

REFUGEE HEALTH SCREENER - 15 (RHS-15)

DISCLAIMER

The English Version of the RHS-15 is for informational purposes only. It is **not** intended for use in refugee populations. Bilingual versions of the RHS-15 have been translated by professional translations and with the participation of the community so that each question is asked correctly according to language and culture. Using the English version negates the sensitivity of this instrument.

If you would like to receive bilingual versions of the RHS-15, please contact Pathways to Wellness at bfarmer@lcsnw.org.

Pathways to Wellness

Integrating Refugee Health and Well-Being

Creating pathways for refugee survivors to heal



REFUGEE HEALTH SCREENER - 15 (RHS-15)

Pathways to Wellness is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Services, Public Health Seattle & King County, and Michael Hollifield, M.D. Generously funded by the Robert Wood Johnson Foundation, The Bill and Melinda Gates Foundation, United Way of King County, The Medina Foundation, Seattle Foundation, and the Boeing Employees Community Fund

UTILIZATION REQUEST AND AGREEMENT

Date of Request:	Name:		
Institution:			
Department (if applicable):			
Your Position:			
Address 1:			
Address 2:			
City:	State:	Zip:	
Country:	Email:		
Phone Number:			

INSTRUCTIONS

Please complete the fields below

Where did you hear about the RHS-15?	<input type="checkbox"/> In a journal publication <i>List: _____</i>	<input type="checkbox"/> From a colleague	<input type="checkbox"/> Other (please specify): _____
What is your intended use of the RHS-15?	<input type="checkbox"/> Clinical assessment	<input type="checkbox"/> Research	<input type="checkbox"/> Other (please specify): _____
If you plan to use the RHS-15 for research, please briefly describe your research or use:	Ethnic and/or language group(s): <input type="checkbox"/> Arabic <input type="checkbox"/> Russian <input type="checkbox"/> Nepali <input type="checkbox"/> Spanish <input type="checkbox"/> Karen <input type="checkbox"/> Somali <input type="checkbox"/> Burmese	Age range <input type="checkbox"/> 14-21 <input type="checkbox"/> 21-64 <input type="checkbox"/> 65-older	Context: (check all that apply) <input type="checkbox"/> Refugees <input type="checkbox"/> Asylum seekers <input type="checkbox"/> Validity for Screening <input type="checkbox"/> Comparison to another instrument
How many refugees do you screen a year?	<input type="checkbox"/> 25-50	<input type="checkbox"/> 50-100	<input type="checkbox"/> 100-200 <input type="checkbox"/> 200 or more
What is the setting for administering the RHS-15?	Health setting <input type="checkbox"/> Primary care <input type="checkbox"/> Public health	<input type="checkbox"/> Resettlement agency	<input type="checkbox"/> CBO <input type="checkbox"/> Other (please specify)
Funding source?	<input type="checkbox"/> Federal grant	<input type="checkbox"/> Foundation	<input type="checkbox"/> Intramural grant <input type="checkbox"/> None
Is there other pertinent information about how your organization will utilize the RHS-15?			

UTILIZATION REQUEST AND AGREEMENT

Statement of Agreement

I understand that the purpose of this agreement is to improve the use and dissemination of the Refugee Health Screener – 15 (RHS-15). Any and all shared information and data between myself, or my institution, and *Pathways to Wellness* partners is to be utilized to improve the RHS-15. I also understand that I, and/or my institution, may negotiate with *Pathways to Wellness* partners how shared information and data will be used for institutional and/or scientific reports. I agree to utilize the Refugee Health Screener – 15 (RHS-15) in its current form and for its intended use unless otherwise specified in subsequent agreements.

(Please check the box that reflects your desired use of the RHS-15)

I and/or my institution will use the RHS-15 for clinical purposes only. We do not have the capacity to engage in research, but agree to a qualitative interview to discuss challenges and successes with the RHS-15 so the tool can be further developed.

I and/or my institution will use the RHS-15 for clinical purposes only. I/we agree to share with *Pathways to Wellness* partners the following information within a reasonable amount of time of a written request:

- 1. The number of screenings conducted.**
- 2. Time of screening administration during resettlement (i.e., six weeks after date of arrival in the U.S., one year after date of arrival in the U.S., etc.)**
- 3. Age, gender, and ethnic/language group, and screening score of participants screened.**

I and/or my institution are interested in partnering with *Pathways to Wellness* partners on further evaluative projects about the RHS-15 and/or subsequent versions of the RHS-15. I/we understand that I/we will negotiate with *Pathways* how to proceed in such projects regarding lead, institutional review board approvals, data collection and management, and authoring of scientific reports. I/we agree to share with *Pathways to Wellness* partners the following information within a reasonable amount of time of a written request:

- 1. The number of screenings conducted.**
- 2. Time of screening administration during resettlement (i.e., six weeks after date of arrival in the U.S., one year after date of arrival in the U.S., etc.)**
- 3. Age, gender, and ethnic/language group, and screening score of participants screened.**
- 4. Clinical information regarding 1) the number of those screened referred to care, 2) the number of positive screened persons that went to care, and 3) treatment outcomes.**
- 5. A summary of any other qualitative or quantitative evaluations about the utility of the RHS-15 (negotiable on execution of the agreement).**

UTILIZATION REQUEST AND AGREEMENT

Requestors' signature: _____ Date: _____

Requestor's printed name: _____

Thank you for your interest in utilizing the Refugee Health Screener-15 (RHS-15). We are interested in your findings, recommendations for further use and development, and collaboration on research and development.

Please return the form to: *Pathways to Wellness*
Beth Farmer, MSW
International Counseling & Community Services
4040 S 188th St., #200
Seattle, WA 98188
206-816-3252

You may fax to: **206-838-2680**

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REFUGEE HEALTH SCREENER - 15

Development and Use of the RHS-15



Early screening and intervention for emotional distress among newly arrived refugees is rarely conducted. Existing instruments are not designed for refugees or may be cumbersome to administer in health care settings. The RHS-15 was developed in a community public health setting to be an efficient and effective way to sensitively detect the range of emotional distress common across refugee groups.

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Pathways to Wellness is a program of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. Generously supported by the Robert Wood Johnson Foundation, the Bill & Melinda Gates Foundation, United Way of King County, the Seattle Foundation, the Medina Family Foundation, and the Boeing Employees Community Fund.

Background

The United Nations High Commissioner for Refugees lists 16 million refugees and asylum seekers and 26 million internally displaced persons in the world as of mid-2009.¹ Over 1.8 million reside in the United States.² All refugees have experienced extremely stressful events related to war, oppression, migration, and resettlement. The best evidence shows that a large minority of refugees experience multiple, distressing somatic and psychological symptoms and poor mental health³⁻¹¹ that are associated with stressful events in a dose-dependent manner.^{8,12-14}

Because this high burden of combined emotional and physical distress is often symptomatic of pre-existing or developing mental disorders, screening upon arrival in the host country is important. However, screening for mental disorders is not currently a standard practice in the majority of refugee resettlement programs in the U.S. Barriers to screening include time, cost, follow-up, refugees' health seeking behaviors, accessibility and availability of services, language, and cultural or conceptual differences in perceptions of health.¹⁵ Another challenge to screening is that symptoms in refugees are most often not characteristic of single, western-defined psychiatric disorders.¹⁶⁻²⁶ Hence, instruments that effectively screen for distress in general, i.e., predictive of prevalent common mental disorders, have not been developed and tested in refugee populations. The value of such screening has also not been definitively established. Ovitt and colleagues examined refugee perceptions of a culturally-sensitive mental health screening in eight Bosnian refugees in the United States and suggested that screening is a necessary component of refugee resettlement.¹⁵ Savin and colleagues (2005) analyzed data from the Colorado Refugee Services Program in Denver, and found that nearly 14% of the 1,058 refugees over the age of 18 screened positive for a psychiatric disorder using an instrument developed by an expert consensus process. Of those offered mental health services, 37% received such services and the remaining 63% declined.²⁶

Developing an efficient and effective screening instrument

A screening instrument for refugees needs to be efficient and sensitive to a range of common psychiatric diagnoses. The two instruments that have been developed in refugee populations and could be considered screening instruments, the Harvard Trauma Questionnaire (HTQ) and the Vietnamese Depression Scale (VDS), are specific to posttraumatic stress disorder (PTSD) and depression, respectively.^{27,28} The New Mexico Refugee Symptom Checklist-121 (NMRSC-121), which was developed to assess the broad range of distressing physical and emotional symptoms in refugees,⁵ is a reliable and a valid predictor of traumatic

events and mental health symptoms. However, it is long and comprehensive and was not intended to be a screening instrument.

Other scales developed for specific illness states in western populations have been adapted for use with refugees. For example, the Hopkins Symptom Checklist-25 (HSCL-25) has been adapted for several populations including Indochinese and Bosnian.^{15,29} However, the HSCL-25 assesses clinically significant anxiety and depression, not PTSD, and was not intended for screening. A standard instrument that is effective and efficient in screening for emotional distress that is a common marker across psychiatric diagnoses in many ethnic groups would be helpful for resettled refugees.

Items used as a basis for developing an efficient screening instrument for emotional distress

PTSD, anxiety, and depression symptoms are the most common mental symptoms in refugees. Psychotic illnesses are relatively easy to detect by non-psychiatric providers. Thus, initial screening programs in two locales in the U.S. utilized instruments that have the best empirical support for assessing relevant symptoms. These included:

- *The New Mexico Refugee Symptoms Checklist-121 (NMRSC-121)* assesses the broad range of persistently distressing somatic and psychological symptoms in refugees, and is reliable and a valid predictor of traumatic experiences, PTSD, anxiety and depression in both Kurdish and Vietnamese refugees.⁵ The NMRSC-121 is formatted for possible responses from 0 (not at all) to 4 (extremely), and may be scored as a sum or an item average.
- *The Hopkins Symptom Checklist-25 (HSCL-25)* assesses anxiety and depression symptoms, is valid for the general U.S. population and for Indochinese refugees,^{30,31} and has transcultural validity.^{32,33} The HSCL-25 is formatted for possible responses from 0 (not at all) to 4 (extremely), and is scored as an item average. Item-average cutoff scores of ≥ 1.75 for each scale predict “clinically significant” anxiety and depression in general U.S. and refugee samples and are valid as diagnostic proxies.^{30,31}
- *The Posttraumatic Symptom Scale-Self Report (PSS-SR)* is a reliable predictor of the PTSD diagnosis in U.S. populations.³⁴ The 17 items on the scale, each scored from 0 to 3 for symptom frequency, are essentially DSM-IV PTSD diagnostic items. PSS-SR continuous scores and the diagnostic proxy were highly correlated with war-related trauma and anxiety and

depression in Kurdish and Vietnamese refugees,¹³ and Cronbach's alpha in these samples was 0.95. The dichotomous proxy and the cutoff score were used for the current analyses.

The process of screening and assessing diagnostic proxies

For development of the Refugee Health Screener 15 (RHS-15), twenty-seven NMRSL-121 items (each scored on a 0 to 4 severity scale) that were found to be most predictive of anxiety, depression, and PTSD in a refugee cohort were collectively utilized as the primary screening instrument. Six items were added to this screening based on clinical experience and empirical data about assessing emotional distress, including questions about family psychiatric history, personal psychiatric history, stress reactivity, coping capacity, and a distress thermometer. The HSCL-25 and the PSS-SR were used as diagnostic proxies to evaluate items that would comprise the RHS-15.

All instruments were translated into four languages using a rigorous, iterative back-and-forth participatory consensus process with refugees from each language group. This process ensured relevant language-specific semantics yielding accuracy and clarity of meaning. This phase of development is critical to obtain culturally-responsive items in each language. The four language groups were chosen because they are spoken by the highest number of refugees currently being resettled in King County, as well as in the United States.

