with local voiceover actors to achieve professional results. This process enables NLG to maintain a high quality of translation and training results.

LEARNING FROM IMPLEMENTATION

To offer a preliminary review of its training videos, NLG conducted a one-month pilot study in April-May 2019 in the Rohingya refugee camps in Bangladesh. Seeing positive indicators after implementing the NLG training platform at Safe Haven, we conducted the pilot study with the CFS coordinators of Samaj Kalyan Unnayan Shangstha's, a local Bangladeshi child rights organization. We chose this organization for the pilot because it had recently hired a dozen CFS coordinators who had no formal training in ECD or child mental health, thus it provided a unique opportunity to measure their pre- and post-training knowledge and assess the program's efficacy. The 12 CFS coordinators met weekly for one month to watch the training videos and participate in follow-up discussions.

The study participants responded enthusiastically to receiving video training in their own language. It was the first child-focused mental health toolkit they had encountered in the Rohingya language. Based on comments recorded during three focus group sessions as part of the pilot study, the training appeared to help them reflect on their previous harsh treatment of children, and they reportedly adopted more supportive interaction styles informed by their understanding of childhood. The CFS coordinators reported that, after the training, they used more motivating, positive, age-appropriate words of encouragement with children; learned how to support children's healing more effectively; appreciated the importance of getting enough sleep and proper nutrition during the children's recovery process; and prioritized the children's needs when organizing activities in a CFS by considering their opinions, wishes, choices, etc.

After watching one of the training videos, a study participant who was a Rohingya genocide survivor himself raised his hand and said:

> I know these videos are made for us to better understand how to support children, but it's helping me as well. I have been wanting to kill myself lately because I didn't know what was happening inside of me . . . Now, I have the words to understand why I feel this way, and that it is normal because of what I have been through. I feel better knowing there are actions I can take to get better.

His remarks inspired other study participants who were genocide survivors to speak up in agreement and share their own experiences. These comments demonstrate anecdotally that NLG training helped the participating CFS coordinators to rethink not only how they work with children but how they look after their own wellbeing and self-care. They requested longer training videos and more translations into the Rohingya language.

Finally, the children participating in the pilot environment noticed positive changes in their CFS coordinators' behavior. Children reported that, after the training, their coordinators were friendlier and more engaged in the day-to-day experiences and that they were more caring. For example, they said the coordinators gave them a voice in choosing the CFS activities and that they didn't get as "panicked or as upset" when things didn't go as planned. The children also said that the coordinators organized awareness-raising sessions with their parents, at which they offered ECD lessons consistent with the NLG training videos.

We presented these findings in May 2019 at the American Psychiatric Association annual conference in San Francisco, at UNHCR's Mental Health Working Group session in Cox's Bazar, and at the Child Protection Subsector Working Group in Cox's Bazar in September 2019. This helped expand awareness of and access to NLG's training content for humanitarian efforts in more than 100 countries, including refugee resettlement programs, human trafficking prevention initiatives, in prison systems, for children displaced and traumatized by natural disasters, and in postconflict zones.

CHALLENGES OBSERVED

The development and implementation of this new training approach brought unique challenges that provided opportunities for further innovation and refinement, which we describe here.

Need for Culturally Scalable Resilience Measures

In its pilot program, NLG used the Child and Youth Resilience Measure, a self-reported measure of social and ecological resilience used worldwide by practitioners in the field. Despite having been translated into more than 20 languages, including Bengali, it was challenging to culturally adapt or translate some aspects into the Rohingya language, which is primarily an oral language that has no standard script. The measure was translated from English into Bengali and then into Rohingya at the time of administration. Given our limited language resources, it was not possible for our team to ascertain the accuracy or quality of the translations.

We took great care to maximize the integrity of results by asking the children to be as honest as possible and creating supportive environments for them to feel comfortable to reflect freely, which included having their daily educators and caregiver professionals in another room so they could feel honest in expressing their experiences. Despite this, we observed that the children were giving overwhelmingly positive responses. We hypothesized that, given the formal nature of the assessment, their answers reflected what they felt the administrator would like to hear, rather than how they truly felt. We then focused our assessment on small group discussions with children and their caregivers, which we conducted separately pre- and poststudy, in particular our observations of the children's feedback in this new setting.

Long, Complex Approval and Funding Cycles Stifle Innovation

The material resources and funding available in a humanitarian crisis skew heavily toward legacy processes, systems, and organizations. For newer or smaller organizations with innovative approaches, the approval process and funding cycles are long and complex. This system—however well-intentioned—locks out or disincentivizes innovative, mission-driven start-ups with promising solutions. As a result, innovation is slowed or stifled.

NLG was able to navigate these barriers by (a) taking a research- and data-driven approach; (b) collaborating with respected professionals and humanitarian veterans to design a quality intervention model and training content; and (c) building partnerships with progressive, forward-looking organizations that understand the gap in child mental health care and provided space to test the NLG training resources.

Technology Limitations

Bangladeshi authorities shut off internet and mobile access in the Rohingya refugee camps, which limited the use of computers. NLG found two ways to get around this. First, we made it possible to download the training videos from the website onto thumb drives; they could do this in an NGO office, for example. This made it possible to conduct training sessions in the refugee camps by projecting the videos onto a white board. Second, given the widespread use of smartphones observed in the camps, NLG developed, and is currently testing, a smartphone app that allows users to download the training content for offline viewing.

Additional Testing

NLG produced, published, translated, launched, and piloted more than 150 training videos on a shoestring budget of less than $50,000. This was made possible by technical experts, child health professionals, and generous volunteers who provided hundreds of hours of pro-bono support. Based on personal communications with leading humanitarian agencies in the field, the value of this contribution has been assessed at around US$500,000.

Due to these resource constraints, the scope and duration of the pilot was limited, thus the findings presented here are based on a one-month study. Additional funding for research would enable NLG to assess the longer-term viability of its approach. Moreover, with global audiences now accessing the training platform, additional research would enable NLG to systematically assess the cultural applicability and scalability of this approach.

CONCLUSION

I began this article by recounting what happened when I asked a group of children at the Safe Haven what they wanted to be when they grew up. After initially hesitating, one girl held up a picture of herself standing in front of a group of children; she wanted to be a teacher. Then a young boy held up an image of a colorful airplane soaring through the clouds; he wanted to be a pilot. Then another young girl stood up in the back of the classroom, held up her picture, and declared, "I will be prime minister, so that I can write the laws for us to go back to our homes one day." All the children around her cheered.

NLG's experience with the training platform suggests that transformation is possible when frontline aid workers, parents, and caregivers are trained to support young children's mental health and wellbeing, and to create environments in which they can heal and thrive. These children's newfound aspirations are an indication that their healing progress has begun and that their hopefulness is a powerful resource that can be harnessed to shape their own futures and that of their societies. While the NLG training approach would benefit from impact research, our initial results demonstrate that accessible, thoughtfully curated, culturally contextualized video training resources can be an engaging and supportive asset for scaling the impact and sustainability of global ECD interventions. As a global community, our children's mental health and resilience is an investment we must make—not only for their wellbeing and prosperity, but for the wellbeing and prosperity of a world we will create together.

REFERENCES

Alexander, Paul. 2017. "Traumatized and Needy, Rohingya Children Make Up 60 Percent of Myanmar Refugees." *VOA News,* October 21, 2017. https://www.voanews.com/east-asia/traumatized-and-needy-rohingya-children-make-60-percent-myanmar-refugees.

Alvarez, Hector A. Olvera, Laura D. Kubzansky, Matthew J. Campen, and George M. Slavich. 2018. "Early Life Stress, Air Pollution, Inflammation, and Disease: An Integrative Review and Immunologic Model of Social-Environmental Adversity and Lifespan Health." *Neuroscience and Biobehavioral Reviews* 92: 226-42. https://doi.org/10.1016/j.neubiorev.2018.06.002.

Betancourt, Theresa S., Elizabeth A. Newnham, Christopher M. Layne, Soeun Kim, Alan M. Steinberg, Heidi Ellis, and Dina Birman. 2012. "Trauma History and Psychopathology in War-Affected Refugee Children Referred for Trauma-Related Mental Health Services in the United States." *Journal of Traumatic Stress* 25 (6): 682-90. https://doi.org/10.1002/jts.21749.

Center on the Developing Child. n.d. *Toxic Stress Derails Healthy Development*. Cambridge, MA: Center on the Developing Child. https://developingchild.harvard.edu/resources/toxic-stress-derails-healthy-development.

Charlson, Fiona, Mark van Ommeren, Abraham Flaxman, Joseph Cornett, Harvey Whiteford, and Shekhar Saxena. 2019. "New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis." *The Lancet* 394 (10194): 240-48. https://doi.org/10.1016/S0140-6736(19)30934-1.

"Contribution to the Fifteenth Coordination Meeting on International Migration." 2017. Geneva: United Nations High Commissioner for Refugees. https://www.un.org/en/development/desa/population/migration/events/coordination/15/documents/papers/14_UNHCR_nd.pdf.

Dominguez-Salas, Paula, Sharon E. Cox, Andrew M. Prentice, Branwen J. Hennig, and Sophie E. Moore. 2012. "Maternal Nutritional Status, C(1) Metabolism and Offspring DNA Methylation: A Review of Current Evidence in Human Subjects." *Proceedings of the Nutrition Society* 71 (1): 154-65. https://doi.org/10.1017/S0029665111003338.

Esthimer, Marissa. 2014. *World Confronts Largest Humanitarian Crisis since WWII.* Washington, DC: Migration Policy Institute. https://www.migrationpolicy.org/article/world-confronts-largest-humanitarian-crisis-wwii.

Hamdan-Mansour, Ayman, Nadin Abdel Razeq, Bayan AbdulHaq, Diana Arabiat, and Amani Khalil. 2017. "Displaced Syrian Children's Reported Physical and Mental Wellbeing." *Global Child Mental Health Special Issue* 22 (4): 186-93. https://doi.org/10.1111/camh.12237.

IASC (Inter-Agency Standing Committee). 2007. *Guidelines for Mental Health and Psychosocial Support in Emergency Settings.* Geneva: World Health Organization. http://www.who.int/mental_health/emergencies/9781424334445/en.

Monnat, Shannon M., and Raeven Faye Chandler. 2015. "Long Term Physical Health Consequences of Adverse Childhood Experiences." *The Sociological Quarterly* 56 (4): 723-52. https://doi.org/10.1111/tsq.12107.

National Scientific Council on the Developing Child. 2010. "Persistent Fear and Anxiety Can Affect Young Children's Learning and Development." Working Paper No. 9. Cambridge, MA: Center on the Developing Child. https://developingchild.harvard.edu/resources/persistent-fear-and-anxiety-can-affect-young-childrens-learning-and-development.

Ramo-Fernández, Laura, Anna Schneider, Sarah Wilker, and Iris-Tatjana Kolassa. 2015. "Epigenetic Alterations Associated with War Trauma and Childhood Maltreatment." *Behavioral Sciences & the Law* 33 (5): 701-21. https://doi.org/10.1002/bsl.2200.

Richter, Linda, Maureen Black, Pia Britto, Bernadette Daelmans, Chris Desmond, Amanda Devercelli, Tarun Dua et al. 2019. "Early Childhood Development: An Imperative for Action and Measurement at Scale." *BMJ Global Health* 4 (Suppl. 4): e001302. https://doi.org/10.1136/bmjgh-2018-001302.

Save the Children. 2019. *Road to Recovery: Responding to Children's Mental Health in Conflict.* London: Save the Children. https://resourcecentre.savethechildren.net/library/road-recovery-responding-childrens-mental-health-conflict.

UNICEF (United Nations Children's Fund). 2016, December 9. *Nearly a Quarter of the World's Children Live in Conflict or Disaster Stricken Countries.* New York: UNICEF. https://www.unicef.org/press-releases/nearly-quarter-worlds-children-live-conflict-or-disaster-stricken-countries.

UNICEF (United Nations Children's Fund). 2020. *Child Displacement*. New York: UNICEF. https://data.unicef.org/topic/child-migration-and-displacement/displacement.

von Werthern, Martha., Katy Robjant, Zoe Chui, Rachel Schon, Livia Ottisova, Claire Mason, and Cornelius Katona. 2018. "The Impact of Immigration Detention on Mental Health: A Systematic Review." *BMC Psychiatry* 18 (382). https://doi.org/10.1186/s12888-018-1945-y.

WHO (World Health Organization). 2020, June 8. "Violence against Children." Fact Sheet. Geneva: WHO. https://www.who.int/news-room/fact-sheets/detail/violence-against-children.

JOURNAL ON EDUCATION IN EMERGENCIES

Commentary: Newborns in Fragile and Humanitarian Settings: A Multi-Agency Partnership Roadmap

Author(s): Saverio, Bellizzi, Lori McDougall, Sheila Manji, and Ornella Lincetto

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 164-170

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62228

DOI: https://doi.org/10.33682/eqk0-0zek

REFERENCES:

COMMENTARY: NEWBORNS IN FRAGILE AND HUMANITARIAN SETTINGS: A MULTI-AGENCY PARTNERSHIP ROADMAP

Saverio Bellizzi, Lori McDougall, Sheila Manji, and Ornella Lincetto

ABSTRACT

Current estimates are that more than one-third of the annual neonatal deaths worldwide occur in humanitarian and fragile settings (United Nations Population Fund 2015). In this article, we focus on the recent multistakeholder effort to produce the Roadmap to Accelerate Progress for Every Newborn in Fragile and Humanitarian Settings 2020-2025. *This effort, led by Save the Children, the UN Children's Fund, the UN High Commissioner for Refugees, and the World Health Organization, calls for a representation of newborn health issues and action across all phases of emergency response. It specifically emphasizes the need to "engage stakeholders from across humanitarian and development sectors to ensure that mothers and newborns survive and thrive even in the most difficult circumstances" (Save the Children et al. 2020, 5). This commentary also emphasizes basic needs that are vital to the survival and adequate development of newborns, such as avoiding separation from the mother, support for early and exclusive breastfeeding, infection prevention, basic resuscitation, and kangaroo mother care. At the same time, it is critical to establish interventions that create an environment of nurturing care to promote early childhood development.*

THE NEED FOR COORDINATED HUMANITARIAN SUPPORT FOR NEWBORNS

Released in April 2020, the *Roadmap to Accelerate Progress for Every Newborn in Fragile and Humanitarian Settings 2020-2025* (hereafter *Roadmap*) represents an important step forward for the existing programs on newborn health in humanitarian settings. It will enable the voices of children and mothers to be

Journal on Education in Emergencies, Vol. 7, No. 1

ISSN 2518-6833

heard in the zones of the world with the highest mortality and morbidity burdens.[1] More importantly, the *Roadmap* could become an instrument for more effective and coordinated stakeholder action across different constituencies and sectors, both development and humanitarian, to reestablish and maintain the continuum of care that is so critical for the survival and health of women and newborns in fragile and humanitarian settings.