Two-hundred fifty-one refugees 14 years or older in these four groups (93 Iraqi, 75 Nepali Bhutanese, 36 Karen, and 45 Burmese Speaking (including Karenni and Chin ethnic groups) coming for health screening at Public Health Seattle and King County (Public Health SKC) between April 2010 and November 2010 were screened by the *Pathways to Wellness* evaluation coordinator. Those screened were administered the diagnostic proxies usually within 2 weeks of screening. One hundred and ninety persons were administered the proxies. Those missed were due to shortage in available interpreters, out-migration, and other reasons (i.e. during time of diagnostic assessment, some participants had other medical concerns that warranted immediate attention). It is important to note that the development of the RHS-15 was an integral part of the overall *Pathways* mission, which included the integration of health services, outreach and education about refugee health, and an evaluation component. Stand-alone screening for emotional distress may not be useful if treatment services are not available or accessible.

Methods for evaluating the most valid set of items for screening

To establish the RHS-15, all items from the screening instrument and diagnostic proxy instruments (N=75 items) were analyzed together to improve on validity and efficiency of the initial screening instrument. Multiple exploratory methods were used, including initial correlations and general linear models using t-tests and analysis of variance. Three methods were then used and compared to establish the most useful and efficient set of items that would classify persons as most likely to have diagnostic proxy level anxiety, depression, or PTSD: discriminant analysis (DA), naïve Bayesian classification (BAY), and chi-square (CHI) for each item by diagnostic proxy. Diagnostic proxies used were (1) clinically significant anxiety, (2) clinically significant depression, (3) PSS-SR diagnostic PTSD, (4) moderate-severe PTSD or greater, and (5) any of the four previous diagnostic entities on Bayesian analysis.

Results of analyses

Most of the 75 items were significantly correlated with diagnostic proxies, reflecting their usefulness in the extant instruments. Some of the same and some different items were found to classify by diagnostic proxy when using each of the three classification methods. To establish the items that had the highest chance of correctly classifying a refugee with a likely diagnostic proxy, a grid of strength of association of item by classification method was constructed. Items that were high for classifying persons by at least 2 of the 3 methods were then subjected to BAY to maximize for classification sensitivity. Fourteen items were important for classifying by at least one of the 5 diagnostic proxies with sensitivity of at least .89 and specificity of at least .83. The table shows items included by BAY for each diagnostic proxy and the sensitivity and specificity of each item-group by proxy diagnosis. One item, HSCL 9 was not significant in other linear analyses, so was dropped from the final screening instrument. One item, HSCL 4 was significant in other BAY and CHI analyses so was added to the final instrument. Another item, HSCL 13, was significant in all 3 prior methods so was added to the final instrument. The distress thermometer was a significant predictor of each diagnostic proxy.

Table. Items selected for the RHS-15 by final Bayesian analysis

Items selected by BAY	PSS-SR ≥ 16	PTSD diagnosis	HSCL-25 Anxiety	HSCL-25 Depression	Any Proxy
NM 5_1	X		X	X	
NM 5_12				X	
NM 5_19				X	
NM 5_22					X
“Coping”			X		
PSS 3	X				
PSS 5				X	
PSS 11	X	X	X		X
PSS 17				X	
HSCL 1		X	X	X	X
HSCL 3			X		
HSCL 9	X				
HSCL 10	X				
HSCL 11				X	
Sensitivity	1.00	0.89	1.00	1.00	0.96
Specificity	0.94	0.83	0.91	0.93	0.86

“NM” is an item from the New Mexico Refugee Symptom Checklist

“PSS” is an item from the Posttraumatic Stress Symptoms-Self-Report

“HSCL” is an item from the Hopkins Symptom Checklist

The sensitivity and specificity values assume optimal scores to proxy diagnoses in BAY analyses

Current Recommendations for Scoring and Using the RHS-15

Past analyses of the initial screening instrument consisting mostly of NMRSC-121 items determined that an item-average of 0.88 or greater was optimally associated with significant emotional distress (i.e., diagnostic level distress on proxy instruments). However, the RHS-15 now includes items from 3 different instruments, which had different instructions, response scales, and scoring. In particular, the PSS-SR items are rated more by frequency than severity on a scale from 0 to 3. The NMRSC-121 and the HSCL-25 both have items rated from 0 to 4, but the instructions specify a different time frame of the symptoms. We have constructed the RHS-15 so that each item has the same response possibilities from 0 (not at all) to 4 (extremely).

Post-hoc analyses of the RHS-15 with items standardized to the current scoring scale were conducted to determine the optimal cut-off score to predict a positive case. One assumption of such analysis is that future

samples will score similar to our initial sample on the RHS-15 items and the diagnostic proxies. These analyses showed that an item-average of 1.18 may result in the most optimal sensitivity and specificity. However, a screening instrument is generally utilized to be highly sensitive, in order to identify all cases, particularly when missing any case would result in a significantly adverse outcome. An item-average of 0.88 and 1.18 on the 14 RHS-15 items translates to a total score of 12.32 and 16.52, respectively. Our data suggest that using the former cut score will result in identifying approximately 38% of refugees as positive for emotional distress. The latter cut score has not been tested in a separate or split sample, but we estimate it will result in identifying between 25% and 33% of refugees as positive for emotional distress. For now, we recommend that the item average of 0.88 (total ≥ 12) or higher be used to identify a positive case. Further evaluation is necessary to determine the sensitivity and specificity of the RHS-15 at various cut-off scores to find significant emotional distress, as well as other outcome measures that have yet to be investigated.

In the current analyses, a distress thermometer score of 5 or greater was 85% specific for being positive on any of the diagnostic proxies. The sensitivity of this cut score was .87, .85, and .66 for PTSD, depression, and anxiety, respectively. If a cut score of 6 or greater was used, then specificity increased to .93, but the sensitivity was below .50 for the three diagnostic proxies. Thus, to optimize for sensitivity and include cases that may be missed by the 13 symptom items plus the coping item, we recommend that a distress thermometer score of 5 or greater be considered a positive screen. Thus, our current recommendation is that a score of ≥ 12 OR a distress thermometer score of ≥ 5 is considered a positive case. We believe that the best process will eventually be to utilize the RHS-15 as a highly sensitive first screen, with intermediate scores (e.g., 12 to 16) warranting a second level, more specific screen. Early results from our second phase where the RHS-15 is integrated into routine health screening at Public Health SKC indicates that the administration time is approximately 5 minutes for those who are literate and self-administer the RHS-15, and up to 15 minutes for those who are administered the instrument regardless of literacy level. Public Health SKC has been forward-looking and innovative as a *Pathways* partner and by advocating for a pay-line for the time to administer the RHS-15.

We highly recommend the use of the RHS-15 in settings where there are adequate resources to conduct and score the screening, and to develop a source and method of referral for further diagnosis and treatment. Another decision point is about when in the course of resettlement is the best time to administer the RHS-15. While our premise is that it should be administered early in the course of resettlement, it is also clear in our work and from other studies that a significant proportion of newly arrived refugees will have a delayed onset of emotional distress. We are currently working on better understanding the proportion of refugees with distress on arrival, delayed distress, and factors that predict each.

Finally, the *Pathways* project invites collaborative work with other groups who wish to use and/or evaluate the effectiveness of the RHS-15. It is expected that the form and method of screening may vary from locale to locale, dependent on the health care setting, the population served, and the resources available. As of September 2011, the RHS-15 is available in English, Arabic, Burmese, Karen, Russian and Nepali (Bhutanese), with a Somali version soon available. We are beginning the process to have the RHS-15 also available in Spanish. Current development and evaluation of the RHS-15 has had institutional review board (IRB) approval and oversight at The Pacific Institute for Research and Evaluation. Any further collaborative evaluation and/or research will necessarily involve a discussion about how and where to obtain IRB approval to proceed with the work.

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ENGLISH VERSION

DEMOGRAPHIC INFORMATION

NAME: _____

DATE OF BIRTH: _____

ADMINSTERED BY: _____

DATE OF SCREEN: _____

DATE OF ARRIVAL: _____ GENDER: _____

HEALTH ID #: _____

Developed by the *Pathways to Wellness* project and generously supported by the Robert Wood Johnson Foundation, The Bill and Melinda Gates Foundation, United Way of King County, The Medina Foundation, Seattle Foundation, and the Boeing Employees Community Fund.

Pathways to Wellness: Integrating Community Health and Well-being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Services, Public Health Seattle & King County, and Dr. Michael Hollifield. For more information, please contact Beth Farmer at 206-816-3252 or bfarmer@lcsnw.org.

REFUGEE HEALTH SCREENER (RHS-15)

Instructions: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."



SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

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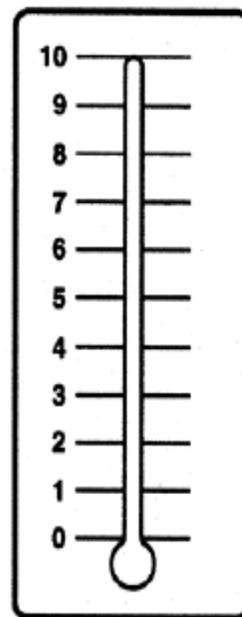
14. Generally over your life, do you feel that you are:

- Able to handle (cope with) anything that comes your way0
- Able to handle (cope with) most things that come your way1
- Able to handle (cope with) some things, but not able to cope with other things.....2
- Unable to cope with most things.....3
- Unable to cope with anything4

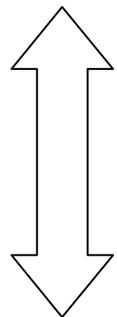
15.

Distress Thermometer

FIRST: Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



“I feel as bad as I ever have”



“Things are good”

ADD TOTAL SCORE OF ITEMS 1-14: ____

SCORING

Screening is POSITIVE

1. If Items 1-14 is ≥ 12 OR
2. Distress Thermometer is ≥ 5

Self administered: ____

Not self administered: ____

CIRCLE ONE:

SCREEN NEGATIVE

SCREEN POSITIVE

REFER FOR SERVICES

Refugee Health Screener-15 (RHS-15) REPLICATION GUIDELINES

Counties and states resettling refugees differ in their approach to refugee health screening. The RHS-15 is best suited for communities that have mental health resources available to refugees or potential for building that capacity.



When adapting the RHS-15 for use in your community:

- **Identify who will be screened using the RHS-15 and consider demographics**
 - Which ethnic population(s)?
 - What age(s) to target?
 - Literacy, gender, etc.
 - At what point in time during resettlement?

In King County, the RHS-15 was administered to newly arrived refugees age 14 years and older (among 4 ethnic groups) during their 1st month of resettlement and again at 12-16 months during the limited Civil Surgeon visit.

- **Identify the refugee health screening entity in your community and consider the screening setting**
 - Public health department
 - Primary care clinic
 - Resettlement agency

In King County, health screening for refugees occurs at the public health department. Refugee clients are referred for ongoing care to primary care clinics. If a refugee client screens significant for emotional distress they are referred to a central referral source.

- **Consider the capacity of community mental health providers and build capacity if needed**
 - Are there mental health agencies that can effectively serve refugees?
 - What additional education, training or support do mainstream providers need to serve the population?
 - Expect referral rates to be 10-15 % of those screened per month
 - The cut off score can be based on your local conditions * (See "Development and Use" paper for more discussion)

In King County, while piloting the RHS-15 the average rate for screening positive was 25% of total screened per month. The project had a robust outreach component to build provider capacity.

- **Innovate a better continuum of care for refugees and consider local conditions**
 - What does the structure of healthcare delivery look like in your community?
 - How can this system be improved to better serve refugees?
 - Where are the gaps in service?
- **Convene stakeholders to implement the RHS-15**
 - Primary care doctors, refugee health-screening entity, and resettlement agencies can oversee the implementation and adaptation of the RHS-15 in your community.
 - Document your results and share with health, resettlement and social service communities.