Our purpose with this commentary is to highlight the mechanism that led to the conception of the *Roadmap* and to advocate for its specific aspects that have been proven to greatly improve newborns' chances to survive and thrive in fragile and humanitarian settings.

Humanitarian crises threaten the health and safety of communities, both directly and by destroying health systems and infrastructure. The perinatal period is a critically vulnerable time for pregnant women and newborns, and countries experiencing conflict and political instability have the highest rates of neonatal mortality (death during the first 28 days of life) and stillbirths (Wise and Darmstadt 2015). Excluding India and China, which have the highest percentage of neonatal deaths globally, countries experiencing chronic conflict or political instability account for slightly less than 45 percent of all neonatal deaths worldwide (Wise and Darmstadt 2015). Moreover, 75 percent of the 49 countries that experienced an acute or protracted humanitarian crisis in the past five years have fallen short of UN Sustainable Development Goal target 3.1 (IAWG 2019; UNICEF and WHO 2018).[2] It is important to note that many of the infant deaths that occur around the time of birth and in the postnatal period are preventable, even in the most precarious situations ("Newborn Health in Emergencies" 2020). Clearly, additional action is urgently needed to protect women and newborns in fragile and humanitarian settings.

Beyond the key features of the *Roadmap* described below, we would like to emphasize the need for multisectoral participation along the preparedness-response-recovery continuum in order to accelerate progress in the survival and health of every newborn. While newborn health is underscored in Sustainable Development Goal target 3.2 and humanitarian interventions that prioritize child and maternal health are emerging, our experience in the field suggests that newborn health is often missing from the list of priorities during a humanitarian

1 Morbidity burden refers to having a disease or a symptom of disease, or to the amount of disease within a population.

2 Acknowledging the high number of mothers who die from preventable causes during pregnancy and childbirth, especially in lower income countries, Sustainable Development Goal target 3.1 aims to "reduce the global maternal mortality ratio to less than 70 per 100,000 live births" by 2030 (United Nations 2020).

response. In fact, it may be regarded as a development-sector activity and thus be left till the later stages of an emergency response. When the issue is addressed, it is often limited to immediate care at birth (such as resuscitation), leaving gaps in the provision of interventions essential to the survival and health of newborns and their mothers in this critical period.

RECENT COORDINATION EFFORTS FOR NEWBORNS

In 2014, the Every Newborn Action Plan (ENAP) was launched under the lead of UNICEF and WHO. The primary goal—to provide strategic actions aimed at ending preventable newborn mortality and stillbirth—included meeting specific global and national milestones by 2030 (WHO 2014). However, in recent years, gaps emerged in ENAP's ability to engage stakeholders across the humanitarian sector. In addition, despite the strong political foundations provided by ENAP and the Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030, the effort lacked a global vision, strategy, and commitment to scale-up newborn interventions in populations affected by violence, acute and protracted conflict, and disasters.

Based on these needs, key stakeholders from multiple sectors within the humanitarian and development fields gathered at the Geneva Newborn Health in Humanitarian Settings stakeholder meeting, which led to the release of the "Declaration to Accelerate Newborn Health in Humanitarian Settings" in February 2019. Convened by Save the Children, UNICEF, UNHCR, and WHO, the effort aimed to catalyze a global agenda for improving newborn health in humanitarian settings (WHO et al. 2019). The declaration was an urgent call to uphold and prioritize the dignity, health, and wellbeing of every woman, every child, and every newborn living in humanitarian and fragile settings.

The close collaboration of the ENAP's multistakeholder humanitarian effort triggered the production of the dedicated *Roadmap,* whose aim is to accelerate progress in reducing newborn mortality in humanitarian and fragile settings within five years (2020-2025). A wide range of stakeholders contributed to the *Roadmap,* including clinicians, implementers, academicians, policymakers, donors, government and private-sector representatives, and professional associations across the reproductive, maternal, neonatal, and child and adolescent health and nutrition continuum. The work was led by a steering committee, whose members had a strong stake in improving maternal and newborn health in humanitarian settings.

The ENAP partnership was expanded to include humanitarian partners, such as UNHCR, Save the Children, the Global Health Cluster, and the Inter-agency Working Group for Reproductive Health in Crises. They all were dedicated to implementing the activities and achieving the tangible objectives set out by the *Roadmap,* such as providing guidance, mobilizing resources, monitoring progress, raising awareness, liaising with other key initiatives, and providing technical assistance. This multisectoral approach was designed to provide leadership and coordination of activities at different levels.

THE *ROADMAP* VISION

The *Roadmap* calls for collective and accountable action to ensure that newborns and their mothers survive and thrive in emergency contexts (Save the Children et al. 2020, 5). It emphasizes the need to engage stakeholders from across the humanitarian and development sectors, and calls for solid investment in the training and support of the care providers on whom health and humanitarian interventions depend. It also calls for practical research that will help to ensure that interventions in humanitarian settings are increasingly effective, efficiently delivered, and—let it never be forgotten—able to safeguard the human rights and dignity of the women and children they serve. The *Roadmap* specifically calls for action across all phases of emergency responses using a health-systems approach, and for putting newborn health issues on the agendas of humanitarian coordinating platforms, including monitoring and evaluation frameworks. This would include factoring maternal and neonatal mortality rates into decisionmaking processes related to humanitarian assistance and ongoing health-system support.

The *Roadmap* is guided by three key elements of the Global Strategy for Women's, Children's and Adolescents' Health: survive, thrive, and transform (Save the Children et al. 2020). Key aspects of the Global Strategy were pivotal in facilitating the adoption of particular mechanisms needed to craft the *Roadmap.* They also highlighted the need to include government, civil society, UN agencies, and nongovernmental organizations in emergency response efforts, as they provide different types of specialized support at different phases.

The *Roadmap* emphasizes the fact that emergency actors often underestimate or overlook the mother-newborn relationship, and that interventions such as promoting early and exclusive breastfeeding and skin-to-skin care are at times disregarded during a humanitarian response, despite their cost-effectiveness and efficacy.

CRITICAL INSIGHTS THAT ENABLE NEWBORNS TO SURVIVE AND THRIVE

As mentioned in the first lines of this commentary, we would like to emphasize basic elements of the *Roadmap* that are vital to the survival and healthy development of newborns. These elements cannot be implemented widely and consistently without the synergic actions of the multisectoral partnership, which range from advocacy to policy to commodities and training.

Lifesaving newborn care interventions, such as avoiding separation from the mother, support for exclusive breastfeeding, preventing infection, basic resuscitation, and "kangaroo mother care," should be provided during humanitarian responses for both healthy and high-risk newborns (Victora et al. 2016; Shaker-Bebari et al. 2018).[3]

The importance of interventions that provide nurturing care for mothers and ensure children's healthy early development is underrated by global, national, and local actors. If the mother-newborn dyad is weakened because their care is compromised, humanitarian responses risk being counterproductive, even if an initial intervention appeared effective. The mother-newborn dyad is often threatened in situations of emergency, which results in increased maternal death rates and more orphaned newborns; in emergency situations, there also is a higher risk of newborns being separated from their parents. In such cases, permanent, nurturing alternatives must be found as soon as possible.

It is critical that health providers in humanitarian and fragile settings are competent in providing essential newborn care, including basic neonatal resuscitation, breastfeeding support, and monitoring oxygen, since referral to specialized care may not be feasible. Therefore, it must be a priority that all staff members working in the early stages of a humanitarian intervention are trained in essential newborn care (WHO 2016).

Leadership by national and local governments, particularly in preparing for emergencies, is fundamental to making rapid improvement in maternal and newborn survival during crises and vital to maintaining sustainable progress. Governments can develop policies and allocate resources to ensure that pregnant women, mothers, and newborns receive the care they need during an emergency. The resilience of health systems at the national and subnational levels should be strengthened by

3 Kangaroo mother care is a method of care for preterm infants. The method involves infants being carried, usually by the mother, with skin-to-skin contact.

integrating priority maternal and newborn health interventions into preparedness and response plans, and by using global guidance and evidence to inform policies.

Mounting community messaging campaigns about available lifesaving newborn care can improve social perceptions and norms about newborn survival and promote behavioral change (Sami et al. 2017). Moreover, community engagement can be a powerful way to increase the cooperation of host and crisis-affected populations, to promote trust between emergency staff members and mothers and pregnant women and their families, and to spread information about maternal and newborn care. By focusing on fragile and humanitarian settings, the *Roadmap* helps to achieve the objectives set out in the Global Strategy for Women's, Children's and Adolescent's Health, 2016-2030, and builds on the momentum of the ENAP by providing guidance to ensure that the most vulnerable newborns receive the care they need, even in the most challenging situations.

REFERENCES

IAWG (Inter-Agency Working Group on Reproductive Health in Crises). 2019. *Surviving Day One: Caring for Mothers and Newborns in Humanitarian Emergencies on the Day of Childbirth*. New York: Inter-Agency Working on Reproductive Health in Crises and Save the Children US. https://healthynewbornnetwork.org/hnn-content/uploads/SavetheChildren-NBH-16Pager-ProductionV4.pdf.

"Newborn Health in Emergencies." 2020. London: Healthy Newborn Network, Save the Children Federation. https://healthynewbornnetwork.org/issue/emergencies/.

Sami, Samira, Kate Kerber, Barbara Tomczyk, Ribka Amsalu, Debra Jackson, Elaine Scudder, Alexander Dimiti et al. 2017. "You Have to Take Action: Changing Knowledge and Attitudes towards Newborn Care Practices during Crisis in South Sudan." *Reproductive Health Matters* 25 (51): 124-39. https://doi.org/10.1080/09688080.2017.1405677.

Save the Children, WHO, UNHCR, and UNICEF. 2020. *Roadmap to Accelerate Progress for Every Newborn in Humanitarian Settings 2020-2025*. Geneva: UNHCR, WHO, UNICEF, Save the Children US. https://www.healthynewbornnetwork.org/hnn-content/uploads/Roadmap-to-Accelerate-Progress-for-Every-Newborn-in-Humanitarian-Settings-1-1.pdf.

Shaker-Berbari, Linda, Hala Ghattas, Andrew G. Symon, and Annie S. Anderson. 2018. "Infant and Young Child Feeding in Emergencies: Organisational Policies and Activities during the Refugee Crisis in Lebanon." *Maternal & Child Nutrition* 14 (3): e12576. https://doi.org/10.1111/mcn.12576.

UNICEF, WHO, World Bank, and UN-DESA Population Division. 2018. *Levels and Trends in Child Mortality: Report 2018.* New York: UNICEF, WHO, World Bank, UN-DESA Population Division. https://www.unicef.org/publications/index_103264.html.

United Nations. 2020. "Goal 3: Ensure Healthy Lives and Promote Well-Being for All at All Ages." https://www.un.org/sustainabledevelopment/health/.

United Nations Population Fund. 2015. *Shelter from the Storm: A Transformative Agenda for Women and Girls in a Crisis-Prone World*. New York: United Nations Population Fund.

Victora, Cesar G., Rajiv Bahl, Aluisio J. D. Barros, Giovanny V. Franca, Susan Horton, Julia Krasevec, Simon Murch, Mary J. Sankar, Neff Walker, and Nigel C Rollins. 2016. "Breastfeeding in the 21st Century: Epidemiology, Mechanisms, and Lifelong Effect." *The Lancet* 387 (10017): 475-90. https://doi.org/10.1016/S0140-6736(15)01024-7.

WHO. 2014. *Every Newborn Action Plan Consultation 2014.* Geneva: World Health Organization. https://www.who.int/maternal_child_adolescent/topics/newborn/enap_consultation/en/.

WHO. 2016. *Oxygen Therapy for Children.* Geneva: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/204584/9789241549554_eng.pdf?sequence=1.

WHO, UNICEF, Save the Children, and UNHCR. 2019. "A Declaration to Accelerate Newborn Health in Humanitarian Settings." Geneva: WHO, UNICEF, Save the Children, UNHCR.

Wise, Paul H., and Gary L. Darmstadt. 2015. "Confronting Stillbirths and Newborn Deaths in Areas of Conflict and Political Instability: A Neglected Global Imperative." *Paediatrics and International Child Health* 35 (3): 220-26. https://doi.org/10.1179/2046905515Y.0000000027.

JOURNAL ON EDUCATION IN EMERGENCIES

Commentary: Supporting Maternal Mental Health and Nurturing Care in Humanitarian Settings

Author(s): Bernadette Daelmans, Mahalakshmi Nair, Fahmy Hanna, Ornella Lincetto, Tarun Dua, and Xanthe Hunt

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 171-183

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62229

DOI: https://doi.org/10.33682/9s48-6d0x

REFERENCES:

COMMENTARY: SUPPORTING MATERNAL MENTAL HEALTH AND NURTURING CARE IN HUMANITARIAN SETTINGS

Bernadette Daelmans, Mahalakshmi Nair, Fahmy Hanna, Ornella Lincetto, Tarun Dua, and Xanthe Hunt

INTRODUCTION

The estimated number of forcibly displaced persons around the globe is at a record high—nearly 70.8 million (UNHCR 2019)—75 percent of whom are women and children. This includes 34 million adolescent girls and young women, who are among the groups with the highest risk for health concerns. Indeed, many of the countries with the worst maternal and child health indicators are currently experiencing or have recently experienced a humanitarian crisis. The breakdown of health systems in humanitarian settings can cause a dramatic rise in mortality that would otherwise be easily preventable (Al Gasseer et al. 2004), including some 60 percent of maternal deaths (UN OCHA 2019), excess stillbirths, and high mortality rates for newborns and children (Morof et al. 2014; Zeid et al. 2015).