Pathways to Wellness

*Integrating Refugee
Health & Well Being*

*Creating pathways for
refugee survivors to heal*

A program of:

Michael Hollifield, M.D.
Psychiatrist, Family Practice
Pacific Institute for Research &
Evaluation



We want to hear from you!
Please consider reporting
information to our *Pathways*
team so we can continue to
improve.

Contact Information:

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Generously funded by The Robert Wood Johnson Foundation, The Bill and Melinda Gates Foundation, United Way of King County, The Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund.



“It is so simple, but it makes such a huge difference.”

~ Lisa Buckner, Registered Nurse



Pathways is generously funded by The Robert Wood Johnson Foundation, The Bill and Melinda Gates Foundation, United Way of King County, M.J. Murdock Trust, The Medina Foundation, The Seattle Foundation, and Boeing Employees Community Fund.

Pathways to Wellness

Creating pathways for refugee survivors to heal

Pem came from a small country in Asia.

As a young mother, Pem fled her village when civil war broke out and soldiers began burning and looting homes. She spent over a month walking with her infant daughter to safety. For the next 13 years, Pem languished in a refugee camp. Fortunately, she was one of the lucky few that received an opportunity to come to the United States. When she arrived, Pem was given a required health screening that also looked for signs of depression and anxiety. Pem admitted to not being able to sleep at night and crying on an almost daily basis. Her body hurt, she said. “Too many thoughts. So many thoughts, I can not think well.” Pem was immediately connected to support to help her with these symptoms, and is now thriving with a new job and new hope. Pem’s assessment took less than 10 minutes, but it is not happening for most refugees.

Pathways to Wellness is a new approach to finding depression, anxiety, and traumatic stress in refugees and connecting them to the care they need to heal. We provide training for mental health providers to effectively deliver services to refugee populations, and partner with refugee communities to better understand and address mental health issues. *Pathways* is working with other cities across the United States to duplicate its success.

No refugee should suffer any more than they already have. Contact us to get more information on how *Pathways* can benefit your community.

Beth Farmer, Project Director

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Pathways to Wellness is a partnership project between Lutheran Community Services NW, Asian Counseling and Referral Service, Public Health Seattle & King County, and Dr. Michael Hollifield of the Pacific Institute for Research and Evaluation.

Help Your Child Manage Traumatic Events

Children rely on the support of parents and teachers to help them deal with their emotions during and after traumatic events. Parents should decide how much information their children can handle.

ADAA member Aureen Wagner, PhD, Director of The Anxiety Wellness Center in Cary, North Carolina, offers this recommendation for parents:

“Remain as calm as possible; watch and listen to your child to understand how upset he or she is. Explain a traumatic event as accurately as possible, but don’t give graphic details. It’s best not to give more information than your child asks for. Let your child know that it is normal to feel upset, scared or angry. If older children or teenagers want to watch television or read news online about a traumatic event, be available to them, especially to discuss what they are seeing and reading.”

These tips are important for children and adolescents of all ages:

- Reassure them that you’ll do everything you can to keep them and their loved ones safe.
- Encourage them to talk and ask questions
- Let them know that they can be open about their feelings.
- Answer questions honestly.
- Protect them from what they don’t need to know.
- Avoid discussing worst-case scenarios.
- Limit excessive watching and listening to graphic replays of the traumatic event
- Stick to your daily routine as much as possible.

Most children and teenagers will recover from their fear. But you can watch for these signs of ongoing distress:

- Difficulty sleeping
- Change in eating habits
- Clinginess
- Re-experiencing the event through nightmares, recollections, or play
- Avoidance anything reminiscent of the event
- Emotional numbing or lack of feeling about the event
- Jumpiness
- Persistent fears about another disaster

If after a month or so your child is still showing signs of distress, professional help may be indicated. Children who have trouble getting beyond their fears may be suffering from PTSD, or posttraumatic stress disorder. And that’s when it’s time to seek the assistance of a mental health professional. Many effective treatments are available for children and teens



Resources for Immigrant and Refugee Families in Minneapolis Public Schools

Minneapolis Public Schools is a safe place for all students and families, regardless of their immigration status, national origin or language. The Minneapolis Board of Education affirmed this in a resolution passed in December 2016. It is not the role of the district to ask about the citizenship or immigration status of any of our students or families, or to enforce federal immigration laws. It has been our practice to only provide information when required by law or a valid court order. MPS will continue to ensure all students have equitable access to educational and extracurricular opportunities, including rigorous courses, engaging activities, high-quality athletics and supportive services, regardless of immigration status.

Frequently Asked Questions

Recent executive orders declare that undocumented persons who receive certain government aid will be deported. What does this mean related to receiving Free/Reduced Price lunch?

This is not new, however, what may happen is more vigorous enforcement as it called for the identification and removal “as expeditiously as possible.” It is important to know that participation in public schools, including the free/reduced price lunch program is available to all children regardless of their status or a parent's status.

What about the data in the Free/Reduced Price lunch forms? What is in there and who has access?

The data needed to apply for Free/Reduced Price lunch does not include citizen status, and only the last four digits of an adult member’s social security number is required or to make an indication of “none” if the adult has none. Other foreign adults, in addition to undocumented persons, do not have social security numbers. The data provided in the form is subject to strict privacy protections put forth by the United States Department of Agriculture (“USDA”). The USDA has consistently communicated that “all school-aged children in income eligible households can receive school meal benefits regardless of the immigration status of household members, and that information provided by the household will not be used for immigration-related purposes.”

What happens with the data required in background checks for parents who wish to volunteer?

In order to conduct a background check, the District requires a social security number. It is important to know that all parents can volunteer in different capacities even if they do not have a social security number or do not want the District to use it. It does mean that certain volunteer opportunities like overnight trips will not be available to such parents. The District uses a service to gather information relevant to the background check, and securely stores the background check results. Such documentation is regularly shredded and purged.

What is MPS’ equal education policy?

The purpose of this policy is to ensure that equal educational opportunity is provided for all students regardless their immigration status, national origin or language. MPS is committed to the success of every student, and our mission is to support students to be career and college ready.

Will MPS turn-over citizenship or immigration status information, if requested by a government agency representative?

MPS does not collect or keep citizenship and immigration status information or enforce immigration laws.

What happens when a representative of any government agency comes to the schools or makes a request?

If a representative of any government agency inquires about a student or family, they are referred to the MPS Office of General Counsel. General Counsel then requires substantiation of legal authority or a court order before releasing any information the district may have about a student or family. General Counsel will provide notice to families



unless the governmental agency has required the District not to provide notice, and has provided appropriate legal authority.

How can families prepare for the possibility of deportation?

- Update your emergency contact information with Minneapolis Public Schools by contacting the main office of your student's school.
- Create and discuss a Family Preparedness Plan. The Immigrant Legal Resource Center has a guide for creating a plan at: <https://www.ilrc.org/family-preparedness-plan>
- Parents may designate a temporary legal guardian for their children for a period of up to one year with a Delegation of Parental Authority. With this form, a temporary legal guardian will be able to enroll children in school and deal with other educational matters so that children can continue their education uninterrupted. More information about this form is available at <http://bit.ly/2mxfa47>

Where can families find legal advice on immigration matters?

- The Immigrant Law Center of MN operates an **Immigrant and Refugee Rights Helpline** to connect community members with a free legal consultation. The Helpline is available for immigrants and refugees living in MN whose household income is below 250% of the federal poverty level. **For immediate legal advice and assistance from an attorney, call 651-287-3715 during the following hours: Tuesdays 1pm – 3pm or Thursdays 6pm – 8pm.** Help is available regarding;
 - Know Your Rights legal guidance
 - Questions about President Trump's immigration Executive Orders
 - Travel ban questions
 - Immigration court and detention information
 - Advice for emergency family planning
- **Mid-Minnesota Legal Aid** (mylegalaid.org) offers free civil legal assistance to low-income community members in many areas of law, including immigration. For assistance, contact a client specialist at **612-334-5970** on weekdays between 8:30am to 4:30pm. You will be asked a series of questions regarding your legal issue.
- View a **directory of Immigration Legal Services in Minnesota** from the Immigration Advocates Network at <http://bit.ly/2oNdorA>

Where can families find information about their rights, regardless of immigration status?

- Know Your Rights resources from the Immigrant Law Center of MN: <https://www.ilcm.org/immigration-resources/know-your-rights/>
- Fact sheet on rights to access health care from the National Immigration Law Center: <https://www.nilc.org/issues/health-care/health-insurance-and-care-rights/>
- Information on the current status of the DACA (Deferred Action for Childhood Arrivals) program from the Immigrant Legal Resource Center: <https://www.ilrc.org/daca>

What resources are available regarding the travel restrictions for citizens of Muslim countries?

- Contact CAIR MN by calling **612-206-3360**. CAIR MN has many online resources for American Muslims, including;
 - Guide to legal rights: <https://www.cairmn.com/civil-rights.html>
 - Community Advisory on the Executive Order signed March 6, 2017: <http://bit.ly/2qbVzre>
- Resources for Travelers from the Immigrant Law Center of MN (flyers in English, Arabic, Somali, Spanish, German, Pashto, French, Farsi, and Kurdish): <http://bit.ly/2qbW04Q>
- Contact the American Civil Liberties Union of Minnesota (ACLU-MN) by calling **651- 645-4097**

More information at: http://multilingual.mpls.k12.mn.us/resources_for_immigrants

Supporting Refugee Children & Youth Tips for Educators

As a result of violence and oppression around the world, many families are forced to flee their countries as refugees. Consequently, schools across the country are welcoming and serving students from diverse nations. These students bring their unique individual cultures and backgrounds while bearing some of the challenges and stresses of the refugee experience. The following tips and related resources can help educators meet the unique needs of refugee students.

Understand and recognize stressors. Refugee children and youth are often traumatized from premigration and resettlement experiences. They may have been exposed to violence and combat, home displacement, malnutrition, detention, and torture. Many have been forced to leave their country and cannot safely return home. Some may have come without their parents and without knowing of their health or safety. Psychological stress and traumatic experiences are often inflicted upon these children over months or even years, and many experience some kind of discrimination once entering U.S. schools. Additionally, they often resettle in high-poverty and high-crime neighborhoods, increasing exposure to stressful conditions.

Understand the effect of trauma on school functioning. Extreme stress, adversity, and trauma can impede concentration, cognitive functioning, memory, and social relationships. Additionally, stress can contribute to both internalized symptoms—such as hypervigilance, anxiety, depression, grief, fear, anger, isolation—and externalized behaviors—such as startle responses, reactivity, aggression, and conduct problems. Given the often chronic and significant stress placed on refugee students, many are at increased risk for developing trauma and other mental health disorders, undermining their ability to function effectively in school. Further, given the environment of their previous schooling and the immigration to the United States, many have experienced significantly interrupted schooling; coupled with language gaps, many students arrive unprepared to participate in school with their same-age peers.

Equip staff to provide trauma sensitive responses and supports. Creating trauma-sensitive schools greatly enhances supports for all traumatized students, including refugees. A trauma-sensitive school views behaviors as a potential outcome of life circumstances rather than willful disobedience or intentional misbehavior. Trauma-sensitive approaches emphasize helping school staff understand the impact of trauma on school functioning and seeing behavior through this lens; building trusting relationships among teachers and peers; helping students develop the ability to self-regulate behaviors, emotions, and attention; supporting student success in academic and nonacademic areas; and promoting physical and emotional health. Additional information is available at <http://traumasensitiveschools.org/>

Understand the challenges of relocation and acculturation. Refugee children and youth often have significant adjustments to life in their new communities and schools. This includes language differences, not understanding how schools function, not knowing where to go for help, little familiarity with the curriculum or social mores, and difficulty making friends. Some refugees are relocated to communities with an existing population from their country. Others may be the only people from their country, heightening the sense of isolation. Also note that children frequently adapt culturally and linguistically more quickly than their parents. Over time, this can cause conflict when children deviate from tradition and can increase the burden on children when parents rely on them to navigate their new environment and to act as language translators.