Beyond these dismal mortality statistics, the coping capacities of women, children, and their families are seriously affected by stressors associated with humanitarian disasters. Crises greatly increase social and economic insecurity, which undermines families' physical and mental wellbeing and weakens their ability to provide nurturing care for young children. This is due to a lack of shelter and access to basic services, as well as disrupted family networks and exposure to violence. Instability, discrimination, and exclusion in the host community can also restrict displaced people's access to health services, education, and social and child protections. Even if families remain in or return to their homes, it can take years to restore stability and safety, and enduring emergency conditions may become a fact of life for many generations.

Journal on Education in Emergencies, Vol. 7, No. 1

ISSN 2518-6833

The concentration of adversities associated with humanitarian settings puts young children at great risk of impaired development. Despite the enormous need for early childhood services in humanitarian settings—some 250 million children are living in countries affected by armed conflict—there is a severe lack of such support. Approximately 2 percent of global humanitarian funding goes to education, and early childhood development programming accounts for only a tiny fraction of that. Additionally, issues related to the mental health and wellbeing of caregivers are often overlooked, despite evidence that attending to their needs is essential in effective interventions (Casey 2015; Chynoweth et al. 2018).

Children need caregivers who are physically and mentally able to provide quality child care, which includes adequate nutrition, security, and opportunities for early learning. In humanitarian settings, responsive caregiving is often compromised by poor maternal mental health and its cascading effects. Though limited, current evidence shows that psychological, economic, social, and environmental stressors in humanitarian settings lead to mental health conditions that diminish primary caregivers' capacity to respond sensitively and appropriately to their children's cues (Ehrlich et al. 2010; Silove et al. 2015; Hirani and Richter 2019). Refugee populations and others living in humanitarian settings have higher rates of common mental disorders (Steel et al. 2009), including those specifically affecting mothers (Stevenson et al. 2019; Tobin, Di Napoli, and Beck 2018; Rees et al. 2019; Charlson et al. 2019). Recent estimates set the prevalence of mental disorders in conflict settings, including depression, anxiety, posttraumatic stress disorder, bipolar disorder, and schizophrenia, at 22.1 percent, or one in five people, compared to the mean global prevalence of one in fourteen (Charlson et al. 2019; Vos et al. 2017). Exposure to stress is not only detrimental to the mother and family, it increases the risk of pregnancy complications, such as prematurity and low birth weight, which increase newborns' risk of death, impairment, and developmental delay.

Young children in humanitarian settings are exposed to many of the same stressors and risks as their caregivers, and to the effects of those risks through suboptimal care. Advancements in neuroscience, genetics, epigenetics, developmental psychology, and many other fields have led to the recognition that deficits in early childrearing environments place children at risk of cascading negative development (see Figure 1). To provide children living in humanitarian settings with the best possible chance of achieving their full developmental potential, caregivers' mental and physical health must be at the heart of providing responsive care.

Figure 1: Cascading Negative Impact of Humanitarian Settings on Caregiver Mental Health and Child Development

TAKING THE AGENDA FORWARD

The World Health Organization (WHO) has made it a priority to address health care in humanitarian emergencies, in keeping with the UN Sustainable Development Goals and the Global Strategy for Women's, Children's and Adolescents' Health. Understanding health-care needs in these contexts and developing effective guidance materials has been an increasingly important topic on the WHO's global health agenda over the last few years, as illustrated by three examples below.

The Nurturing Care for Early Childhood Development framework (WHO 2018) provides a roadmap for addressing children's health and developmental needs in the early years, starting with pregnancy. It is based on an ecological approach that recognizes the profound roles primary caregivers play in the lives of young children and highlights the importance of caring for the caregiver as well as for the child. Responsive caregiving, safety and security, and opportunities for early learning are the central tenets of nurturing care that can be promoted and supported in caregivers' routine contacts with the health-care system and other systems. These tenets also can be applied at the community level. Various countries' experiences illustrate that support for nurturing care strengthens caregivers' capacities, efficacy, and self-esteem, and that the activities offered provide joyful moments for families and their children, even when living in conditions of hardship. Support for nurturing care can be provided in humanitarian settings through a variety of channels, including caregiver group sessions, health-care contacts, child day-care or play sessions, mobile phone messaging, and preschool education. More investment is needed to demonstrate how humanitarian settings

affect parents' responsive caregiving capacity and what intervention options are effective in terms of fidelity, intensity, and duration.

The WHO also collaborated with Every Newborn Action Plan partners to develop and disseminate *Newborn Health in Humanitarian Settings: Field Guide* (Save the Children and UNICEF 2018); a companion publication, the *Newborn Care Supply Kits for Humanitarian Settings: Manual* (IAWG 2019); and a *Roadmap to Accelerate Progress for Every Newborn in Humanitarian Settings 2020-2025* (Save the Children et al. 2020). Special consideration for women and newborns living in humanitarian and fragile settings is included in the WHO and the UN Children's Fund report titled *Survive and Thrive: Transforming Care for Every Small and Sick Newborn* (2019), in the *Standards for Improving the Quality of Care for Small and Sick Newborns in Health Facilities* (WHO 2020a), and in the operational guidance for addressing child and adolescent health in humanitarian settings in the Eastern Mediterranean region, which was developed by the WHO (forthcoming).

These documents emphasize the need to ensure that mothers and newborns receive quality health-care services in order to reduce unnecessary mortality, disability, or developmental delay, even under the most difficult circumstances.

In parallel to this work with children, international momentum has been building for more than a decade around efforts to provide mental health and psychosocial support (MHPSS) services to adults, including mothers, in humanitarian settings. The Inter-Agency Standing Committee (IASC) guidelines for providing these services in emergencies established the core principles that guide such interventions. A wide range of publications by the IASC Reference Group on Mental Health and Psychosocial Support in Emergencies are available, including MHPSS guidelines, a monitoring and evaluation framework, assessment and referral tools, and a dedicated portal for mental health and psychosocial resources in the context of COVID-19 (IASC 2020). Other key guidance documents include the *Core Humanitarian Standard on Quality and Accountability* (CHS Alliance, Groupe URD, and Sphere Association 2014, 2018), which describes elements of "principled, accountable and quality humanitarian action"; the *Child Protection Minimum Standards* (Alliance for Child Protection in Humanitarian Action 2019); and the *Inter-Agency Standing Committee Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* (IASC 2015). The latter outlines how, while doing humanitarian work, to coordinate, implement, monitor, and evaluate actions for the most effective prevention and mitigation of gender-based violence.

Regardless of the setting, much mental health programming must center around interventions that are evidence based, brief, deliverable by nonspecialist workers, culturally and contextually adaptable, affordable, and cost-effective. Many MHPSS interventions use simple generic techniques and are designed with adaptation and scaling in mind. The strength of these approaches lies in the fact that they are constructed using nondiagnostic approaches and therefore are agile and responsive. For instance, interpersonal therapy and Step-by-Step—a guided, technology-supported intervention for depression—are general mental health interventions targeting depression, anxiety, and other symptoms that have been implemented successfully in humanitarian settings; this is because the underlying principles are broad and can be adapted to particular contexts. Step-by-Step provides psychoeducation and training in behavioral activation through an illustrated narrative, with additional therapeutic techniques such as stress management, identifying strengths, positive self-talk, increasing social support, and relapse prevention. Interpersonal therapy is a form of psychotherapy for depression that focuses on relationships with other people. It is based on the idea that personal relationships are at the center of psychological problems.

These approaches have been applied successfully in several countries and territories, including Bangladesh, The Bahamas, Colombia, Iraq, Jordan, Lebanon, Nigeria, South Sudan, Syria, Turkey, Ukraine, and the West Bank and Gaza Strip. These efforts have provided an opportunity to build back better, and in many countries the presence of refugees has been a catalyst for the development of sustainable mental health care for both the refugees and the host population. During the past two decades, some of the most significant leaps forward in mental health in low- and middle-income countries occurred following emergencies. Despite the adverse and often tragic impact they have on people's mental health and wellbeing (Epping-Jordan et al. 2015), emergencies also draw attention and resources to these issues and provide an opportunity to develop mental health services. A prime example of this is Lebanon, where an influx of Syrian refugees led to widespread mental health care reform (El Chammay and Ammar 2014).

FILLING THE GAPS

To bridge the gap between evidence and action for the health and wellbeing of women, children, and adolescents, the WHO examined existing research and practical guidance on sexual, reproductive, maternal, newborn, child, and adolescent health in humanitarian settings. In 2018-2019, the WHO developed research questions through a two-step approach, one being to solicit suggestions

from 177 experts in the field. Research priorities were set for five domains: four were population groups—women, newborns, children, and adolescents—and the fifth was sexual and reproductive health. Top priorities for child health revolved around testing whether (1) integrating inclusive nurturing care into early childhood development promotes children's better health and development; (2) community-based management approaches are effective in reducing morbidity and mortality for children under five in humanitarian settings; and (3) the current delivery of nutrition interventions in refugee camps meets the needs of high-risk infants and children, such as those born prematurely, with low birth weight, or with perinatal injury (Aboubaker et al. 2020).

The objective of the review of internationally available guidance documents for providing sexual and reproductive, maternal, newborn, child, and adolescent health and nutrition services in conflict situations was to determine the scope and quality of currently available guidance documents on a variety of parameters. This work included (1) identification and review of the guidance, (2) review and appraisal of the content and quality, (3) key informant interviews with representatives from the implementing agencies about their process of making decisions for action, and (4) a stakeholder survey on the perceived sufficiency and applicability of, and gaps in, the currently available guidance.

The assessment of 105 guidance documents solicited from 75 organizations revealed important gaps in the guidance, especially in the procurement and provision of emergency contraception, safe abortion care, newborn care, early childhood development, mental health, health among migrant or five- to nine-year-old children, adolescent health beyond sexual and reproductive health, and noncommunicable diseases. In March 2020, the WHO published *Improving Early Childhood Development: WHO Guideline* (WHO 2020b), which lays out four recommendations for governments, policymakers, and other stakeholders to adopt. The WHO is currently developing guidance for implementing these recommendations in humanitarian contexts. Selected tools to support maternal mental health and nurturing care for young children are summarized in the Appendix.

CONCLUSIONS

Addressing the health and developmental needs of newborns, children, and adolescents in conflict situations and other humanitarian emergencies is a critical global priority, yet there are still marked gaps in the research and in actions taken. Evidence-based programs for maternal mental health do exist, but

tailoring approaches to include content on nurturing care and acknowledge the link between maternal mental health and child development must be a priority for multiple interventions and platforms. Similarly, providing nurturing care for children that includes giving attention to good health, adequate nutrition, security and safety, responsive caregiving, and early learning opportunities at every phase of development must be planned and adapted to a range of humanitarian settings. Moreover, if no child is to be left behind in such complex and stressed environments, sustained investment is essential.

REFERENCES

Aboubaker, Samira, Egmond Samir Evers, Loulou Kobeissi, Lauren Francis, Robinah Najjemba, Nathan P. Miller, Steve Wall, Daniel Martinez, Joseph Vargas, and Per Ashorn. 2020. "The Availability of Global Guidance for the Promotion of Women's, Newborns', Children's, and Adolescents' Health and Nutrition in Conflicts." *BMJ Global Health* 5 (1): 1-8. https://doi.org/10.1136/bmjgh-2019-002060.

Al Gasseer, Naeema, Elissa Dresden, Gwen Brumbaugh Keeney, and Nicole Warren. 2004. "Status of Women and Infants in Complex Humanitarian Emergencies." *The Journal of Midwifery & Women's Health* 49 (S1): 7-13. https://doi.org/10.1016/j.jmwh.2004.05.001.

Alliance for Child Protection in Humanitarian Action. 2019. *Minimum Standards for Child Protection in Humanitarian Action.* https://alliancecpha.org/en/system/tdf/library/attachments/cpms_2019_final_en.pdf?file=1&type=node&id=35094.

Casey, Sara E. 2015. "Evaluations of Reproductive Health Programs in Humanitarian Settings: A Systematic Review." *Conflict and Health* 9 (S1). https://doi.org/10.1186/1752-1505-9-s1-s1.

Charlson, Fiona, Mark van Ommeren, Abraham Flaxman, Joseph Cornett, Harvey Whiteford, and Shekhar Saxena. 2019. "New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis." *The Lancet* 394 (10149): 240-48. https://doi.org/10.1016/s0140-6736(19)30934-1.

CHS Alliance, Groupe URD, and Sphere Association. 2014. *Core Humanitarian Standard on Quality and Accountability.* Geneva: CHS Alliance, Groupe URD, Sphere Association. https://corehumanitarianstandard.org/files/files/Core%20Humanitarian%20Standard%20-%20English.pdf.

CHS Alliance, Groupe URD, and Sphere Association. 2018. *Core Humanitarian Standard on Quality and Accountability: Updated Guidance Notes and Indicators 2018*. Geneva: CHS Alliance, Groupe URD, Sphere Association. https://corehumanitarianstandard.org/files/files/CHS_GN%26I_2018.pdf.

Chynoweth, Sarah K., Ribka Amsalu, Sara E. Casey, and Therese McGinn. 2018. "Implementing Sexual and Reproductive Health Care in Humanitarian Crises." *The Lancet* 391 (10132): 1770-71. https://doi.org/10.1016/S0140-6736(18)30803-1.

Ehrlich, Matthew, Emily Harville, Xu Xiong, Pierre Buekens, Gabriella Pridjian, and Karen Elkind-Hirsch. 2010. "Loss of Resources and Hurricane Experience as Predictors of Postpartum Depression among Women in Southern Louisiana." *Journal of Women's Health* 19 (5): 877-84. https://doi.org/10.1089/jwh.2009.1693.

El Chammay, Rabih, and Walid Ammar. 2014. "Syrian Crisis and Mental Health System Reform in Lebanon." *The Lancet* 384 (9942): 494. https://doi.org/10.1016/S0140-6736(14)61329-5.

Epping-Jordan, JoAnne E., Mark van Ommeren, Hazem Nayef Ashour, Albert Maramis, Anita Marini, Andrew Mohanraj, Aqila Noori et al. 2015. "Beyond the Crisis: Building Back Better Mental Health Care in 10 Emergency-Affected Areas Using a Longer-Term Perspective." *International Journal of Mental Health Systems* 9 (1): 1-10. https://doi.org/10.1186/s13033-015-0007-9.

Hirani, Shela Akbar Ali, and Solina Richter. 2019. "Maternal and Child Health During Forced Displacement." *Journal of Nursing Scholarship* 51 (3): 252-61. https://doi.org/10.1111/jnu.12460.

IASC. 2015. *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery.* https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf.

IASC. 2020. *Mental Health and Psychosocial Support: Resources for COVID-19.* https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-resources-covid-19.

IAWG (Inter-agency Working Group on Reproductive Health in Crises), Save the Children, and UNICEF. 2019. *Newborn Care Supply Kits for Humanitarian Settings: Manual.* New York: Save the Children, WHO, and UNICEF. https://www.healthynewbornnetwork.org/hnn-content/uploads/Newborn-Care-Supply-Kits-Manual_DIGITAL-131219.pdf.

Morof, Diane F., Kate Kerber, Barbara Tomczyk, Joy Lawn, Curtis Blanton, Samira Sami, and Ribka Amsalu. 2014. "Neonatal Survival in Complex Humanitarian Emergencies: Setting an Evidence-Based Research Agenda." *Conflict and Health* 8 (1): 1-2. https://doi.org/10.1186/1752-1505-8-8.

Rees, Susan J., Jane R. Fisher, Zachary Steel, Mohammed Mohsin, Nawal Nadar, Batool Moussa, Fatima Hassoun, Mariam Yousif, Yalini Krishna, and Batoul Khalil. 2019. "Prevalence and Risk Factors of Major Depressive Disorder among Women at Public Antenatal Clinics from Refugee, Conflict-Affected, and Australian-Born Backgrounds." *JAMA Network Open* 2 (5): e193442. https://doi.org/10.1001/jamanetworkopen.2019.3442.

Save the Children and UNICEF. 2018. *Newborn Health in Humanitarian Settings: Field Guide.* New York: Save the Children, UNICEF. https://www.unicef.org/media/61561/file.

Save the Children, WHO, UNHCR (UN High Commissioner for Refugees), and UNICEF (United Nations Children's Fund). 2020. *Roadmap to Accelerate Progress for Every Newborn in Humanitarian Settings 2020-2025.* Geneva: UNHCR, WHO, UNICEF, Save the Children US. https://www.healthynewbornnetwork.org/hnn-content/uploads/Roadmap-to-Accelerate-Progress-for-Every-Newborn-in-Humanitarian-Settings-1-1.pdf.

Silove, Derrick, Susan J. Rees, Alvin Kuowei Tay, Zelia Maria da Costa, Elisa Soares Savio, Cesarina Soares, and Wietse Tol. 2015. "Pathways to Perinatal Depressive Symptoms after Mass Conflict in Timor-Leste: A Modelling Analysis Using Cross-Sectional Data." *The Lancet Psychiatry* 2 (2): 161-67. https://doi.org/10.1016/S2215-0366(14)00054-6.

Steel, Zachary, Tien Chey, Derrick Silove, Claire Marnane, Richard A. Bryant, and Mark van Ommeren. 2009. "Association of Torture and Other Potentially Traumatic Events with Mental Health Outcomes among Populations Exposed to Mass Conflict and Displacement: A Systematic Review and Meta-Analysis." *Journal of the American Medical Association* 302 (5): 537-49. https://doi.org/10.1001/jama.2009.1132.

Stevenson, Kerrie, Reina Alameddine, Ghaith Rukbi, Mario Chahrouri, Jinan Usta, Bassem Saab, Phillip Bennett, Vivette Glover, and Rebecca M. Reynolds. 2019. "High Rates of Maternal Depression amongst Syrian Refugees in Lebanon: A Pilot Study." *Scientific Reports* 9 (1): 1-6. https://doi.org/10.1038/s41598-019-48247-5.

Tobin, Carolyn L., Pam Di Napoli, and Cheryl Tatano Beck. 2018. "Refugee and Immigrant Women's Experience of Postpartum Depression: A Meta-Synthesis." *Journal of Transcultural Nursing* 29 (1): 84-100. https://doi.org/10.1177/1043659616686167.

UNHCR (UN High Commissioner for Refugees). 2019. *Global Trends: Forced Displacement in 2018*. Geneva: UNHCR. https://www.unhcr.org/5d08d7ee7.pdf.

UN OCHA (UN Office for the Coordination of Humanitarian Affairs). 2019. *Global Humanitarian Overview 2019: Trends in Humanitarian Needs and Assistance*. New York: OCHA.

Vos, Theo, Amanuel Alemu Abajobir, Kalkidan Hassen Abate, Cristiana Abbafati, Kaja M. Abbas, Foad Abd-Allah, Rizwan Suliankatchi Abdulkader et al. 2017. "Global, Regional, and National Incidence, Prevalence, and Years Lived with Disability for 328 Diseases and Injuries for 195 Countries, 1990-2016: A Systematic Analysis for the Global Burden of Disease Study 2016." *The Lancet* 390 (10100): 1211-59. https://doi.org/10.1016/S0140-6736(17)32154-2.

WHO. 2018. *Nurturing Care for Early Childhood Development: A Framework for Helping Children Survive and Thrive to Transform Health and Human Potential*. Geneva: WHO. https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf.

WHO. 2020a. *Standards for Improving the Quality of Care for Small and Sick Newborns in Health Facilities.* Geneva: WHO. https://www.who.int/publications/i/item/9789240010765.

WHO. 2020b. *Improving Early Childhood Development: WHO Guideline.* Geneva: WHO. https://www.who.int/publications/i/item/improving-early-childhood-development-who-guideline.

WHO. Forthcoming. *Child and Adolescent Health in Humanitarian Settings: Operational Guide – A Holistic Approach for Programme Managers.* Cairo: WHO Regional Office for the Eastern Mediterranean.

WHO and UNICEF. 2019. *Survive and Thrive: Transforming Care for Every Small and Sick Newborn.* Geneva: WHO. https://apps.who.int/iris/bitstream/handle/10665/326495/9789241515887-eng.pdf.

Zeid, Sarah, Kate Gilmore, Rajat Khosla, Heather Papowitz, Danielle Engel, Henia Dakkak, Njoki Rahab, Anita Sharma, and Mollie Fair. 2015. "Women's, Children's, and Adolescents' Health in Humanitarian and Other Crises." *British Medical Journal* 351: h4346. https://doi.org/10.1136/bmj.h4346.

APPENDIX

WHO MHPSS Interventions Relevant to Mothers in Humanitarian Settings		
Program Name	**Aim**	**Content**
Thinking Healthy	Reduce prenatal depression	16 sessions delivering evidence-based cognitive-behavioral techniques recommended by the mhGAP program
Caregiver Skills Training (CST)	Train caregivers of children with developmental conditions	Nine sessions addressing communication, engagement, daily living skills, challenging behaviors, and caregiver coping strategies
Problem Management Plus (PM+)	Improve the mental health of adults experiencing distress in communities affected by adversity	Five 90-minute individual sessions delivered by non-specialists that combine problem-solving with behavioral strategies to build clients' ability to manage their own emotional distress and reduce their own practical problems
Early Adolescent Skills for Emotions (EASE)	Improve the mental health of young adolescents ages 10-14 who are experiencing high psychological distress	Seven 90-minute sessions that teach young people skills to enhance their psychological coping
Self-Help Plus	Improve the mental health and functioning of people affected by humanitarian emergencies	Self-help package delivered by multimedia that provides recommendations for managing stress and coping with adversity
Operational Guidance for Addressing Child and Adolescents Health in Humanitarian Settings	Provide guidance on addressing child and adolescent health in a comprehensive manner	Forthcoming guidance that considers children's physical and mental health needs as part of integrated services by frontline workers

WHO Interventions Relevant to Child Development in Humanitarian Settings		
Program Name	**Aim**	**Content**
Care for Child Development	Provide resources for building providers' skill in counseling on responsive caregiving and early learning in contacts that caregivers and young children have with health care and other services	Age-appropriate counseling guidance to strengthen caregivers' knowledge and skills in responsive caregiving, and opportunities for early learning through guidance on play and communication
Caring for Children's Healthy Growth and Development	Strengthen capacity of community health workers and primary health-care workers to support children's growth and development	Age-appropriate counseling guidance to support feeding infants and young children, responsive caregiving, illness prevention, and seeking care in a timely manner
The Newborn Health Field Guide	Ensure access to quality care and essential interventions for newborn health in humanitarian settings	Document defines essential interventions and services for newborn care in conditions of conflict, disaster, or forced displacement
The Newborn Health Commodities Kit	Improve quality of newborn care through procurement and availability of essential commodities	Guide lists essential medicines and equipment for providing newborn care, including management of complications
The Newborn Health Roadmap	Increase investment in evidence-based interventions to address the health and development needs of newborn infants in humanitarian settings	Document lays out essential actions to establish and resurrect newborn care services in conditions of conflict, disaster, or forced displacement

JOURNAL ON EDUCATION IN EMERGENCIES

Commentary: Children with Developmental Disorders in Humanitarian Settings: A Call for Evidence and Action

Author(s): Xanthe Hunt, Theresa Betancourt, Laura Pacione, Mayada Elsabbagh, and Chiara Servili

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 184-195

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62230

DOI: https://doi.org/10.33682/6vgm-5n34

REFERENCES:

COMMENTARY: CHILDREN WITH DEVELOPMENTAL DISORDERS IN HUMANITARIAN SETTINGS: A CALL FOR EVIDENCE AND ACTION

Xanthe Hunt, Theresa Betancourt, Laura Pacione, Mayada Elsabbagh, and Chiara Servili

The effects disability has on children, including those with developmental disorders, are magnified in humanitarian contexts (Zuurmond et al. 2016), as the infrastructure needed to support these children's ability to function and participate is undermined by crisis.[1] Children in these settings who have developmental disorders are particularly vulnerable, as they often have limited access to services (Peek and Stough 2010), their caregivers' ability to cope is undermined (Dababnah et al. 2019; Beatson 2013), they may be separated from their caregivers (Peek and Stough 2010), and they are likely to experience abuse, exploitation, and neglect, including sexual and gender-based violence (Reilly 2010). Moreover, people who are poor and living in resource-scarce settings are more likely than individuals in high-income contexts to be adversely affected by developmental disorders and exposure to humanitarian crises (Casillas and Kammen 2010; UN Office for the Coordination of Humanitarian Affairs 2019; Braithwaite and Mont 2009).

The relationship between developmental disorders and humanitarian settings is a complex one: conflict and natural emergencies can contribute to developmental disorders, largely by compromising women's prenatal and perinatal environment and their access to perinatal care (Zuurmond et al. 2016). Children and adults with disabilities often shoulder a disproportionate burden of the suffering experienced in such settings (UN Human Settlements Programme 2007; Peek and Stough 2010).

1 Developmental disorders are a group of conditions that begin in the child's developmental period, affect the brain and/or nervous system, result in motor, cognitive, language, and/or behavioral impairments and limited functioning, and typically are lifelong.

The authors alone are responsible for the views expressed in this article and they do not necessarily represent the views, decisions, or policies of the institutions with which they are affiliated.

Journal on Education in Emergencies, Vol. 7, No. 1

ISSN 2518-6833

It is challenging to provide appropriate and responsive care in emergency contexts to children with developmental disorders and their caregivers (Davidson et al. 2004). Nevertheless, the public health significance of supporting these children and intervening with those at risk of suboptimal developmental trajectories due to their exposure to a humanitarian emergency cannot be ignored.

In recognition of this, our commentary poses three interlinked questions:

1. Which areas of programming and research need more attention in order to effectively support young children with developmental disorders and their caregivers?

2. In emergency contexts, what principles should guide work with young children who have disabilities?

3. What is known about how to plan and program for this group and what gaps in the evidence need to be addressed?

The Inter-Agency Standing Committee (IASC 2007, 2019), in its guidance on providing mental health and psychosocial support in emergency settings, gives specific consideration to children with severe mental health difficulties, including developmental conditions, as evidenced in discussions during the International Conference on Mental Health and Psychosocial Support in Crisis Situations (Government of The Netherlands 2019). The World Health Organization, as part of the WHO Mental Health Gap Action Programme (mhGAP) response (WHO and UNHCR 2015), has also issued guidance on the clinical management of mental, neurological, and substance use conditions for people in humanitarian emergencies. Many of the recommendations made in these documents and in the wider literature point to the key domains of planning and intervention, which must give appropriate and adequate consideration to children with developmental disorders and their families.