Be sensitive to family stressors. Parents and other family members are also dealing with the stress of relocation, including trying to navigate and achieve self-sufficiency in their new community. This includes overcoming language and cultural barriers, finding housing and employment, establishing a social network, understanding their role in their children's schooling, accessing social services, and connecting with their faith community. For many, having to ask for help or rely on others is not their norm and contributes to stress. Additionally, some parents may have experienced significant stress or trauma during the migration process, which can lead to increased risk for a range of negative outcomes for their children.

Identify children and youth who are at high risk, and plan interventions. Schools bear a responsibility to identify refugee students that may be at heightened risk based on the factors outlined above. In general, interventions delivered within comprehensive service models (i.e., multitiered systems of support) and focused on educational, social, and economic outcomes are more effective than clinical treatment alone, and can often prevent the need for intensive, direct services. However, by maintaining close contact with teachers and parents, the school crisis response team can determine which students may require more intensive crisis intervention and counseling services. Schools should also create a mechanism for self-referral and parental referral of students.

Understand cultural views regarding mental health. It is important that mental health professionals be aware of attitudes toward mental illness and the role of mental health services when providing assistance to students. Many cultures may have a minimal understanding of mental illness, and in some cultures and faith communities, mental health problems are greatly stigmatized. Some cultures may view emotional problems as a weakness in character as opposed to a natural response to adversity. Understanding these barriers is an essential first step to reassuring and engaging students and their families and ultimately building the trust necessary to provide effective services and supports.

Engage and empower families. Families from other countries may have different views about education, including the assumption that education remains the duty of the school and any involvement would encroach on that responsibility. Some families may not be proficient enough in English to know how to engage, despite a desire to do so. Additionally, many families may experience practical barriers, such as not having a car or employment that does not allow for active engagement during school hours. Schools can work with cultural liaisons and the families to find ways to connect with parents and ensure they have opportunities to participate in their child's schooling.

Focus on student strengths. Many refugee students bring many unique skills, strengths, and knowledge into the classroom. Build on those strengths of resilience, and consider having them share their knowledge about their country, customs, and culture. Educators should also support maintaining the home culture and language, while also balancing the importance of developing the skills and knowledge to succeed in the United States.

Access community resources. Reach out to community organizations that specialize in working with refugee families, if those resources are available, such as the [International Rescue Committee \(http://www.rescue.org/where/united_states\)](http://www.rescue.org/where/united_states). Maintain an accurate and evolving list of community resources available to help affected families. It is imperative to compile a list of community resources, including the names, telephone numbers, websites (if available), contact persons (if appropriate), descriptions of services, and any fees. Try to determine if support groups are being provided at local churches or community agencies. Consider also reaching out to state refugee coordinators (<http://www.acf.hhs.gov/programs/orr/resource/orr-funded-programs-key-contacts>).

Stop any type of harassment or bullying immediately. Refugee children may be at risk for harmful behavior by others if classmates or even teachers unfairly stigmatize them. Make it clear that such behavior, in any form (in person, online, on social media) is unacceptable. Promote acceptance and actively teach conflict resolution skills to both the perpetrators and the refugee student(s).

Note: Refugees who seek political asylum in the United States must gain approval from multiple federal agencies before immigrating. More information is available at <http://www.uscis.gov/humanitarian/refugees-asylum/refugees>.)

External Resources:

- Bridging Refugee Youth and Children's Services (<http://www.brycs.org/>)
- The Center for Health and Healthcare in Schools (<http://www.healthinschools.org/Immigrant-and-Refugee-Children.aspx>)
- Spring Institute for Intercultural Learning (<http://www.springinstitute.org/>)
- National Childhood Traumatic Stress Network, Child and Adolescent Refugee Trauma (<http://www.nctsn.org/trauma-types/refugee-and-war-zone-trauma>)
- Screening and Assessing Immigrant and Refugee Youth in School-Based Mental Health Programs (http://www.issuelab.org/resource/screening_and_assessing_immigrant_and_refugee_youth_in_schoolbased_mental_health_programs)
- Partnering With Parents and Families to Support Immigrant and Refugee Children at School (<http://www.rwjf.org/en/library/research/2009/06/partnering-with-parents-and-families-to-support-immigrant-and-re.html>)

Note: Some of this handout was adapted from "School-Based Services for Traumatized Refugee Children", *Communique*, Vol. 39. Issue 5

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Children of Immigrants and Refugees: What the research tells us

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Background

Updated April 2011

Recent immigration trends: In 2009, the foreign-born population in the United States (US) numbered 38.5 million, or 12.5% of the population. Between 2000 and 2009, the foreign-born population increased by 7.4 million or 24%.¹ Among all foreign-born residents, 59% entered the US during the last two decades and 21% entered the US prior to 1980.²

The US immigrant population represents every corner of the world, but the largest numbers, by far, come from Mexico. An estimated 11.5 million foreign-born individuals in the US are from Mexico, representing 30% of the total foreign-born population. Individuals born in Central American countries represent 37% of the total foreign-born population; 27.7% are from Asia and Pacific Islands; 12.7% are from Europe; 3.9% from Africa, and 2.7% from other regions of Oceania and Northern America.²

Racial/ethnic minorities will become the numerical majority in the US within a few decades.³ Three-fourths of immigrant children live in just ten states—Arizona, California, Florida, Georgia, Illinois, Massachusetts, New Jersey, New York, Texas, and Washington. Nearly half of all immigrant children live in just three states (California, Texas and New York), and California alone is home to 28% of this group. California has not only the largest number of immigrant youth but also the highest concentration; roughly half of the children in the state are children of immigrants, more than twice the national share of 23%.⁴ These trends are expected to continue.⁵

Children and immigration: In 2009, there were 74.5 million children ages 0–17 in the US, constituting nearly 24% of the population.⁶ About 16.9 million children age 17 and under, or nearly 24% of this age cohort, had at least one immigrant parent.⁷

Immigrant youth—defined as those children under age 18 who are either foreign-born or US born to immigrant parents—now approximately account for one-fourth of the nation's 75 million children. By 2050, they are projected to make up one-third or more than 100 million US children. Demographers estimate that by 2050, when one-third of all US children will be Hispanic, non-Hispanic whites will make up 40 percent of the child population.⁴

Families and immigration: Official poverty rates for children in immigrant families are substantially higher than for children in native-born families (23% versus 18%).⁴

Immigrant families frequently lack health insurance and are much more likely to live in crowded housing. The Urban Institute's 1999 National Survey of America's Families (NSAF) reports that, compared with children in native-born families, children in immigrant families are generally poorer, in worse health, and more likely to experience food insecurity and crowded housing conditions.⁸

Younger immigrant children are both more likely to experience these circumstances, and to be negatively affected as a result. Younger children, rather than older children, are most likely to live in families that entered the United States after 1996, when welfare legislation was enacted that barred immigrants from receiving many public benefits. As a result, younger immigrant children are more likely to live under conditions of extreme hardship despite high workforce participation by their parents.⁷

However, foreign-born children may have certain protective factors that can help them withstand the severe adjustments that accompany migration to a new country. They tend to live in two-parent and multigenerational households with high levels of family support and other social supports that can mitigate stress, especially during the initial settlement period.^{9,10}

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Background *continued*

Schools and immigration: Many “new destination communities,” having no recent experience with immigrant populations, may be unprepared for an influx of students, who sometimes may comprise as much as 50% of the school enrollment.⁵

Six “gateway” states (California, New York, Texas, Florida, Illinois, and New Jersey) accounted for roughly 60 percent of the 5.6 million foreign-born who moved to the US from abroad between 1995 and 2000.¹¹ In 2000, almost 70 percent of school-age children of immigrants lived in the six states with the largest immigrant populations: California, Texas, New York, Florida, Illinois, and New Jersey. 47% of California’s students in PreK to fifth grade were children of immigrants. Nine other states had percentages above the national average of 19%: Nevada, New York, Hawaii, Texas, Florida, Arizona, New Jersey, Rhode Island, and New Mexico. The highest growth in school enrollment of immigrant children was in new gateway states in the Southeast, Midwest, and interior West. Between 1990 and 2000, children of immigrants in PreK to fifth grade grew most rapidly in Nevada (206%), followed by North Carolina (153%), Georgia (148%), and Nebraska (125%).¹²

Immigrant children—particularly recent immigrants—are less likely to receive necessary mental health services than their nonimmigrant peers. A shortage of bilingual/bicultural mental health professionals, unfamiliarity with US mental health services, lack of health insurance, and the stigma associated with treatment may prevent immigrant families from getting their children the help they need. Thus, a school-based approach seems especially promising.¹³

Mental Health, Language and Culture

Prevalence: Between 14-20% of young people in the US have one or more mental, emotional, and behavioral (MEB) disorders at any given time. Among adults, half of all MEB disorders were first diagnosed by age 14 and three-fourths were diagnosed by age 24.¹⁴

Mental, emotional, and behavioral disorders—such as depression, conduct disorder and substance abuse—among children, youth, and young adults create an enormous burden for them, their families, and the nation. They threaten the future health and well being of young people.¹⁴

While the rates of mental disorder are not sufficiently studied in many specific ethnic groups to permit conclusions about overall prevalence, in general, incidence rates in the United States appear to be similar across minority and majority populations.¹⁵

Many things about the immigrant experience are stressful for children: They are often separated from family for extended periods of time.¹⁶ Some children come from rural or farming communities and are ill-equipped to cope with urban settings; others come from refugee camps, after witnessing or experiencing wartime atrocities or personal or family violence.¹⁵ Many suffer from post-traumatic stress disorder.¹⁷

Access to care: In 2005, nearly 5% of all US children 4–17 years were prescribed medication for emotional or behavioral difficulties. About 6% of these children received some type of mental health treatment or help other than medication during the past year.¹⁸

While access to mental health care is a problem for all children and adolescents, minority adolescents are at particular risk of not receiving care. Among suicidal adolescents, Latino, African American, and Asian American youth were less likely to receive psychological or emotional counseling than white adolescents. The lack of treatment was particularly acute for Asian American youth, who were less than half as likely to receive counseling as white youth.⁹

Compared with proficient English speakers, people with limited English proficiency (LEP) are less likely to seek care and to receive needed services. They have fewer physician visits and receive

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Mental Health, Language and Culture *continued*

fewer preventive services, even after such factors as literacy, health status, health insurance, regular source of care, economic indicators, or ethnicity are accounted for.¹⁹

Mental health and culture: In the mental health care setting, culture affects how people label and communicate distress, explain the causes of mental health problems, perceive mental health providers, and respond to treatment.²⁰

Cultures vary with respect to the meaning they impart to illness, their way of making sense of the subjective experience of illness and distress.¹⁵ Cultural meanings of illness have real consequences. “Meanings” influence whether people are motivated to seek treatment, how they cope with their symptoms, how supportive their families and communities are, where they seek help (mental health specialist, primary care provider, clergy, and/or traditional healer), the pathways they take to get services and how well they fare in treatment.¹⁵ Immigrant children who have experienced stressful events in their home country, during migration, or while living in the US show high levels of psychological distress.¹³

Build Cultural Competence—Advice from the Experts

Understand why cultural competence is important: In mental health care, key elements of therapeutic success depend on rapport and upon the clinician’s understanding of the patient’s cultural identity, social supports, self-esteem, and reticence about treatment due to societal stigma.¹⁵ Americans find it respectful and direct to look someone in the eye when speaking, and to respond with feedback in conversation. This may seem aggressive or dominating to immigrants whose culture customarily shows respect by looking away or remaining passive in conversation with strangers or persons of authority.

Strive for competence: Work to build rapport, a critical component of competency development. Knowing whom the person perceives as a “natural” helper or as a traditional helper (such as elders or the church) can facilitate the development of trust and continued participation in treatment.²¹ Assess possible school problems in light of other factors, such as the family income, jobs, work schedules, the need for food or shelter, the presence of many other people in the home, or concerns about becoming involved with authorities.²¹

Facilitate language access: Language barriers create problems for both providers and recipients of care. For immigrant families with low English proficiency (LEP), language and communications influence not only how but if they access and experience health care.²² Language barriers have a demonstrable negative impact on health care access, quality, patient satisfaction, and sometimes cost.¹⁹

Start with communication: Children who have difficulty speaking English may face greater challenges progressing in school and in the labor market. In 2008, 21% of children ages 5–17 spoke a language other than English at home. Sixteen percent of school-age Asian children and 17% of Hispanic children spoke a language other than English at home and had difficulty speaking English.²³ Court decisions and other federal actions have established that Title VI of the Civil Rights Act of 1964 requires all recipients of federal aid to provide limited English proficient (LEP) individuals with “meaningful access” to their federally subsidized services.²⁴ If an organization receives any federal aid, effective language assistance to the limited English proficient individuals must be provided.²⁵

Encourage adaptation: The cohesiveness and commitment that make families such strong survival units can also be barriers to adaptation. Adaptation to the new country, language, and culture can be viewed as a betrayal of traditional values and the country of origin.²⁶ About two-thirds of English-language learners (ELL) students are second or third generation immigrants, some of whom are from families that have remained linguistically and culturally isolated.²⁷

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Build Cultural Competence—Advice from the Experts *continued*

Hiring staff from a language community can be fostered by placing ads in ethnic-specific newspapers, thus increasing the diversity of staff and building community trust.²⁸

Develop outreach materials—booklets, fotonovelas, video programs—on how to use school or health care resources, and translate them into the languages used in the community.

Keep in mind that “staff diversity” does not equal cultural competence or language access. It helps to have various cultures represented on the staff but competence and language access require a more active, comprehensive approach. In health care, specific training in medical translation is considered essential for good quality care.²⁹

What Can Schools Do?

Schools are already responding to the mental health needs of their students. In addition to hiring school psychologists, social workers, and counselors, nearly half of all schools contract or make other arrangements with community-based organizations to provide mental health or social services to students.³⁰

Keep in mind that school-based mental health interventions may be more acceptable to immigrant families because they may carry less stigma for the child and the family than service through a mental health agency.¹⁷

Cultural Competency is the acceptance and respect for difference, a continuous self-assessment regarding culture, an attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations.²¹ Cultural competence is not an endpoint but a continuous process of assessing people's needs and incorporating what is learned into the provision of services.²⁰

Work from the top down; involve the whole school: Success begins with the principal, whose attitude and commitment set the tone for the entire staff, the student body, and the community.⁵ Remain alert to the needs of all students. Beware of assuming that smaller groups don't need as much support, or that a certain group is doing well enough without help.³¹

Language Access is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. The linguistically accessible organization should provide the policy, structure, practices, procedures, and resources to support this communication.³²

Be aware of federal law: The federal Elementary and Secondary Education Act (ESEA), formerly known as the No Child Left Behind Act (NCLB), requires schools to assess student performance in reading and math, beginning in the third grade, and report student performance in “major racial and ethnic groups.” ESEA also requires schools to measure and improve LEP students' English proficiency.³³

ESEA poses particular challenges for children of immigrants, LEP students, and the schools that serve them. LEP students tend to cluster in some schools while English-proficient students are

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What Can Schools Do? *continued*

clustered in others. Schools serving large numbers of LEP students are expected to meet general performance standards or face interventions required by ESEA.³³ The extra staff and services required to help LEP students attain required English levels strain limited school budgets and busy calendars.

Invite innovation: Invite students to teach their language to others. Reversing the roles—especially of students and parents who are usually the linguistic outsiders—can boost the self-esteem of the new “teachers” and raise the parents’ status in the eyes of their children.⁵

Partner with existing groups. Neighborhood cultural associations in one town are housed in a school-sponsored Resource Center, providing easy access to support both academic and family needs.⁵

10 Tips for Schools

1. Embrace diversity and accept the challenges.
2. Be flexible and creative—explore other ways of communicating.⁵
3. Communicate clearly, use simple language, and highlight important points.²¹
4. Utilize community resources and cultural intermediaries.⁹
5. Reach out to parents, families—offer educational support, English classes, computers, introduction to resources.
6. Send staff to community meetings, create liaisons with cultural community leaders and organizations.²⁸
7. Foster community partnerships by including community organizations in school activities.
8. Ask yourself about your own cultural viewpoint—review and update your own information.
9. Develop and “bank” resources—language help, cultural resources, community elders, outreach opportunities.
10. Make services available to all students; emphasize strategies that meet the unique needs of children from immigrant or refugee families.²⁸

Support families: Make programs, materials, and personal communications available in parents’ native languages, to make families comfortable and ensure that the correct information is being delivered.⁹

Regardless of race/ethnicity or immigrant origin, the family feature most relevant to overall child well-being and development is parental education.³ Providing after-work educational and English language programs for parents can improve their job potential, increase their self-esteem, and enhance their ability to relate to and support their children’s schoolwork.

Review and renew programs regularly: Frequent change is a major part of the immigrant experience. It is important for school faculty and staff to constantly update their information on shifting community demographics, and changes in family status and income. This information should be added to faculty and staff training and considered in outreach to the school community.

- Expect patterns to keep changing as the population changes.
- Take advantage of technology.
- Keep an open mind.

Additional Information and Resources

African American Mental Health Research Center

Institute for Social Research
University of Michigan
<http://www.psc.isr.umich.edu/research/project-detail.html?ID=32965>

American Community Survey US Census Bureau

<http://www.census.gov/acs/www/>

BRYCS Bridging Refugee Youth & Children's Services

US Conference of Catholic Bishops
<http://www.brycs.org>

Center for Healthy Families and Cultural Diversity

University of Medicine and Dentistry of New Jersey
Robert Wood Johnson Medical School, Department of Family Medicine
<http://www2.umdnj.edu/fmedweb/chfcd/index.htm>

Child and Adolescent Mental Health

Substance Abuse and Mental Health Services Administration
<http://www.mentalhealth.samhsa.gov/child/childhealth.asp>

Cross Cultural Health Care Program

Cultural competence and medical interpretation trainings
<http://www.xculture.org>

Hablamos Juntos

UCSF Fresno Center for Medical Education and Research
<http://www.hablamosjuntos.org>

Harvard Immigration Project

Graduate School of Education
Harvard University
<http://news.harvard.edu/gazette/2004/12.09/11-louie.html>

Hogg Foundation for Mental Health

at the University of Texas at Austin
<http://www.hogg.utexas.edu>

The Future of Children: Children of Immigrant Families

Princeton University and The Brookings Institution. 2011; 21(1). Available online at:
http://futureofchildren.org/futureofchildren/publications/journals/journal_details/index.xml?journalid=74

Migration Policy Institute

<http://www.migrationpolicy.org>

National Alliance for Hispanic Health

(formerly COSSMHO)
<http://www.hispanichealth.org>

National Asian American and Pacific Islander Mental Health Association

<http://www.naapimha.org>

National Center for American Indian and Alaska Native Mental Health Research

University of Colorado Health Sciences Center
<http://www.healthfinder.gov/orgs/HR2873.htm>

National Center for Cultural Competence

Georgetown University
<http://nccc.georgetown.edu/>

National Center on Minority Health and Health Disparities

National Institutes of Health
<http://www.ncmhd.nih.gov>

NHeLP-National Health Law Program

<http://www.healthlaw.org>

NICHQ-National Initiative for Children's Healthcare Quality

http://www.nichq.org/areas_of_focus/cultural_competency_topic.html

Office of Minority Health Resource Center

US Department of Health and Human Services
<http://www.omhrc.gov>

Pew Hispanic Center

<http://www.pewhispanic.org>

Refugee Health Issues Center

American Refugee Committee
<http://www.archq.org>

Refugee Mental Health Links

National Mental Health Information Center
Child and Adolescent Mental Health
Substance Abuse and Mental Health Services Administration
<http://www.mentalhealth.samhsa.gov/CMHS/SpecialPopulations/refugeelinks.asp>

Urban Institute

<http://www.urban.org/immigrants/index.cfm>



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Refugee Education

A Global Review

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University of Toronto

November 2011

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Acronyms

AAH-I	Action Africa Help-International
ANC	African National Congress
CAR	Central African Republic
CARA	Control of Alien Refugees Act (Uganda)
CNA	Comprehensive Needs Assessment
COPE	Complementary Opportunities for Primary Education
CRC	Convention on the Rights of the Child
CREPS	Complementary Rapid Education Programme for Schools
DAFI	German-language acronym for Albert Einstein German Academic Refugee Initiative
DIP	Division of International Protection
DOS	Department of Operational Support
DPSM	Division of Programme Support and Management
DRC	Democratic Republic of Congo
EFA	Education for All
EGMA	Early Grade Math Assessment
EGRA	Early Grade Reading Assessment
GER	Gross Enrolment Ratio
IASC	Inter-Agency Standing Committee
IBT	Initial Budget Target
IDP	Internally Displaced Person
IIEP	International Institute for Educational Planning
INEE	Inter-Agency Network for Education in Emergencies
IP	Implementing Partner
IRC	International Rescue Committee
JPO	Junior Professional Officer
JRS	Jesuit Refugee Service
MoE	Ministry of Education
MoU	Memorandum of Understanding

NER	Net Enrolment Ratio
NGO	Non-Governmental Organisation
NRC	Norwegian Refugee Council
NWFP	Pakistan's Northwest Frontier Province
OECD	Organisation for Economic Co-operation and Development
PDES	Policy Development and Evaluation Service
PEP	Peace Education Programme
PSLE	Primary School Leaving Exams
RET	Refugee Education Trust
SADR	Sahrawi Arab Democratic Republic
SGBV	Sexual and Gender-Based Violence
SMC	School Management Committee
TDA	Targeted Development Assistance
TVSD	Technical and Vocational Skills Development
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief Works Agency for Palestinian Refugees in the Near East
UNV	United Nations Volunteers
UPE	Universal Primary Education
YEP	Youth Education Pack
WUSC	World University Service of Canada

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Access to education is limited and uneven, particularly for girls, at secondary levels, and in Eastern and the Horn of Africa

Executive Summary

Education is one of the highest priorities of refugee communities. Yet there is little evidence of tangible organisational commitment by UNHCR to guaranteeing the right to education for refugee children and young people. The lack of high quality and protective education for refugees stands in the way of meeting Education for All goals, of achieving durable solutions, and of sustainable development and reconstruction of home and host countries.

■ The Current State of the Field

- *Access to education for refugees is limited and uneven across regions and settings of displacement, particularly for girls and at secondary levels.* Enrolment in primary school is only 76% globally and drops dramatically to 36% at secondary levels. Girls are at a particular disadvantage; in Eastern and the Horn of Africa, only 5 girls are enrolled for every 10 boys.
- *Refugee education is generally of a very low quality, with ineffective indicators that measure inputs rather than outcomes.* Teacher-pupil ratios average as high as 1:70 and, in many situations, teachers do not have even the ten days of training that would categorise them as “trained.” Available data indicate that many refugee children are learning very little in schools; among Eritrean refugees in Ethiopia, less than 6% of refugee children had reached benchmark reading fluency by grade 4.

- *Refugee education is not serving its protective function due to a lack of focus on learning.* Current indicators are based on the assumption that schools are useful only as “spaces” to identify protection issues.
- *UNHCR cannot meet its mandate to provide high quality and protective refugee education with the current level of human and financial resources.* Globally, there are only two education officer positions (2011), and Implementing Partners often do not have technical capacity in education. Education received only 4% of UNHCR’s total comprehensive budget in 2010.