KEY RECOMMENDATIONS FOR PROGRAMMING

Communication and Evacuation

Emergency evacuation planners should work with developmental disorder advocates, users of mental health and neurological services, and the caregivers of children with developmental disorders to identify and accommodate these children's specific needs and leverage social networks to ensure that they have

adequate support during emergencies (Battle 2015). This recommendation is reflected in some mental health response programming. For example, the mhGAP-HIG, an intervention guide that contains first-line management recommendations for mental, neurological, and substance use conditions for nonspecialists in humanitarian settings, advocates for the inclusion of key stakeholders, such as service users, in emergency planning and response. Moreover, training for humanitarian workers should include sensitization to the need for inclusive evacuation models that make provisions for people with different types of impairments (e.g., providing evacuation messaging in Braille, audio, easy-read, and standard written forms) (Battle 2015). To develop an adequate emergency preparedness plan, families with children who have special health-care needs must be given particular information, education, and training (Hipper et al. 2018).

Mental Health and Psychosocial Support

Children with developmental disorders face a higher rate of mental health comorbidities than their typically developing peers. In humanitarian settings, caregivers of all children are at risk of developing mental health disorders (Henley and Robinson 2011; Panter-Brick, Grimon, and Eggerman 2014), and caregivers of children with developmental disorders in these settings may be at particular risk (Zuurmond et al. 2016; Power et al. 2019). Evidence-based mental health and psychosocial support (MHPSS) interventions need to address both the needs of the caregiver and the condition-specific needs of the child, as well as the child's comorbidities and the stress and trauma caused by the crisis (IASC 2007). However, Stough, Ducy, and Kang (2017) note that diagnostic overshadowing, whereby service providers assume that a child's condition is due to their existing developmental disorder rather than fully exploring the cause or the child's experience of symptoms, can hinder the recognition of trauma-related problems in children with developmental disorders. After an emergency, these children may need additional MHPSS and a longer period of intervention and follow-up than their typically developing peers (Peek and Stough 2010). Therefore, where appropriate, interventions for at least some of these children and their families should include trauma-focused components (Dababnah et al. 2019).

MHPSS interventions must be grounded in strong evidence and be adapted to the specific context and delivery platform when applied in humanitarian settings (IASC 2007). In general, MHPSS interventions aim to improve developmental outcomes and functioning in children with developmental disorders, improve the wellbeing of those who have been exposed to adverse experiences and trauma at a young age or have comorbid mental health conditions, and improve their

caregivers' wellbeing and parenting skills. Various guidance documents for the delivery of psychological first aid in humanitarian settings note the special provisions needed for individuals with disabilities (WHO 2011; Save the Children 2013; IASC 2007).

Health Care

Identifying children with developmental disorders on their arrival at a refugee camp, temporary shelter, or treatment facility is a priority in monitoring the health of refugee and internally displaced populations. Identifying these children can prevent unnecessary suffering and comorbidity by providing them and their caregivers with appropriate services (Davidson et al. 2004). In the rebuilding phase of emergencies, early stimulation programs, including those delivered in early childhood care and education centers, can be used to screen children, detect those with developmental disorders, and refer them to the appropriate health and psychosocial services for them and their caregivers (Hurley et al. 2013). Monitoring young children's development during routine points of contact, including getting a vaccination, social protection, nutrition/feeding, and early childhood development initiatives, can also provide a platform for identification and referral.

In emergency contexts, children with developmental disorders may be at risk for additional medical conditions. Health-care workers can appraise their developmental progress as part of an overall health assessment (Davidson et al. 2004; National Organization on Disability 2005). Institutional exclusion, such as centralized health-care centers that are not accessible to children with physical impairments or where health-care providers do not know how to cater to the needs of children with intellectual disability or autism, can create additional vulnerabilities for these children (Peek and Stough 2010; Hemingway and Priestley 2006). Therefore, health-care services provided during crises must be fully accessible to children with developmental disorders, provide the appropriate assistive devices and supports, and attend to their comorbidities (Battle 2015).

Education

For children with developmental disorders, especially girls and children of secondary school age, access to education in emergency settings is uneven across regions and settings, and according to the nature of the crisis (Battle 2015). Emergencies often disrupt education infrastructure and reduce access to appropriately trained teachers, which may delay the establishment of inclusive

education during the rebuilding phase after an emergency. Thus, there is a marked need to plan for the provision of education services in crisis-affected areas, including appropriate and inclusive education for children with developmental disorders, and for the human resources needed to provide it (Peek and Stough 2010; Battle 2015). Successful early childhood intervention programs in Nepal and Thailand identified refugee children with developmental conditions and helped them integrate into mainstream schools. Their teachers were trained and mentored to provide specific classroom support (Reilly 2010). Nevertheless, those providing inclusive education to children who require special services in emergency contexts still require more training and skills development (Barrett, Marshall, and Goldbart 2019).

Rebuilding

Inclusivity should be fostered in the reconstruction programs that follow an emergency (Miles 2002). Research with adults has shown that people with disabilities require more ongoing structural interventions in the rebuilding phase of an emergency than people without disabilities (Peek and Stough 2010; Battle 2015). The major focus of most United Nations responses to people in postconflict settings centers on "building back better" (WHO 2013; Epping-Jordan et al. 2015). Appropriate resources, technical assistance, and targeted implementation research have been brought to bear on scaling and sustaining evidence-based interventions for populations in humanitarian settings as part of multisectoral plans to strengthen the overall emergency response system following a crisis (UN Office for Disaster Risk Reduction 2015). Evidence-based approaches to supporting children with developmental disorders are essential in such efforts.

Enabling Environments

For children with developmental disorders, the environment in humanitarian settings is often characterized by adversity, stigma, deprivation, and a lack of access to important supports (Zuurmond et al. 2016). Furthermore, creating an environment in humanitarian settings that supports children with developmental disorders and their families requires recognizing the family unit as the intervention target, and the use of integrated cross- or multisectoral approaches.[2] Adequate policy structures, financing, technical input, staff, supervisory structures,

2 Enabling environments are the systems and contexts that enable individuals to participate, function, and thrive.

and implementation research must be part of any effort to improve external contexts (e.g., the built environment, health-care infrastructure, community practices) so they can sustain evidence-based practices that support children with developmental disorders in humanitarian settings. Protections and safeguards for children should target those who have particular vulnerabilities, including developmental disorders. Serious threats to these children's wellbeing, such as long-term detention in refugee or asylum centers, are unacceptable because of the high risk to the mental health of refugee children and their caregivers, particularly children with mental health conditions (Kronick, Rousseau, and Cleveland 2015).

GUIDING PRINCIPLES

The literature offers general good practices and important principles for working in emergency contexts with young children who have disabilities. These guidelines, which are broader than any given intervention, can be described more accurately as the values and ethos the programming and research in these situations should embrace. They must undergird efforts to support young children with developmental disorders, and their caregivers, who are living in emergency situations.

The need for cultural and contextual sensitivity recurs throughout the literature (Dababnah et al. 2019; Kroening et al. 2016; Beatson 2013). In humanitarian settings, encounters with biomedical services can be alienating for the caregivers of children with developmental disorders unless an effort is made to adapt these programs to the worldview of the individuals they serve. In this respect, much can be learned from the immigration literature. For instance, recommendations for those providing pediatric rehabilitation services to immigrant families that are raising a child with developmental disorders include extensive training in cultural issues and the practice of culturally sensitive care (Bhayana and Bhayana 2018). There also is a need for systematic protocols to guide the rapid and efficient cultural adaptation of evidence-based interventions.

Integrated cross-sectoral actions that advance evidence-based practices in the provision of child and family-centered care and support are also necessary. Cross-sectoral and intersectoral coordination among health, education, and social protection services are needed to ensure that children and their caregivers are provided for.

Engaging the community and other stakeholders in the identification of available resources in a child's environment is also imperative. Leveraging these networks to identify existing services and other resources for children with developmental disorders and their families is vital to finding sustainable supports.

Family-centered action must be the gold standard of intervention work, as the family plays a vital role in shaping children's survival and development in conflict and postconflict settings. This is perhaps particularly true for children with developmental disorders (Denov and Shevell 2019). However, the trauma of an emergency can undermine caregivers' capacity to cope, which may limit their ability to provide optimal care for their children (Alipui and Gerke 2018; Appleyard and Osofsky 2003). Therefore, when intervening to support children with developmental disorders in humanitarian settings, it is crucial that the capacity of their primary caregivers is a central focus.

Finally, engaging youth with developmental conditions, their families, and advocacy organizations in planning and programming must be a priority in inclusive humanitarian responses. Children with disabilities are experts who have lived experience, and they and their caregivers can provide vital information and perspectives that inform programming priorities and drive meaningful monitoring and evaluation.

EVIDENCE GAPS

As we synthesized the available evidence to develop the argument we present here, it became clear that the knowledge base for supporting this key population in humanitarian settings is limited. We found that data on developmental disorders, at least among refugee and war-affected populations, is collected infrequently, and that intervention work often takes place in the absence of accurate—or in fact any—data (Simmons 2010). For national and international agencies to gauge the extent and types of services needed to support children with developmental disorders in humanitarian settings, they will need to collect, analyze, and interpret data on developmental disorders and associated outcomes. Priority areas in which to generate evidence are noted in the literature, including the need for refined tools to raise awareness and provide technical assistance for planning screening, diagnosis, and treatment; better data about prevalence of different developmental disorders and comorbidities; literature that clearly addresses which policy and legislative provisions are most effective; and stronger monitoring by the public health system of children with developmental disorders and their families. There

also is a dearth of research literature that examines how well current guidance and frameworks are "working" for these children and their families. Such tools and resources are simply unavailable in many district hospitals and in the community health and early childhood development centers that serve children in humanitarian settings.

RELEVANCE FOR KEY STAKEHOLDERS

This commentary has highlighted areas of programming and research that need to give greater attention to supporting young children with developmental disorders, and their caregivers, in emergency contexts. As described, in order to provide concrete programming guidance, significant gaps in the evidence must be resolved. However, having perfect evidence is not a prerequisite to acting in response to urgent needs. The priorities discussed above and the guiding principles for planning and programming foreground the following for key stakeholders:

Caregivers: The mental health and wellbeing of caregivers must be buoyed if children with developmental conditions are to be properly supported. Caregivers are key partners and stakeholders in any intervention, and they must be adequately equipped to fulfil their caregiving role.

Teachers: Education infrastructure is often disrupted during crises, and appropriately trained teachers may not be available. Priority interventions must include training teachers to support inclusive education and providing classroom support for refugee children with special learning needs.

Health-care workers: Communication, the provision of appropriate assistive devices and supports, accessible health-care spaces, attention to comorbidities, and identification are priorities for the training of health-care providers working with children in these settings. As part of their overall health assessment of a child, health-care workers might appraise their developmental progress.

Policymakers: Planning and action in emergencies must be inclusive, and humanitarian organizations should include local disabled people's organizations in their emergency responses. Gender and caregiving roles should be kept in mind in the policymaking process. Evidence is critical to informed policymaking, including what intervention options can be scaled with sustained quality to serve vulnerable children and families.

REFERENCES

Alipui, Nicholas, and Nicole Gerke. 2018. "The Refugee Crisis and the Rights of Children: Perspectives on Community-Based Resettlement Programs." *New Directions for Child and Adolescent Development* 159: 91-98. https://doi.org/10.1002/cad.20228.

Appleyard, Karen, and Joy D. Osofsky. 2003. "Parenting after Trauma: Supporting Parents and Caregivers in the Treatment of Children Impacted by Violence." *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health* 24 (2): 111-25. https://doi.org/10.1002/imhj.10050.

Barrett, Helen, Julie Marshall, and Juliet Goldbart. 2019. "Refugee Children with Communication Disability in Rwanda: Providing the Educational Services They Need." *Forced Migration Review* (60): 36-38. https://www.fmreview.org/sites/fmr/files/FMRdownloads/en/education-displacement/barrett-marshall-goldbart.pdf.

Battle, Dolores E. 2015. "Persons with Communication Disabilities in Natural Disasters, War, and/or Conflict." *Communication Disorders Quarterly* 36 (4): 231-40. https://doi.org/10.1177/1525740114545980.

Beatson, Jean E. 2013. "Supporting Refugee Somali Bantu Mothers with Children with Disabilities." *Pediatric Nursing* 39 (3): 142-45.

Bhayana, Anjali, and Bhooma Bhayana. 2018. "Approach to Developmental Disabilities in Newcomer Families." *Canadian Family Physician* 64 (8): 567-73.

Braithwaite, Jeanine, and Daniel Mont. 2009. "Disability and Poverty: A Survey of World Bank Poverty Assessments and Implications." *Alter* 3 (3): 219-32. https://doi.org/10.1016/j.alter.2008.10.002.

Casillas, Christian E., and Daniel M. Kammen. 2010. "The Energy-Poverty-Climate Nexus." *Science* 330 (6008): 1181-82. https://doi.org/10.1126/science.1197412.

Dababnah, Sarah, Serene Habayeb, Benjamin J. Bear, and Dana Hussein. 2019. "Feasibility of a Trauma-Informed Parent-Teacher Cooperative Training Program for Syrian Refugee Children with Autism." *Autism* 23 (5): 1300-10.

Davidson, Natasha, Sue Skull, Gervase Chaney, Alexis Frydenberg, David Isaacs, Paul Kelly, Basiliki Lampropoulos et al. 2004. "Comprehensive Health Assessment for Newly Arrived Refugee Children in Australia." *Journal of Paediatrics and Child Health* 40 (9-10): 562-68. https://doi.org/10.1111/j.1440-1754.2004.00465.x.

Denov, Myriam, and Meaghan C. Shevell. 2019. "Social Work Practice with War-Affected Children and Families: The Importance of Family, Culture, Arts, and Participatory Approaches." *Journal of Family Social Work* (22) 1: 1-16. https://doi.org/10.1080/10522158.2019.1546809.

Epping-Jordan, JoAnne E., Mark Van Ommeren, Hazem Nayef Ashour, Albert Maramis, Anita Marini, Andrew Mohanraj, Aqila Noori et al. 2015. "Beyond the Crisis: Building Back Better Mental Health Care in 10 Emergency-Affected Areas Using a Longer-Term Perspective." *International Journal of Mental Health Systems* 9 (1): 15. https://doi.org/10.1186/s13033-015-0007-9.