■ An Agenda for Change

Based on extensive analysis, this review sets out an agenda for change, aimed at promoting high quality and protective education for refugees, in keeping with education as a durable solution and as a core element of UNHCR’s mandate:

- *Integration of refugees into national education systems*, particularly in urban areas where half of refugees now live, working closely with Ministries of Education and UNICEF to strengthen national systems for the benefit not only of refugees but also host communities;
- *Provision of post-primary education for all refugees* up to the end of secondary school, with emphasis on access for girls and other marginalised groups, and provision of additional opportunities for higher education, both scholarships and site-based programmes that use open and distance learning;
- *Investment in teacher training* that cultivates high quality skills related to both pedagogy and content and that is sequential, leading towards a basic qualification that is recognised in home and/or host countries;
- *Development of new standards and indicators for education* that measure learning outcomes, including formative in-class assessments and summative independent sample testing, drawing on the Early Grade Reading Assessment (EGRA) and on partnerships with UNESCO International Institute for Educational Planning (IIEP), national Ministries of Education, and other bilateral partners supporting education;
- *Recognition of the connections between education and conflict in all education policy and planning*, emphasising the use of conflict-sensitive analyses to assess the content and structures of education, including curriculum, language, and relationships between actors; the importance of education for political stability and leadership in host countries and upon repatriation; and the reinstitution of peace education as a core component of refugee education;
- *Support for increased and predictable human and financial resources in education*, including hiring of Regional Education Advisors, Education Officers in country offices, and Community Services and Protection Officers with educational expertise; the selection of Implementing Partners (IPs) with proven technical capacities in education; and formalised operational and field-level partnerships between UNHCR and national Ministries of Education, UNICEF, and the Education Cluster.



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The quality of education refugee children receive in exile determines their ability to contribute to their home and host societies



Introduction

The provision of educational opportunities is one of the highest priorities of refugee communities. Refugee mothers, fathers, and children the world over emphasise that education is “the key to the future,” that it will help bring peace to their countries, that despite not knowing “what will happen tomorrow,” education brings stability and hope.

Access to education is a basic human right and is linked to poverty reduction, holding promises of stability, economic growth, and better lives for children, families, and communities. In 1948, the Universal Declaration of Human Rights recognised compulsory primary education as a universal entitlement. The 1979 Convention on the Elimination of All Forms of Discrimination Against Women (United Nations, 1979) called for no discrimination in educational provision for men and women, and the 1989 Convention on the Rights of the Child (CRC) affirmed the right of all children, regardless of status, to free and compulsory primary education, to available and accessible secondary education, and to higher education on the basis of capacity (United Nations, 1989, Article 28). The right to education for *refugees* is articulated in Article 22 of the 1951 Convention relating to the Status of Refugees, resolution 64/290 (July 2010) of the Human Rights Council of the United Nations General Assembly on the right to education in emergencies (United Nations, 2010a), and in the draft resolution to the Human Rights Council on the right to education for refugees, migrants and asylum seekers (June 2011) (United Nations, 2010b).

Education is a rising concern for the United Nations High Commissioner for Refugees (UNHCR). The importance of education is articulated in documents emanating from throughout the agency, as “a

basic right” (Executive Committee of the High Commissioner’s Programme, 2006, p. 6) and as an “enabling right,” a right through which other rights are realised (UNHCR, 2011e, p. 18). Since 2010, education has taken on new prominence within the agency. It has a new institutional place as part of the agency’s core mandate to protect, having moved from Operations to the Division of International Protection, and it is one of the Global Strategic Priorities (2010-2011 and 2012-2013) (UNHCR, 2011e).

Yet despite the binding language and institutional reorganisation, there is little evidence of tangible organisational commitment by UNHCR to guaranteeing the right to quality education for refugee children and young people. Access to education for refugees is limited and uneven across regions and settings of displacement, and particularly at secondary levels and for girls.

Further, refugee education has been described by top UNHCR staff members and refugees alike as “education for ultimate disappointment.” The UNHCR Education Strategy 2010-2012 goes so far as to presuppose that “[t]he need for quality services is beyond UNHCR’s existing capacity” (UNHCR, 2009c, p. 28). Educational capacity within UNHCR is shockingly limited, both in terms of human and financial resources. Within the entire organisation there are only two education officer positions in 2011, one at Headquarters in Geneva and one in the field, created just this year; designated education “focal points” are drawn from Community Services Officers, Protection Officers, and Programme Assistants. Education receives only 2% of humanitarian aid, the lowest of all sectors, and just 38% of requests for education funding are met, which is approximately half the average for all sectors (UNESCO, 2011, p. 3). UNHCR is not currently recognised as an actor in education by other actors in the field, including Non-Governmental Organisations (NGOs), scholars, and other UN agencies (P. W. Jones, 1999; P. W. Jones & Coleman, 2005; Klees, 2002; Mundy, 1999, 2002; UNESCO, 2011, pp. 4-23).

What accounts for the discrepancy in how refugees view education and how UNHCR as an institution views education? The discrepancy is one of priority but also one of approach. There are generally three conceptual approaches that guide the field of refugee education and education in emergencies more broadly (Burde, 2005, pp. 10-11).

First is the *humanitarian approach*, which describes UNHCR’s general institutional approach to refugee education at present. This approach views education as one component of a rapid response, providing immediate protection to children and preventing human rights violations. It does not frequently involve collaboration with governments or institution-building.

Second is the *human rights approach*, which emphasises education as a human right to be realised and cultivated through education in any situation, including crises; furthermore, it defines education as an “enabling right,” providing “skills that people need to reach their full potential and to exercise their other rights, such as the right to life and health” (INEE, 2010b, p. 7). Education can only fulfil this promise if it is of high quality, meaning that it is available, accessible, acceptable, and adaptable (Tomaševski, 2001). This approach to education is consistent with the fundamental mandate of UNHCR but does not align with current practice, particularly in relation to quality.

Third is the *developmental approach*, which recognises education as a long-term investment for society and the lack of quality education in a crisis as holding back development potential, even allowing “backward development.” This approach, most commonly expressed by refugee parents and children, takes a long-term view of education, with priority on current access to quality education but always with a sense of future relevance toward individual livelihoods and societal advancement.

Support for high quality education based on the human rights approach and the developmental approach to education is especially critical given several new realities in refugee work. First is recognition of the protracted nature of contemporary conflicts. The education that most refugee children receive in exile is not a stop-gap measure but their main shot at education. Second, the increasing number of urban refugees, and policy that attends to this reality, means a transformation of the way that assistance is delivered. For education, it means high-level advocacy to facilitate integration of refugee children into national schools and on-going support to the building of national education systems in collaboration with the United Nations Children’s Fund (UNICEF). Third is the acceptance

that education can both mitigate and exacerbate conflict. Establishing conditions for peace requires intense analysis of the sources of conflict and active engagement with the content and pedagogy of refugee education as a positive force. Reconceptualising refugee education to account for these realities and to align with the human rights approach and the developmental approach will be critical to meeting UNHCR's Global Priorities and to achieving sustainable durable solutions.

This study was commissioned by UNHCR's Policy Development and Evaluation Service (PDES) in an attempt to chart a way forward for policy and programming in refugee education. It is not an evaluation of UNHCR's education programmes but instead a general, global review that identifies common patterns and categories within the field of refugee education. It examines the central role of UNHCR in the provision of refugee education but situates refugee education historically, from World War II to the present, and within the global Education for All (EFA) movement and the burgeoning literature on education in conflict more broadly.

Data sources include a review of the literature; analysis of internal UNHCR data and documents; an online survey (79 respondents); and telephone interviews with UNHCR staff, Implementing Partners (IPs), and other refugee education organisations in priority field sites (42 respondents). The review is also based on three in-depth field-based case studies including a camp (Uganda), an urban setting (Malaysia), and a repatriation context (Mauritania), for which Master's students from the University of Neuchâtel, Switzerland conducted three months of anthropological fieldwork in each country under the supervision of Marion Fresia and myself (more information on the case study methodology can be found in each of these three reports: Rahman, 2011; Rezzonico, 2011; Wettstein, 2011).

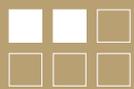
This study is global in scope. The three case studies represent important settings in which refugee education occurs – in a camp, in a city, and upon repatriation. Case study methodology does not capture the wide range of context-specific realities of refugee education, yet it provides in-depth understandings of particular contexts that allow for the testing of theories. Despite the wide array of sources mobilised, there are important limitations of the study. The availability of financial and human resources has meant that the study is not exhaustive. In particular, the search for global comparisons to inform and contextualise the case studies has been challenging, given the decentralisation of the most relevant information on refugee education that could help to unpack the stories behind the limited global numbers that are available. While many IPs continuously evaluate their work, there is no system of knowledge management in place, such that documentation is inaccessible outside of UNHCR field offices, often residing only with individual staff members who rotate frequently. Further, the numbers that are available are often incomplete, non-comparable, and not up-to-date. Finally, archives are slim and comparisons over time thus limited. The study does not analyse early childhood education or adult education, and it is limited to refugees and does not include Internally Displaced Persons (IDPs).

The rest of the report is organised as follows. Section 2 traces the history of refugee education. Section 3 presents the current "state of the field" of refugee education in terms of what is known about access, quality, and protection, and relevant institutional, resource, and coordination constraints. Out of this "state of the field" emerge seven challenges to refugee education, which I explore in detail in Section 4. Each of these challenges leads to a specific recommendation. Section 5 concludes with overarching commitments that UNHCR should make to refugee education, framed around the central idea of education as a durable solution.



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Refugee education has a long history. In 1956, Hungarian refugee children were given German language courses to prepare them for the Austrian school system



The Development of Refugee Education

“Since wars begin in the minds of men, it is in the minds of men that the defences of peace must be constructed” Preamble to the 1945 Constitution of UNESCO (UNESCO, 2004a).

Schools for children were set up in emergencies prior to World War II, by organisations such as Save the Children, but the provision of education became more common during and in the aftermath of the Second World War. It is at this time that a coherent field of refugee education has its origins. The political dynamics of the Cold War led to burgeoning refugee populations the world over, and the horrors of World War I and World War II ignited a belief in the power and necessity of education, as expressed in this preamble to the 1945 Constitution of the United Nations Educational, Scientific and Cultural Organization (UNESCO).

The development of refugee education since this time is connected integrally to international instruments, institutional relationships, and shifting understandings of the purposes of education. A timeline of these major developments is summarised in Box 2.1 (page 14-15).

■ The mandate for refugee education

The underpinnings of the provision of refugee education are articulated in Article 22 of the 1951 Convention Relating to the Status of Refugees, which states that signatory states “shall accord to refugees the same treatment as is accorded to nationals with respect to elementary education.... [and] treatment as favourable as possible... with respect to education other than elementary education” (UNHCR, 2010c). Even among signatories to the Convention, realisation of the right to education has depended on the laws, policies, and practices in place at different historical times and in each national context (see Box 2.2).

Box 2.2. Refugee governance and education

Access to education depends on the refugee governance structures and asylum policies in different locations and at different historical times. For example, as early as 1975, refugee children from Burundi, Rwanda, and Zaire in Tanzania were integrated into the national education system (Dodds & Inquai, 1983, p. 11), although they were later relocated into refugee camps (Obura, 2003). In Iran, Afghan refugees were able to exercise the right to education before voluntary repatriation to Afghanistan began in 2002; however Afghans remaining in Iran are systematically denied access to education through discrimination and the levy of additional tuition fees (Ebadi, 2008; UNHCR, 2010d).