Government of The Netherlands. 2019. *International Conference on Mental Health and Psychosocial Support in Crisis Situations: Background Document and Recommendations.* Amsterdam: Netherlands Ministry of Foreign Affairs.

Hemingway, Laura, and Mark Priestley. 2006. "Natural Hazards, Human Vulnerability and Disabling Societies: A Disaster for Disabled People?" *Review of Disability Studies* 2 (3): 57-67. https://www.rdsjournal.org/index.php/journal/article/view/337.

Henley, Joh, and Julie Robinson. 2011. "Mental Health Issues among Refugee Children and Adolescents." *Clinical Psychologist* 15 (2): 51-62. https://doi.org/10.1111/j.1742-9552.2011.00024.x.

Hipper, Thomas J. Hipper, Renee Davis, Philip M. Massey, Renee M. Turchi, Keri M. Lubell, Laura E. Pechta, Dale A. Rose et al. 2018. "The Disaster Information Needs of Families of Children with Special Healthcare Needs: A Scoping Review." *Health Security* 16 (3): 178-92. https://doi.org/10.1089/hs.2018.0007.

Hurley, Jennifer J., Saveta Saini, Rachel A. Warren, and Alissa J. Carberry. 2013. "Use of the Pyramid Model for Supporting Preschool Refugees." *Early Child Development and Care* 183 (1): 75-91. https://doi.org/10.1080/03004430.2012.655242.

Inter-Agency Standing Committee. 2007. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva: Inter-Agency Standing Committee.

Inter-Agency Standing Committee. 2019. *Guidelines: Inclusion of Persons with Disabilities in Humanitarian Action*. Geneva: Inter-Agency Standing Committee.

Kroening, Abigail L. H., Jessica A. Moore, Therese R. Welch, Jill S. Halterman, and Susan L. Hyman. 2016. "Developmental Screening of Refugees: A Qualitative Study." *Pediatrics* 138 (3): e20160234. https://doi.org/10.1542/peds.2016-0234.

Kronick, Rachel, Cécile Rousseau, and Janet Cleveland. 2015. "Asylum-Seeking Children's Experiences of Detention in Canada: A Qualitative Study." *American Journal of Orthopsychiatry* 85 (3): 287-94. https://doi.org/10.1037/ort0000061.

Miles, M. 2002. "Formal and Informal Disability Resources for Afghan Reconstruction." *Third World Quarterly* 23 (5): 945-59. https://doi.org/10.1080/0143659022000028567.

National Organization on Disability. 2005. *Report on Special Needs Assessment for Katrina Evacuees (SNAKE) Project*. Washington, DC: National Organization on Disability.

Panter-Brick, Catherine, Marie-Pascale Grimon, and Mark Eggerman. (2014). "Caregiver-Child Mental Health: A Prospective Study in Conflict and Refugee Settings." *Journal of Child Psychology and Psychiatry 55* (4): 313-27. https://doi.org/10.1111/jcpp.12167.

Peek, Lori, and Laura M. Stough. 2010. "Children with Disabilities in the Context of Disaster: A Social Vulnerability Perspective." *Child Development* 81 (4): 1260-70.

Power, Rosalie, Mohammad Muhit, Eamin Heanoy, Tasneem Karim, Claire Galea, Nadia Badawi, and Gulam Khandaker. 2019. "Depression, Anxiety and Stress Among Caregivers of Adolescents with Cerebral Palsy in Rural Bangladesh." *Disability and Rehabilitation*, 1-8. https://doi.org/10.1080/09638288.2019.1692378.

Reilly, Rachael. 2010. "Disabilities among Refugees and Conflict-Affected Populations." *Forced Migration Review* (35): 8.

Save the Children. 2013. *Save the Children Psychological First Aid Training Manual for Child Practitioners*. Copenhagen: Save the Children Denmark. https://resourcecentre.savethechildren.net/library/save-children-psychological-first-aid-training-manual-child-practitioners.

Simmons, Kathleen B. 2010. "Addressing the Data Challenge." *Forced Migration Review* (35): 10.

Stough, Laura M., Elizabeth McAdams Ducy, and Donghyun Kang. 2017. "Addressing the Needs of Children with Disabilities Experiencing Disaster or Terrorism." *Current Psychiatry Reports* 19 (4): 24. https://doi.org/10.1007/s11920-017-0776-8.

UN Human Settlements Programme. 2007. *Enhancing Urban Safety and Security: Global Report on Human Settlements, 2007.* London: Earthscan.

UN Office for the Coordination of Humanitarian Affairs. 2019. *Global Humanitarian Overview.* New York: UN Office for the Coordination of Humanitarian Affairs.

UN Office for Disaster Risk Reduction. 2015. *Sendai Framework for Disaster Risk Reduction 2015-2030 (SFDRR).* Geneva: UN Office for Disaster Risk Reduction.

WHO. 2011. *World Report on Disability*. Geneva: World Health Organization.

WHO. 2013. *Building Back Better: Sustainable Mental Health Care after Emergencies.* Geneva: World Health Organization.

WHO and UNHCR (UN High Commissioner for Refugees). 2015. *mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies.* Geneva: WHO.

Zuurmond, Maria, Velma Nyapera, Victoria Mwenda, James Kisia, Hilary Rono, and Jennifer Palmer. 2016. "Childhood Disability in Turkana, Kenya: Understanding How Carers Cope in a Complex Humanitarian Setting." *African Journal of Disability* 5 (1): 1-8. https://doi.org/10.4102/ajod.v5i1.277.

JOURNAL ON EDUCATION IN EMERGENCIES

Book Review: *Collaborative Cross-Cultural Research Methodologies in Early Care and Education Contexts edited* by Samara Madrid Akpovo, Mary Jane Moran, and Robyn Brookshire

Author(s): Amy Jo Dowd

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 196-198

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62231

DOI: https://doi.org/10.33682/1kxn-8s2a

REFERENCES:

BOOK REVIEW

Collaborative Cross-Cultural Research Methodologies in Early Care and Education Contexts
edited by Samara Madrid Akpovo, Mary Jane Moran, and Robyn Brookshire
Routledge, 2018. xxv + 216 pages
$51.95 (paperback), $46.76 (e-book)
ISBN 978-1-315-46077-2

Collaborative Cross-Cultural Research Methodologies in Early Care and Education Contexts, edited by Samara Madrid Akpovo, Mary Jane Moran, and Robyn Brookshire, offers an array of reflections on how each of the contributors' cross-cultural early childhood research collaborations played out, and what each author learned from the approach they chose to crossing borders, languages, capabilities, and mindsets. This volume of case studies offers rare insights into how the studies we routinely read in journals are carried out and the many processes, principles, and pitfalls involved when crossing cultures. While part one considers research as a situated activity in which context is king, part two takes up the complexities of positionality, ethics, and power, and part three delves into the many ways to share, investigate, and illuminate lived experience. The more I read, the more I wanted to read (or re-read) the research these efforts produced. Akpovo, Moran, and Brookshire's book is an ode in three parts to crossing boundaries on behalf of children and families; the insistence of Thapa, Akpovo, and Young in chapter 5 that collaboration should not be optional in research holds for all who contributed to the volume.

Three main ideas on the centrality of good collaboration ring throughout the book's dozen chapters, thereby painting a coherent picture of the importance of context for child development efforts, research and reciprocity, and reflections on improving cross-cultural research and practice. These themes elicit valuable lessons learned for education in emergencies researchers and practitioners, along with guidelines for good collaborative cross-cultural practice.

The contributors in part one in particular note the power of, and thus press for, good early childhood practice globewide, while also highlighting the need to negotiate hybrid early childhood content that combines the science on early childhood with local practice. Pence (chap. 2) describes this as the need for early

childhood science to "hear more" (p. 25), whereas Kirova, Massing, Cleghorn, and Prochner (chap. 7) refer to it as the need for global early childhood priorities to combine with "unique, traditional and local practices" (p. 109). This combination is clear in the examples offered: collaboration between elders and assistants on faraway Fijian islands (chap. 11) and in Canada (chap. 2); between national early childhood development leaders and rural parents in Kenya (chap. 3); among children using cameras to document their lives and their rights in multiple middle-income countries (chap. 10); and among two groups of teachers reflecting together on their practice in videos they took in the US and Italy (chap. 9). While most studies profiled in this volume are small in scale, their intimate engagement with early childhood content, practice, and impact highlights the centrality of context and speaks to sustainability and self-reliance.

While reading this volume, I actively considered my research practice and priorities through the eyes of each author and came away with a reflection similar to that of one teacher, featured in chapter 9, on co-constructed research design: "There are a lot of things that I've picked up that I'm going to look at as far as my practice goes personally. Definitely" (p. 144). Through rich contextual examples, the contributing authors describe how they engaged with global and local child development priorities by interrogating their meaning in context and their challenges by culture. They show how this collaborative process can enrich curriculum, content, and learning for all involved.

Relationship and reciprocity feature repeatedly in the in-depth cases presented in part two and elsewhere that declare the importance of relationships—between collaborating researchers, between researchers and practitioners, and between researchers and their research participants or subjects. These relationships—whether a longstanding partnership or a fortuitous invitation—are noted repeatedly to be a key starting point for collaborative cross-cultural research. The authors characterize such relationships as needing time and discussion in order to develop fully, which can mean defying planned interview schedules and daring researchers to relinquish their hold on the plan in order to prioritize their investment in the collaboration. Models of reciprocity are shared in authors' descriptions of activities and carefully negotiated power relationships that span the phases of their research practice—design, data collection, interpretation, and reporting results. Every chapter offers perspectives on how to navigate the tension between the power of insider knowledge to illuminate findings and ensure relevance on the one hand, and on the other the value of the outsider in providing new perspectives and giving the researcher an opportunity to see oneself through others' eyes.

Many of the contributing authors conclude with welcome reflections on how to improve cross-cultural collaborations. Mutua and Swadener (chap. 3) recommend "humility, good listening, transparency, humor and interrogating one's power and privilege" (p. 43) in their chapter on decolonizing cross-cultural research. From their perspective as human rights educators, Koirala-Azad, Zanoni, and Argenal (chap. 6) similarly advise taking "a posture of humility geared towards learning" (p. 84) to combat power and privilege inequities. Georgis, Gokiert, and Kirova (chap. 8), who work with immigrant and refugee communities, address the cycle of privilege and power by defining their relationships with parent participants as opportunities for co-learning, based on the parents' strengths and their own aim of co-creating knowledge. Finally, Thapa, Akpovo, and Young (chap. 5) suggest practical tools, such as starting collaborations by sharing narratives to set the tone and making space for multiplicity and diversity, which can reduce miscommunication. They also suggest holding plenaries with study respondents at the end of the research cycle to ensure accurate interpretations. The advice given in each chapter echoes that of the others—take a learning stance, be prepared to reflect, share your perspectives, and make room for others' strengths.

These tips and tricks, values and priorities are implied throughout the book as elements of good qualitative cross-cultural research collaboration, but the authors miss the opportunity to push for their application by all researchers who cross cultures—both qualitative researchers and those who use quantitative and mixed methods. Considering context, positionality, relationship, and reciprocity could take more of researchers' time, funds, and efforts, but building relationships, exploring multiple viewpoints, and ensuring an exchange in both directions will benefit their credibility and ensure sustainable change for children. This volume not only presents readers with reflections on why this is true in the authors' experiences, it also offers guidelines on how readers can learn from their lessons and replicate their good practice.

AMY JO DOWD
The LEGO Foundation

The views expressed here are the author's and do not represent the LEGO Foundation.

JOURNAL ON EDUCATION IN EMERGENCIES

Book Review: *Early Childhood Development in Humanitarian Crises: South Sudanese Refugees in Uganda* by Sweta Shah

Author(s): Kate Schwarz

Source: *Journal on Education in Emergencies*, Vol. 7 No. 1 (June 2021), pp. 199-201

Published by: Inter-agency Network for Education in Emergencies

Stable URL: http://hdl.handle.net/2451/62232

DOI: https://doi.org/10.33682/u3ar-wwzm

REFERENCES:

Schwarz, Kate. 2021. "Book Review: *Early Childhood Development in Humanitarian Crises: South Sudanese Refugees in Uganda* by Sweta Shah." *Journal on Education in Emergencies* 7 (1): 199-201. https://doi.org/10.33682/u3ar-wwzm.

BOOK REVIEW

Early Childhood Development in Humanitarian Crises: South Sudanese Refugees in Uganda
by Sweta Shah
Routledge, 2020. 236 pages
$48.95 (paper), $160.00 (hardcover), $44.05 (e-book)
ISBN 9780367228576

Early Childhood Development in Humanitarian Crises: South Sudanese Refugees in Uganda, Sweta Shah's comprehensive book on early childhood development (ECD) in humanitarian crises, benefits from, and is likely to draw criticism for, its stated desire to appeal to a wide audience. Any part of this expansive work could itself be a book, which runs the risk of leaving some readers wishing for more on a particular topic. It also makes this an excellent text for those looking to be introduced fairly quickly to a wide range of issues of critical importance to improving the long-term outcomes of the tens of millions of children who are currently displaced from their homes due to conflict and disaster, and the countless more likely to be so in the future.

In part one, Shah leverages her 18 years of experience at the crossroads of humanitarian responses, international development, and ECD to present a broad overview of ECD and humanitarian responses, which she examines both separately and as they relate to each other. She also provides a deep look at the South Sudanese conflict, in particular the situation of South Sudanese refugees living in Uganda, and a theoretical underpinning for those thinking about child development and the goals of ECD. While presented as background to her own research, part one encompasses more than half the book, and it is where Shah shines most brightly.