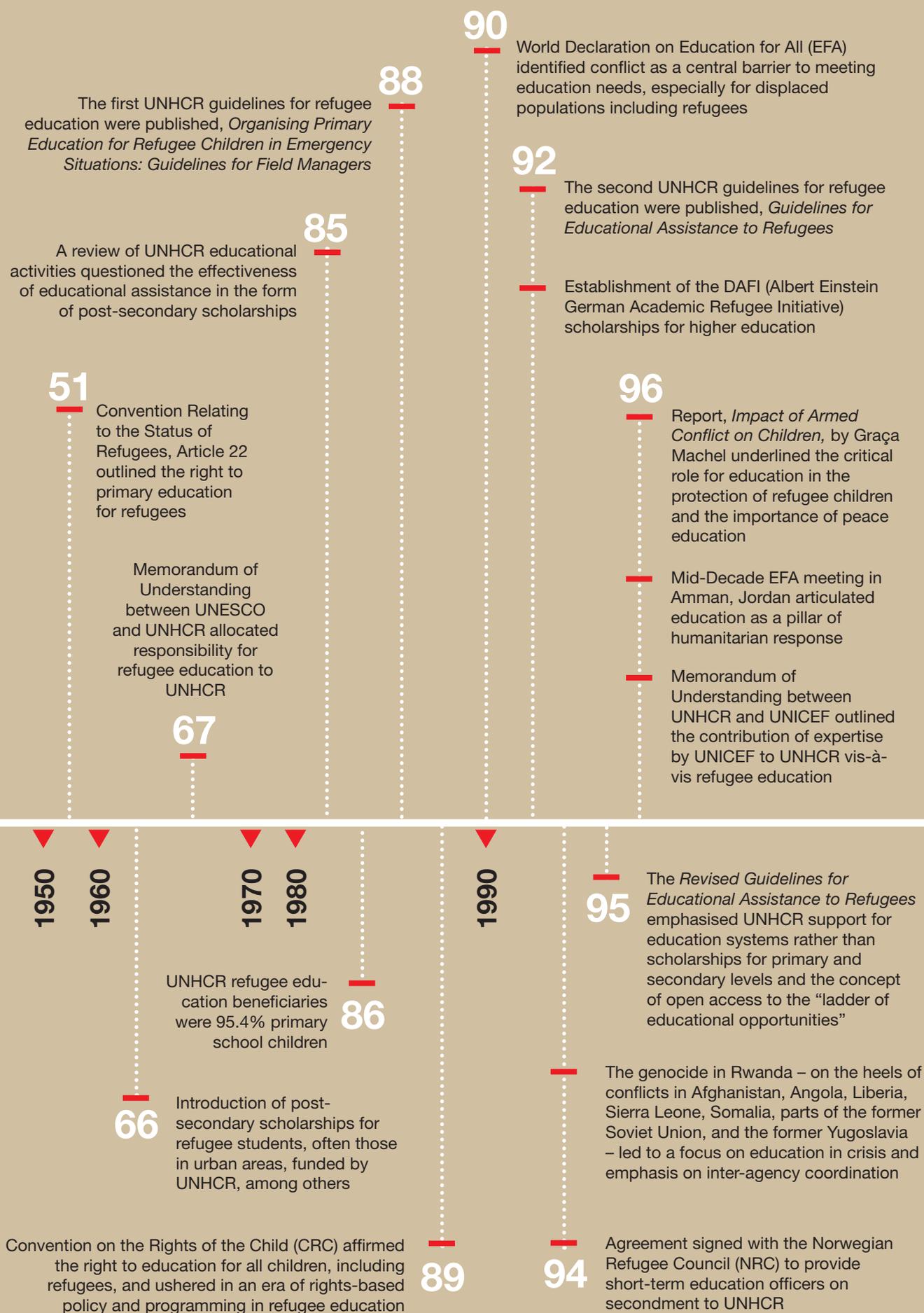
The decentralised and field-oriented operations of UNHCR have positioned the organisation to be central in the realisation of the right to education for refugees. From its origins in 1945, UNESCO carried the global mandate for education, including for refugees and other displaced populations. However, by the mid-1960s, it was clear that with UNESCO’s focus on national-level policy, there was little capacity to act on this field-level responsibility. UNHCR began to create capacity for refugee education, while relying on some expertise and technical support from UNESCO, as outlined in a July 1967 *Memorandum of Understanding between UNESCO and UNHCR* (Retamal, Forthcoming, p. 9; UNESCO & UNHCR, 1984). From that time, UNHCR had education officer posts at the field level and carried the mantle for refugee education among UN agencies.

■ Self-help initiatives and scholarships

Until the 1980s, few resources were allocated to education within UNHCR. UNHCR thus typically relied on refugees to create their own primary school opportunities. A number of empirical case studies dating back to the early 1970s have documented that when education is not available, either in the acute phase of an emergency or due to lack of resources, refugees often do develop their own schools and other informal learning programmes (Dodds & Inquai, 1983; Sinclair, 2001; UNICEF, 2010, pp. 36-39). In the 1960s and 1970s, as today, these initiatives were often overtly political, with refugees’ struggles for self-determination closely linked to the development of refugee educational organisations (see Box 2.3).

While devolving responsibility for primary education to refugee communities, UNHCR at this time focused most of its financial resources and staff on post-primary education. Beginning in 1966, post-secondary scholarships for refugees were introduced and from that time became a central part of UNHCR’s education programme. This focus emphasised “the integration of individual refugees, often in urban areas” (Dodds & Inquai, 1983, p. 10). The number of scholarships increased from about 1,000 in 1966 to over 1,200 in 1982, and to 3,950 by 1987 (Retamal, Forthcoming, p. 13), with direct funding from UNHCR and from other organisations such as the World University Service, World Council of Churches, Lutheran World Federation, and the Commonwealth Secretariat (UNHCR Inspection and Evaluation Service, 1997, p. 5).

Box. 2.1. Timeline of major developments in refugee education



Review of UNHCR's refugee education activities concluded that refugee education programmes are "plagued by inconsistencies" and that existing guidelines are inadequate

97

2K

UNHCR recreated the position of Senior Education Officer in the lead-up to the World Education Forum in Dakar

Thematic assessment of education in emergencies and strategy session of the World Education Forum recognised the role of education in national development and the promotion of peace, especially for refugees in all stages of displacement

Dakar Framework for Action re-emphasised the barrier that conflict poses to reaching EFA goals and Education in Emergencies becomes an EFA flagship programme

01

Inter-Agency Network for Education in Emergencies (INEE) was formed and took on a central role in inter-agency advocacy and information-sharing in emergency education

04

INEE issued the *Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction*, the fundamental tool for quality and accountability in the field of education in emergencies

10

INEE issued the revised version of the *Minimum Standards for Education: Preparedness, Response, Recovery*, which remains the fundamental tool for quality and accountability in the field of education in emergencies

UNHCR Education Unit moved from Operations, first within the Department of Operational Support (DOS) and then within the Division of Programme Support and Management (DPSM), to the Division of International Protection (DIP)

UNHCR Education Unit issued the second triennial *UNHCR Education Strategy*, which continues to focus on issues of access, quality, and protection but which asserts that "[t]he need for quality services is beyond UNHCR's existing capacity"

Education was one of the Global Strategic Priorities (2010-2011) for UNHCR

2000

06

Formation of the Global Education Cluster with the mandate to coordinate humanitarian responses in education, co-led by UNICEF and Save the Children and with an advisory role by UNHCR

02

The 2002 UNHCR Agenda for Protection and subsequent Action Plan approved by the Executive Committee emphasised the importance of "education as a tool for protection"

98

UNHCR eliminated the position of Senior Education Officer, leaving the organisation without any dedicated education staff

2010

12

Education remains one of the Global Strategic Priorities (2012-2013) for UNHCR

07

UNHCR Education Unit issued the first triennial *UNHCR Education Strategy*, focused on issues of access, quality, and protection

Box 2.3. Refugee-initiated schools supported by UNHCR

Refugee-initiated schools were often connected to the process of decolonisation and liberation movements. Such was the case, for example, with schools started by Eritreans and Tigreans in the 1970s in Sudan (Dodds & Inquai, 1983, p. 11); with Nicaraguans in Honduras in the 1980s (Retamal, 2011, pp. 29, 32); and with the Solomon Mahlangu Freedom College started as by the African National Congress (ANC) in Tanzania to “prepare cadres to serve the national struggle of the people of South Africa in the phase of the struggle for seizure of political power and the post liberation phase” and to “produce such cadres as will be able to serve the society in all fields i.e. political, economic, socio-cultural, educational and scientific” (Serote, 1992, p. 49). UNHCR contributed to this school and similar educational initiatives connected to liberation movements by FREMILO in Tanzania, the African Party for the Liberation of Guinea and Cape Verde in Senegal, the Zimbabwean African National Union in Zambia and, more recently, Sahrawi schools led by the Polisario in the Sahrawi Arab Democratic Republic (SADR) nation-state-in-exile in Algeria (Farah, 2011; Morrow, Maaba, & Pulumani, 2004; Retamal, Forthcoming, pp. 14-15).

A 1985 review of UNHCR’s education programmes concluded that post-primary scholarship “assistance requires a disproportionate share of resources for a small amount of refugees both in terms of staff time and project funds.... In a way, scholarships have a tremendous potential for creating an elite group, long accustomed to privileged treatment” (UNHCR, 1985, p.1-2, as quoted in Retamal, Forthcoming). The 1986-1987 school year saw 95.4% of education programme beneficiaries as primary school children. Nevertheless, 58.8% of the education budget provided direct support for secondary schools and scholarships for higher education (Retamal, Forthcoming, pp. 12-13).

■ From scholarships to education systems

By the end of the 1980s, there was a transformation of focus within UNHCR away from individual scholarships and towards education systems at the primary level, a focus that was solidified in the *Revised (1995) Guidelines for Educational Assistance to Refugees* (UNHCR, 1995). This shift had its origins in four developments.

First was UNHCR’s shifting approach to intervention given the vast refugee flows of the 1980s. Large camps such as those for Cambodian refugees on the Thai border and other forms of organised settlements such as the “agricultural settlements” of Uganda or the “refugee villages” of Pakistan took the place of settlement of refugees among local populations. Encampment policies were the preference of host governments, but also of UNHCR, in order to contain perceived security risks, to simplify the provision of humanitarian assistance, to have the kind of visibility that attracts international attention and assistance, and to effectively organise eventual repatriation (UNHCR, 2000, p. 108; Verdirame & Harrell-Bond, 2005, pp. 287-288). The institutionalisation of the refugee camp as the primary mode of assistance often led to the structural necessity of refugee children attending separate schools under the funding and direction of UNHCR rather than through scholarships to local schools.

Second was the institutionalisation of a rights-based framework with the ratification by all but two countries of the 1989 Convention on the Rights of the Child (CRC). The CRC affirms that children have the right to education, with primary education compulsory and available free to all; secondary education, including general and vocational education, available and accessible to all; and higher education accessible to all on the basis of capacity (United Nations, 1989, Article 28). The CRC further specifies that this education be directed toward the full development of the child’s personality, talents, and mental and physical abilities and toward respect for human rights, peace, and tolerance (United Nations, 1989, Article 29).

Third were widespread changing expectations for education, not only among refugees but among the larger populations in countries of origin and of asylum. Previously, education in any form had not been a mass experience. Yet at this time, more people globally wanted and expected education. Desire for education grew out of the structural adjustment policies of the 1980s, which drastically reduced

opportunities for education, and the consequences of which led to shifts in national and international policy away from a sole focus on economic development toward more integrated social development. This broadening of the base in demand for education was manifest in the burgeoning EFA movement and the 1990 Jomtien World Declaration on EFA. At this time, “war, occupation, [and] civil strife” were identified as some of the “daunting problems” that “constrain efforts to meet basic learning needs” (World Conference on Education for All, 1990).