Shah first makes an extremely compelling case for why we must focus on ECD, particularly in emergency situations, while clearly articulating the myriad reasons ECD has been largely overlooked in so many humanitarian responses. These reasons include a general overreliance on Maslow's hierarchy of needs within the humanitarian response, despite compelling evidence opposing the use of this model and the difficulty of providing multisector services in a context of siloed funding streams, service provision, and oversight entities. As Shah makes clear, ECD addresses education *and* parenting *and* health *and* nutrition *and* child protection. She then provides a rich history of the humanitarian sector as a field and describes the current topography, how emergency responses are prioritized,

and the multifaceted and complicated ways emergency responses are usually funded. She then turns to the specific situation in South Sudan.

If anyone wonders why, in presenting its inaugural $100 million award to Sesame Workshop and the International Rescue Committee in late 2017, the MacArthur Foundation identified an early childhood response to address the effects of conflict and displacement as the "idea most likely to change the world," they need only read the first four chapters of Shah's book. While her history stops short of this award and the $100 million Lego Foundation award that followed it, Shah more than makes the case for why the development of young children is of such vital importance in emergency responses, and why responding well to the growing number of conflicts and crises is of such vital importance to global wellbeing.

Shah paints a vivid picture of the conflict in South Sudan before turning to the theoretical approaches underpinning child development responses and goals. While her writing is not always as accessible and straightforward in this chapter on theory as it is in the rest of the text, her combination of central child development theories (Vygotsky's sociocultural theory in particular) and a human capability approach to development more broadly (as put forward by Amartya Sen and colleagues) makes a critical contribution to how the field thinks about the aims, processes, and cultural relevance of child-development initiatives. One of the key questions in education psychology is how one defines teaching and learning and, indeed, what the goal of education is. In combining these two theoretical frameworks, Shah presents an approach to ECD and learning that is both explicitly context specific (i.e., each culture can and should define their own most valued beings and doings) and deeply grounded in the more universal science of child development, which is influenced by both micro and macro cultures and scaffolded throughout children's daily activities and interactions.

It is perhaps the breadth (and success) of these background chapters—and the almost unending stream of ideas and facts they give readers to think about—that make parts two and three of this text feel like a little bit of a letdown. The field undoubtedly needs more qualitative research focused on adapting ECD programs to emergency settings (chap. 6); thoughtful work on measuring ECD outcomes in culturally appropriate ways (chap. 8; she details her research methodology in chap. 7); and more research that examines the effects of ECD in emergency settings (chap. 9). However, in moving on to these specifics, Shah retains only part of the wonderfully rich background she so expertly articulates in the early chapters. Shah's presentation of her own work would benefit from being linked more regularly and explicitly to what came before, especially in relation to the

broader opportunity created through focusing on ECD as a critical part of any humanitarian response, and to the South Sudan refugee response in particular.

This said, Shah's descriptions of her work do concretely highlight lessons learned in adapting ECD models to humanitarian settings, as well as the range of challenges faced in providing services and conducting research in these settings. These include the need to be flexible in terms of what aspects of a model are delivered and how; the realities of dealing with competing needs and time demands (e.g., food distribution lines) during program or research hours; the high mobility of refugees; space constraints and the multi-use nature of the spaces provided; insufficient or culturally inappropriate materials; and ingrained beliefs about what education should look like (i.e., rote learning). Challenges also include difficulties around research design, such as finding a convincing control group, given the realities of refugee environments, and disentangling gains in child development from familiarity with the items on child assessments in settings where such activities are foreign to children who are not enrolled in ECD programs (i.e., most control groups). Understanding these challenges, and the different ways practitioners and researchers approach them, is critical to any effort to expand access to and the quality of ECD in humanitarian settings.

Overall, Shah more than succeeds in pulling together various fields and disciplines to present a comprehensive picture of ECD in humanitarian settings: what it is or is not, what it could be, why we need it, and why it is not already more widespread. She also offers her own experience as a case study of what ECD can look like in these settings and what on-the-ground challenges researchers and practitioners face. Those just entering this field are unlikely to find a better introduction to its complexities than Shah's book, and those already working in ECD are sure to discover new ways of thinking about and framing their own approach. As Shah notes in her conclusion, ECD in emergencies is a hot topic at the moment. And rightfully so.

KATE SCHWARTZ
Global TIES for Children, New York University

The views expressed here are the author's and do not represent Global TIES or New York University.

CONTRIBUTORS

JAHANARA AHMAD (jahanara.ahmad@brac.net) is a Program Specialist at the BRAC Institute of Educational Development (BRAC IED) in Bangladesh. Her work involves strategic planning, project design, and proposal development for BRAC IED interventions that are focused on early stimulation and mental health and target people from marginalized backgrounds.

AYAT AL AQRA (ayat.AlAqra@rescue.org) is the Early Childhood Development Manager for the Ahlan Simsim program in Jordan, which is a partnership between the International Rescue Committee (IRC) and Sesame Workshop. She is responsible for delivering technical support and capacity-building content for early childhood development (ECD) programs that target children and caregivers for the IRC and its partners. She led the contextualization, training, and implementation of Reach Up and Learn in Jordan, and adapted the curriculum to be delivered remotely during the COVID-19 pandemic, in particular content on caregiver and facilitator wellbeing. She is supporting an upcoming evaluation of Reach Up and Learn's impact on caregivers and children during the pandemic. She has worked with IRC for more than four years, and has a bachelor's degree in English language and literature from Hashemite University.

ASHRAFUL HAQUE (mahaque@poverty-action.org) has been with Innovations for Poverty Action (IPA) since 2004 and has been the Country Director for IPA Bangladesh since 2018. He is a researcher, teacher, and public policy professional with 13 years of experience supporting the generation and application of rigorous evidence to inform policy. Currently an adjunct faculty member at North South University, he was previously an assistant professor and lecturer of public administration at Jahangirnagar University. He holds a master's in public administration from the University of Dhaka and a master's in public policy and management from Carnegie Mellon University.

SAVERIO BELLIZZI (bellizzis@who.int) is the Emergency Team Lead for the World Health Organization (WHO) country office in Amman, Jordan, and is coordinating the COVID-19 response at the country level. He has a 15-year background in clinical medicine and epidemiology, with a focus on maternal and child health, and on emergencies. In 2019 he acted as the ECD focal person for the Partnership for Maternal, Newborn & Child Health, and he is the author of more than 40 scientific articles published in globally recognized journals. His recent doctoral thesis from Ghent University in Belgium examines the role

health facility-based childbirth plays in early neonatal mortality in low- and middle-income countries.

THERESA S. BETANCOURT (rpcalab_ssw@bc.edu) is the inaugural Salem Professor in Global Practice at the Boston College School of Social Work, where she directs the Research Program on Children and Adversity. Her research interests include the developmental and psychosocial consequences of concentrated adversity on children and families; resilience and protective processes in child mental health and development; and implementation science. She is leading the investigation of a father-engaged home-visiting intervention to promote ECD and prevent violence that can be integrated into social protection initiatives in low-resource settings. She has published widely on ECD and global mental health topics.

MATTHEW R. G. BROWN (mbrown2@ualberta.ca) is a Research Associate in the Department of Psychiatry at the University of Alberta in Edmonton, Canada. He has expertise in machine learning and its application to cognitive neuroscience and brain imaging. His interests include understanding risk-related decisionmaking in humans and simulated agents. He earned a PhD in neuroscience from the University of Western Ontario in 2007.

BERNADETTE DAELMANS (daelmansb@who.int) is leading the WHO Child Health and Development unit. Since joining the WHO, she has been engaged with a range of issues related to maternal, newborn, and child health, including feeding of infants and young children, integrated management of childhood illness, newborn health, and ECD. She led the development of the Nurturing Care Framework and was a member of the Lancet Global Health Commission on High Quality Health Systems in the SDG era. Her current focus is primary health care and the health and wellbeing of children and adolescents.

SARA DANG (sdang@savechildren.org) is a Senior Early Childhood Care and Development (ECCD) Advisor at Save the Children. She provides technical support to ensure the design quality and delivery of ECCD programs for children from birth to age six in safe and sustainable environments. She also is chair of the Asia Pacific Regional Network for Early Childhood steering committee, where she provides strategic guidance for the network's vision, actions, and strategy. She has worked in Asia, Africa, and the Pacific, has a bachelor's degree in chemical engineering from the University of Toronto, and a master's in mind, brain, and education from Harvard University.

JULIE L. DROLET (jdrolet@ucalgary.ca) is a Professor in the Faculty of Social Work at the University of Calgary. She serves as the Project Director for the Transforming the Field Education Landscape project, which is funded by an SSHRC Partnership grant. She has published extensively on international social work and social development, with a focus on disaster recovery, climate change, social protection initiatives, international and Canadian field education, qualitative research, and international migration and Canadian immigration. She teaches social work research, international social work, social work practice with immigrants and refugees, and field education courses at both the undergraduate and graduate levels.

TARUN DUA (duat@who.int) is the Unit Head of the Brain Health Unit in the Department of Mental Health and Substance Use at WHO headquarters. He leads the unit's work, which is aimed at promoting optimal brain development, cognitive health and wellbeing, and the prevention and management of neurological disorders throughout the life course. His work also focuses on the provision of technical policy and advice to strengthen work in the area of brain health, including developing guidelines and normative tools to address global needs.

MAYADA ELSABBAGH (mayada.elsabbagh@mcgill.ca) is Associate Professor of Neurology and Neurosurgery at McGill University. Her research focuses on understanding the root causes of autism and tracing its developmental pathways. Her approach combines innovative research with the mission of accelerating translation of scientific discoveries into community impact. She has supported the launch of several successful collaborative research and translational networks aimed at accelerating the pace of discovery in autism. She is active in global efforts to improve evidence-based practice in the community and capacity-building in low- and middle-income countries.

ABDULLAH ENSOUR (Abdullah.Ensour@rescue.org) is the Community Health Program Manager at the IRC Jordan, which has been leading the community health and ECD integration activities since 2017. A specialist in program/project and operational management, he has been working with international nongovernmental organizations (NGOs) for more than seven years. He has a bachelor's of science degree in computer information systems and a master's in human resource management.

KIM FOULDS (kim.foulds@sesame.org) is Vice President of Content Research & Evaluation at Sesame Workshop, the media and education nonprofit organization behind *Sesame Street*. She leads a team that conducts research projects across the globe in a variety of curricular areas across media platforms, including literacy, social-emotional wellbeing, and health. Using an array of methodologies to support projects from conception to completion, she works with academic and research institutions to evaluate efficacy and translates data into recommendations that maximize the impact of Sesame Workshop's content around the world.

SAGAR GYAWALI (pri.sagargyawali@gmail.com) is a cofounder of the research firm Pragmatic Research & Innovations Pvt. Ltd. and the Nepal Mother Foundation, a Nepal-based NGO. He has a decade of involvement in the education sector, with specialization in ECD, education in emergencies, and quality assurance systems in the South Asian context. He served as project manager of an early stimulation and ECD project with Save the Children. He earned master's degrees in social work and sociology and an advanced degree in education in emergencies from the Université de Genève.

FAHMY HANNA (hannaf@who.int), a psychiatrist by training, has more than 15 years of experience in mental health services and its development in low- and middle-income settings. He served at several WHO duty stations in countries affected by complex emergencies, including Syria and Libya. He joined the WHO in Geneva in 2014, where his main areas of work include providing technical assistance on mental health to countries during emergencies and supporting governments and WHO partners in scaling-up mental health care. He has represented the WHO as cochair of the Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergencies since 2017. He also is the technical lead for mental health and psychosocial support and COVID-19 at WHO headquarters.

KAYLA HOYER (Kayla.Hoyer@rescue.org) is an Analyst for the IRC Research & Innovation Team. Her work focuses on using research and cost data to inform decisions about the impact and reach of IRC programs to improve outcomes for clients. She holds a master's degree in public policy from the University of Michigan, where she focused on international policy and social science research.

XANTHE HUNT (xanthehuntwrites@gmail.com) is a Senior Researcher at the Institute for Life Course Health Research at Stellenbosch University in South Africa and a consultant to the WHO. Her research interests include ECD and disability studies, with a focus on measurement, implementation, and evidence synthesis in low- and middle-income countries. Her current projects include a multicountry monitoring and evaluation initiative for programming that concerns young children in high-burden HIV communities, and a qualitative exploration into the sexual and reproductive health-care experiences of South African women with disabilities.

IMAN IBRAHIM (iman.ibrahim@rescue.org) is a Child Protection Manager for the IRC. She provides technical support on child protection and integrated early childhood programs for the IRC child protection team working in North and East Syria and oversees the program implementation in different locations. She has worked with the IRC in Syria for five years in the child protection and woman protection and empowerment sectors. She previously coordinated training and capacity-building programs for people constructing a local peacebuilding center. She has a bachelor of sociology from Latakia University and is currently a master's student at Damascus University.

NAUREEN KHAN (naureen.khan@bracu.ac.bd) works at the BRAC Institute of Governance and Development, where she set up and manages the WEE-DiFine Initiative, which funds rigorous impact evaluations. She previously worked as a research associate at IPA, where she led the first IPA Bangladesh research team into the Rohingya refugee camps to conduct fieldwork. She subsequently managed multiple projects in the camps, including quantitative and qualitative studies. She was previously an adjunct faculty member at North South University and is currently an adjunct senior lecturer at the Millennium University. She holds a master's of science with distinction in economics and international financial economics and a bachelor's of science with honors in economics from the University of Warwick.

VALERIA KUNZ (valeria.kunz@savethechildren.ch) is the Head of Education at Save the Children Switzerland, where she provides strategic steer, coordination, and technical support to the organization's global education programs. She has worked in international cooperation for more than 16 years in South Asia, West Africa, and southeastern Europe, where she focused on quality basic education, ECD, and education in emergencies. She has a master's in sociology from the University of Bern and a Certificate of Advanced Studies in development and cooperation from the Swiss Federal Institute of Technology in Zurich.

NASREEN LALANI (lalanin@purdue.edu) is an Assistant Professor at the Johnson School of Nursing at Purdue University. An early career nurse researcher, she has more than 25 years' research experience and has held leadership positions in Pakistan, Canada, and the United States. Her research interest areas are spirituality, resilience, aging and palliative care, and family caregiving.

FABIOLA A. LARA (fabiola.a.lara@gmail.com) is currently a Senior Specialist in ECCD for international programs at Save the Children. A global technical expert in early childhood development and education, her experience spans fragile, conflict- and violence-affected settings in Africa, Latin America and the Caribbean, and beyond. She currently leads cross-sectoral work linking ECCD, child protection, and mental health and psychosocial support. Her specialties include curriculum development and implementation, program design and planning, and national educational planning and advocacy.

ORNELLA LINCETTO (LincettoOr@who.int) is a Senior Medical Officer for Newborn Health with the WHO Department of Maternal Newborn Child and Adolescent Health and Ageing. An Italian neonatologist, pediatrician, and public health expert, she currently leads the department's work on newborn health policies, practices, programs, and birth defects, and coordinates Every Newborn Action Plan activities on behalf of the WHO. With the WHO since 2000, she brings experience from Lao PDR, Vietnam, Papua New Guinea, and Bhutan. She previously worked for various maternal and child health projects in fragile Asian and African countries.

SHEILA MANJI (manjis@who.int) currently works with the Partnership for Maternal, Newborn & Child Health. She is an international ECD specialist with extensive experience working at the national, regional, and global levels to develop contextually appropriate solutions that promote nurturing care. She has led global initiatives to raise attention to and investment in ECD, developed online and offline educational materials to advance understanding and foster collaboration across diverse audiences, and provided in-depth technical support to governments, UN agencies, and civil society organizations in more than 15 countries.

SAMIER MANSUR (samier@nolimitgen.org) is a cofounder of the nationally recognized LiveSafe mobile safety app and founder of No Limit Generation, a global mental health and child wellbeing platform. He is a proven social impact entrepreneur recognized as one of the "top innovators and disruptors" in Washington, DC. He has spent his professional career at the intersection of

effective public policy, mental health, and tech-driven solutions that have saved lives and reached millions of people around the world. He has more than 40 published works on mental health, public policy, and international relations and is a frequent speaker and presenter on global platforms. He also advises executive leaders on personal wellbeing and organizational success.

ERUM MARIAM (erum.m@brac.net) is the Executive Director of BRAC IED in Bangladesh. She has extensive national and global experience scaling-up education interventions, and in the 1990s she was involved in the expansion of the unique BRAC-run Non-Formal Primary Schools. Since 2008, she has promoted BRAC IED's vision of contributing to the improvement of quality, equity, and efficiency in the education system in partnership with the public sector. The globally recognized Play Labs and Humanitarian Play Labs, which focus on early stimulation and children's wellbeing in diverse settings, were developed under her leadership. She was awarded her PhD in education from Cambridge University in 2008.

CAROLINE MCDONALD-HARKER (cmcdonaldharker@mtroyal.ca) is a Sociologist and Associate Professor in the Department of Sociology at Mount Royal University and Director of the Centre for Community Disaster Research. Her many areas of research and expertise include the sociology of disaster, parenting/parenthood, children and youth, trauma and resilience, and mixed research methods. She has carried out numerous community-engaged research studies that examine the impact natural disasters have on families, parents, and children and youth, with a specific focus on trauma, resilience, and recovery.

LORI MCDOUGALL (McDougallL@who.int) is Coordinator of The Partnership for Maternal, Newborn & Child Health at the WHO. She has a 20-year background in designing and leading global, regional, and national multistakeholder advocacy and communication campaigns, including those related to maternal, newborn, and child health, ECD, HIV/AIDS, leprosy, and trachoma. Her recent doctoral thesis from the London School of Hygiene and Tropical Medicine examines how global health advocacy networks secured political attention for maternal and child health during the 2000-2015 Development Goal era.

SARAH MCGREER (sarah.mcgreer2@ucalgary.ca) is a Research Assistant with the Faculty of Social Work at the University of Calgary. Her areas of research and expertise include child mental health, trauma-informed practice in primary education, and trauma and resilience among children and adolescents. Her research involves studying primary school educators' perspectives of trauma-

informed practice in the field of education. She has a master's of social work from the University of Calgary and currently works as a school-based mental health therapist.

KATIE MAEVE MURPHY (katie.murphy@rescue.org) is the Senior Technical Advisor for Early Childhood Development at the IRC. She has more than 15 years of experience working in the fields of ECD, education, and sustainable development. Currently a PhD candidate in applied psychology and human development at the University of Pennsylvania, she has conducted ECD research in Central America, Ecuador, India, Kenya, Mexico, and Thailand. She earned a master's in public health from the University of Pennsylvania, a master's of education in international education policy from Harvard, and a bachelor's from Johns Hopkins University.

MAHALAKSHMI NAIR (consultingmountainside@gmail.com) is a social entrepreneur and the founder of Switzerland-based Mountainside Consulting. Her practice aims to bring efficiency and structure to the implementation processes of social projects. With more than 15 years of experience in project management and service delivery across different sectors of the service industry, she has been a consultant on various projects at the WHO and in the private sector. Private-public partnership projects are her area of specialization and interest, although she also consults for projects outside this construct.

LAURA PACIONE (laura.pacione@utoronto.ca) is a Child and Adolescent Psychiatrist at the SickKids Centre for Community Mental Health and a Lecturer in the Department of Psychiatry, Division of Child and Youth Mental Health at the University of Toronto. She is also a consultant for the WHO Department of Mental Health and Substance Abuse, where she works primarily on WHO's Caregiver Skills Training for developmental disorders and delays. She has provided training for this initiative in Africa and the Middle East, including in Syria, Jordan, and Lebanon. Her interests include global child and adolescent mental health, developmental trauma, post-traumatic growth, and marginalized and homeless adolescents.

CHRISTINE POWELL (capowell24@gmail.com) is a retired Senior Lecturer at the Caribbean Institute for Health Research. She has been retained as a consultant and lead trainer for the Reach Up and Learn Early Childhood Parenting Program. Her principal interest is in implementation research on child development interventions in developing countries. Her research over the last 35

years has focused on the effects of nutrition, health, and the environment on the growth and development of young children. She has designed and evaluated low-cost, sustainable, and culturally appropriate interventions to improve children's development.

SARWAT SARAH SARWAR (sarwat.sarwar@brac.net) is the Deputy Manager of Communications for the Mental Health & Psychosocial Support team at BRAC IED in Bangladesh. An advocate for mental health in disenfranchised and emergency settings, she has lobbied for providing play-based learning systems for young children in rural and suburban spaces in Bangladesh and for children living in humanitarian camp settings. Her primary role is to showcase and foster mental health awareness and the need to address stronger maternal-child relations, stronger family connections, and greater social cohesiveness.

JONATHAN SEIDEN (jseiden@g.harvard.edu) currently works on ECD measurement initiatives with the World Bank and the Global Scales for Early Development. He previously worked as a senior specialist for education research at Save the Children and worked on evaluations and studies of ECD projects around the world. He is a doctoral student at the Harvard Graduate School of Education. His research involves ECD in global contexts, with a focus on quantitative measurement, evaluation, and causal inference.

CHIARA SERVILI (servilic@who.int) is a Technical Officer in the WHO Department of Mental Health and Substance Use. A child neuropsychiatrist by training who has acted as a focal point for child and adolescent mental health, her work focuses on developing guidance and implementation tools. She also provides technical advice to countries on how to integrate mental health promotion and protection for children and adolescents into primary health care, schools, communities, and digital platforms. She has worked for the WHO in the African and Eastern Mediterranean regions. She earned a master's in public health at the London School of Hygiene and Tropical Medicine and a PhD at the Università di Modena.

MATRIKA SHARMA (matrika.sharma@savethechildren.org) is currently a Manager in Monitoring, Evaluation, Accountability, and Learning for Save the Children Nepal. He has more than 20 years of experience in monitoring, evaluation, research, project design, strategic planning, and child rights programming. He has been lead and colead researcher for several research projects, including a recent Save the Children study on impact of COVID-19 on

children's rights, health, and education in Nepal. He earned a PhD in education from Kathmandu University, where his research focused on school governance.

PETER H. SILVERSTONE (peter.silverstone@ualberta.ca) trained in medicine at the University of London and before completing residency training in psychiatry at the Maudsley Hospital and Institute of Psychiatry in London. He spent three years as a research fellow at the University of Oxford, before joining the University of Alberta in 1992. He has an active research interest in several areas, including psychopharmacology, self-esteem, bipolar disorder, imaging, depression in medically ill patients, and training police officers in de-escalation techniques. His current research focus includes children and youth, as well as e-mental health initiatives.

SNEHA SUBRAMANIAN (ssubramanian@poverty-action.org) is a Research Manager at IPA Bangladesh. She manages a comprehensive portfolio of projects in social protection, peace and recovery, education, labor markets, and environment and energy. Consulting with the country director, potential partners, and principal investigators, she identifies and develops potential projects with meaningful research and policy implications. She also stewards relationships and policy implementation of evidence produced in conjunction with other country office leadership members.

ANAS TAHHAN (anas.tahhan@concern.net) is currently the Education Program Manager Syria-Iraq for Concern-Worldwide. He leads the education projects and grants in northeastern Syria. He has worked for six years in education project management with different international NGOs and led the implementation of several education projects, including community-based education, ECD, retention support, home-visiting, parenting, and social and emotional learning. He also was a trainer in early childhood education and basic literacy and numeracy for the IRC in northeastern Syria.

AIMÉE VACHON (avachon@protonmail.com) is currently serving as cochair of the ECD Working Group in Cox's Bazar on behalf of Plan International. An education in emergencies specialist, her work focuses on ECD in crisis settings, including preschool, infant-toddler, and caregiver programming. She has a technical background in teacher training, content development, and coordination for ECD.

KATELIN SWING WILTON (katelin.wilton@rescue.org) is a Senior Specialist for the IRC. She provides technical support on ECD programs, with a particular focus on programs that target caregivers of young children, such as Reach Up and Learn. She has worked with the IRC for seven years in Tanzania, Turkey, and the New York headquarters. She previously consulted for UNICEF in Zanzibar and coordinated a small grantmaking program for a network of people living with HIV/AIDS. She has a master of arts in anthropology and international development from New York University, and a bachelor of arts in African studies and international development from Hampshire College.

JOURNAL ON EDUCATION IN EMERGENCIES

The *Journal on Education in Emergencies (JEiE),* a scholarly, peer-reviewed journal, aims to fill gaps in education in emergencies (EiE) research and policy. Building on the tradition of collaboration between practitioners and academics in the EiE field, *JEiE*'s purpose is to improve learning in and across service-delivery, policymaking, and academic institutions by providing a space where scholars and practitioners can publish rigorous quantitative, qualitative, and mixed methods research articles, and robust and compelling field notes that both inform policy and practice and stir debate. *JEiE* provides access to the ideas and evidence needed to inform sound EiE programming, policymaking, funding decisions, academic program curricula, and future research.

JEiE specifically aims to:

1. **Publish rigorous scholarly and applied work** that sets the standard for evidence in the field

2. **Stimulate research and debate** to build evidence and collective knowledge about EiE

3. **Promote learning across service-delivery organizations, academic institutions, and policymakers** that is informed by evidence

4. **Define knowledge gaps and key trends** that will inform future research

To achieve these goals, *JEiE* seeks articles from scholars and practitioners who work across disciplines and sectors on a range of questions related to education in countries and regions affected by crisis and conflict. *JEiE* is part of and works closely with the Inter-agency Network for Education in Emergencies (INEE), today a network of more than 16,000 scholars and practitioners around the world, to collect new research articles and field note submissions and to distribute high-quality published work. This large global partnership of activists, academics,

policymakers, and practitioners in education enables *JEiE* to make a unique and powerful contribution.

Structure of *JEiE*

According to the INEE Minimum Standards (inee.org/standards), education in emergencies is defined as "quality learning opportunities for all ages in situations of crisis, including early childhood development, primary, secondary, non-formal, technical, vocational, higher and adult education." *JEiE* publishes research related to education activities in the context of natural disasters and fragile or conflict-affected states, conflict-sensitive education, attacks on education, education for peacebuilding, peace education, education for resilience and disaster risk reduction, and forced migration and education.

Issues and Contents

Each issue features 4-6 peer-reviewed articles written by researchers and practitioners in the field of EiE. The three sections of *JEiE* are:

EiE Research Articles (Section 1): Articles in this section have a clear research design; use an explicit, well-recognized theoretical or conceptual framework; employ rigorous research methods; and contribute evidence and advance knowledge on EiE. Articles that develop new EiE theoretical or conceptual frameworks or challenge existing ones are also welcome. Qualitative, quantitative, and mixed methods articles are appropriate.

EiE Field Notes (Section 2): Articles in this section address innovative approaches to EiE; progress and challenges in designing, implementing, and evaluating initiatives; and/or observations and commentary on research work. Articles in this section typically are authored by practitioners or practitioner-researcher teams.

EiE Book Reviews (Section 3): Articles in this section offer a critical review of a recently published or upcoming book, or of substantial studies, evaluations, meta-analyses, documentaries, or other media that focus on EiE.

Please see our website (inee.org/journal) for more information and detailed submission guidelines.

JOURNAL ON EDUCATION IN EMERGENCIES

Dana Burde, Editor-in-Chief

The *Journal on Education in Emergencies (JEiE)* publishes groundbreaking and outstanding scholarly and practitioner work on education in emergencies (EiE).

JEiE was established in response to the growing need for rigorous research to strengthen EiE evidence, support policy and practice, and improve learning in and across organizations, policy institutes, and academic institutions. *JEiE* facilitates EiE knowledge-generation and sharing, thus contributing to the professionalization of the EiE field.

Manuscript submission deadlines:
January 15 | April 15 | July 15 | October 15

inee.org/journal
journal@inee.org

ISSN 2518-6833

Inter-agency Network for Education in Emergencies

NYU International Education
Applied Statistics, Social Science, and Humanities