Fourth in shaping a new systems-based approach to education was the experience of UNHCR in post-Cold War conflicts. These conflicts increasingly played out between groups within national borders and centred on conflicts at the intersections of issues of land, ethnicity, religion, and resources. Out of conflicts in Afghanistan, Angola, Liberia, Sierra Leone, Somalia, parts of the former Soviet Union, Sudan, the former Yugoslavia and, in particular, the 1994 genocide in Rwanda came new understandings of the role of education in both exacerbating and mitigating conflict in crisis situations. There was growing realisation in the scientific literature and education development field of practice that a systematic approach to education was required, necessitating serving populations rather than select individuals (Bush & Salterelli, 2000; Davies, 2005, 2011). In 1992, UNHCR’s Executive Committee emphasised the need for prompt attention to educational needs, even in the early stages of an emergency (UNHCR Executive Committee, 1992).

Graça Machel’s 1996 report, *The Impact of Armed Conflict on Children*, increased the urgency of this growing awareness of the need for widespread refugee education. Commissioned by the UN General Assembly (Machel, 1996; see also, United Nations, 1993), this report outlined the role for education in the “psychosocial recovery” of war-affected children and the reconstruction of societies. By the Mid-Decade EFA meeting in Amman, Jordan in 1996, education was presented as critical to humanitarian response:

Given escalating violence caused by growing ethnic tensions and other sources of conflict, we must respond by ensuring that education reinforces mutual respect, social cohesion and democratic governance; We must learn how to use education to prevent conflict and, where crises do occur, ensure that education is among the first responses, thereby contributing to hope, stability and the healing of the wounds of conflict (UNESCO, 1996b).

■ A field of practice to a field of policy

Through the 1960s, 1970s, and 1980s, refugee education was a field of practice, deeply embedded in the experiences of locally-based UNHCR education officers. The articulation of a universal rights-based framework for education, including refugee education, in the form of the 1989 CRC led to the development of refugee education also as a field of policy. In this environment, UNHCR Headquarters-level policy proliferated, with four sets of guidelines over seven years, between 1988 and 1995 (see Box 2.4). These guidelines provided detailed guidance for field-level educational operations.

This transformation of refugee education from field-based practice to Headquarters-based policy was accompanied by the abolition of field-based education posts within UNHCR. There were few posts between 1997 and 2005, and none between 2005 and 2011. During this period, there was what one former Senior Education Officer described as a “total lack of expertise” in education within UNHCR. Importantly, this abolition also meant that there was no dedicated spokesperson for education within UNHCR at the field level, with responsibilities usually divided between generalist Programme Officers, Community Services Officers, and Protection Officers.

This environment gave rise to several critical inter-agency partnerships in order to improve UNHCR capacity in refugee education. In 1994, UNHCR entered into an agreement with the Norwegian Refugee Council (NRC) through which the NRC would provide short-term education officers on secondment to UNHCR, initially for 3 to 6 months and later at times for 12-month periods. At the time of an evaluation in February 2006, there had been 28 deployments worldwide to Albania, Angola, Chad, DRC, Eritrea, Ethiopia, Guinea, Kenya, Kosovo, Liberia, Pakistan, Sierra Leone, Somalia, and two to UNHCR Headquarters in Geneva (Bethke & de Goys, 2006).

Box 2.4. Refugee education guidelines

- ▶ **1988:** Organising primary education for refugee children in emergency situations: guidelines for field managers (UNHCR, 1988)
- ▶ **1992:** Guidelines for educational assistance to refugees (UNHCR, 1992)
- ▶ **1994:** Refugee children: guidelines on protection and care (UNHCR, 1994)
- ▶ **1995:** Revised guidelines for assistance to refugees (UNHCR, 1995)
- ▶ **2003:** UNHCR Education Field Guidelines (UNHCR, 2003b)
- ▶ **2007:** UNHCR Safe School and Learning Environment Guide (UNHCR, 2007c)
- ▶ **2011:** Ensuring Access to Quality Education: Operational Guidance on Refugee Protection and Solutions in Urban Areas (UNHCR, 2011d)
- ▶ **2011 (forthcoming):** UNHCR Education Policy and Guidelines (UNHCR, 2011, forthcoming)

Further, in 1996, UNHCR and UNICEF developed a Memorandum of Understanding (MoU). While UNICEF has its origins in serving “children in emergency,” refugee children have been outside of its education mandate. The MoU, however, outlined the contribution of expertise by UNICEF to UNHCR in assessing and analysing the needs of refugee, returnee, IDP, and local host children, emphasising the shared mandate to assist national governments vis-à-vis the well-being of children (UNHCR & UNICEF, 1996). In the 1990s, UNICEF and UNESCO contributed to refugee education through the design and distribution of educational kits, including the UNESCO “Teacher Emergency Package” and the UNICEF “School-in-a-Box” (Sinclair, 1998, pp. 57-66). UNHCR also collaborated with UNICEF and UNESCO on a comprehensive discussion document, *Rapid Educational Response in Complex Emergencies*, published in 1997 (Aguilar & Retamal, 1997).

■ Refugee education as part of the EFA movement

In 1993, UNHCR began to collect data systematically on its educational programmes (UNHCR Education Unit, 2002, p. 1), and in 1997 evaluated these education activities. This evaluation concluded that refugee education programmes were “plagued by inconsistencies,” having been “seriously affected by the financial constraints of the past few years” (UNHCR Inspection and Evaluation Service, 1997, p. 1). Available data from 2000, for example, show that while the estimated Gross Enrolment Ratio (GER) for primary education for refugees globally was 50%, country-level ratios varied from 25% in Sudan to 98% in Uganda (UNHCR Education Unit, 2002, p. 6).

The 1997 evaluation also concluded that the existing education guidelines give “limited guidance to managers, and allow for differences in interpretation of policies, determination of methods, and implementation” (UNHCR Inspection and Evaluation Service, 1997, p. 1). Without field-level technical capacity, UNHCR’s refugee education activities were driven by global policy. Yet there was “an absence of simple, universal standards” (UNHCR Inspection and Evaluation Service, 1997, p. 3) and the “quality of refugee primary education remained somehow ‘invisible’”, as it had for decades (Retamal, Forthcoming, p. 19). Interviews for this study suggest the guidelines were drafted this way quite on purpose, with the goal of creating enough latitude to allow for the continued existence of education programmes in the existing environment of limited technical capacity and political support. This approach, however, was proving ineffective at meeting the educational rights of refugee children.

The explicit and disappointing findings of the 1997 evaluation did little immediately to counteract the lack of capacity UNHCR had in education. In fact, in 1998 as part of an economy measure to reduce total staffing, the position of Senior Education Officer at UNHCR Headquarters was eliminated, leaving no dedicated education staff in the entire organisation.

The lead-up to the 2000 World Education Forum in Dakar, Senegal, however, gave renewed legitimacy to education within UNHCR at a time when it had been particularly sidelined. The position of Senior Education Officer was recreated in 2000, a few months before the meetings in Dakar. The 2000 World Education Forum included a background thematic study, *Education in Situations of Emergency and Crisis*; a special strategy session on education in emergencies; and the outcome document, the Dakar Framework for Action, which highlighted the ways in which conflict acts as a barrier to education and outlined a commitment to “meet the needs of education systems affected by conflict, national calamities and instability and conduct educational programmes in ways that promote mutual understanding, peace and tolerance, and help to prevent violence and conflict” (UNESCO, 2000, Article 8v). Education in emergency situations became one of nine EFA flagship programmes.

The UNHCR Senior Education Officer played a critical role in establishing education in emergencies on the world education agenda following Dakar, including in the development of the Inter-Agency Network for Education in Emergencies (INEE), the establishment of working relationships with UNESCO and UNICEF, and publication of the first book on refugee education (Crisp, Talbot, & Cipollone, 2003). The global developments also drew heavily on UNHCR’s historical approach to refugee education, which grew out of UNHCR’s involvement in liberation movements and centred on a humanist approach to education: developing the full potential of each child’s skills and knowledge and preparation for a satisfying and responsible life in society, including attention to the psychosocial well-being of children (Retamal, Forthcoming) and the intensive peace education programme pioneered by UNHCR (Sinclair, 2004; Sommers, 2003). Along these lines, the 2000 World Education Conference background thematic study described the need not only for “basic education in the classical sense of traditional schooling” but also for “education for human rights, education for peace, democracy and tolerance” as well as pedagogical methods that promote participation and conflict resolution (Bensalah, Sinclair, Nacer, Commisso, & Bokhari, 2001, pp. 34-35).

■ Refugee education in the context of education in emergencies

Since 2000, the field of refugee education has been subsumed into the broader field of education in emergencies (EiE), which includes not only education of refugees but also of IDPs, non-displaced children living in conflict and/or fragile settings, and children affected by natural disasters. This larger field of education in emergencies developed first, out of experiences in post-Cold War conflicts in the 1990s in which cross-border displacement was no longer the norm and refugee populations accounted for a declining share of those displaced; second, from the emphasis on the needs of conflict-affected children writ large within the EFA movement; and, third, with the realisation that inter-agency coordination would be critical to meeting the similar, yet context-specific, educational needs of the large group of conflict-affected children, which included refugees (Kagawa, 2005; Novelli & Lopes Cardozo, 2008; Pigozzi, 1996). Before EFA, education in general was primarily coordinated at state and national levels; yet it has since, little by little, become a ‘global good,’ coordinated by an increasing number of actors at local, national, and international levels (Chelpi-den Hamer, Fresia, & Lanoue, 2010). Refugee education is part of this global trend.

The burgeoning field of education in emergencies has centred on the INEE, conceived at the November 2000 workshop hosted at UNCHR, as follow-up to the World Education Forum in 2000. The *INEE Minimum Standards*, which are the normative framework for practice in the field and a companion to the Sphere Project Humanitarian Charter and Minimum Standards were first published in 2004 (INEE, 2004) and revised and updated in 2010 (INEE, 2010b). Since its inception in 2006, the Inter-Agency Standing Committee (IASC) Global Education Cluster has also played a critical role in the field, bringing legitimacy to the role of education in humanitarian response as well as increasing inter-agency coordination and accountability. In the absence of educational capacity within UNHCR, Senior Education Officers who served in the 2000s described looking externally, specifically to INEE and to the Cluster, for communities of education colleagues who could assist in providing expertise and capacity vis-à-vis refugee education both at global and country-levels (Personal interviews, 2011). Successive UNHCR Senior Education Officers have served on the steering group of INEE since the group's inception in 2001; have been integral to various INEE working groups; and have served on the inter-agency advisory group that has assisted with the development of the Cluster.

With this historical view in mind, what is the current state of the field?



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In 2004, the Inter-Agency Network for Education in Emergencies first defined minimum standards





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UNHCR views education as a basic right and a tool of refugee protection



The Current “State of the Field”: Access, Quality, and Protection

The EFA movement focuses both on rights and the development of human capital. The UNHCR Education Strategy, 2010-2012 and the long-standing UNHCR Education Policy Commitments, first published in 2003 (UNHCR, 2003b, p. v) (see Box 3.1), are similarly rights-based: they focus on the right to education for every child, youth, and adult of concern to UNHCR (UNHCR, 2009c, p. 4). The UNHCR Education Strategy, 2010-2012 is also similarly preoccupied with the development of human capital through universal primary education.

As with the EFA movement, UNHCR has focused on access to education and quality of education as the central elements of ensuring the basic right to education. Given UNHCR’s central mandate for refugee protection, a third element frames the Education Strategy: protection.

This report argues that access, quality, and protection must be conceptualised as integrally connected in effective policy and programmatic approaches to refugee education. However, this section presents each of the three elements separately in order to align with the way in which access, quality, and protection are currently defined and measured by UNHCR. The next section turns to an examination of seven challenges to refugee education that highlight the analytic links between access, quality, and protection.

Box 3.1. UNHCR Education Policy Commitments (UNHCR, 2009c, p. 36)

UNHCR advocates for *education as a basic right* in the context of the 1951 Refugee Convention and other international declarations and instruments.

The Agenda for Protection, and the subsequent Action Plan approved by the Executive Committee in October 2002, specifically underline the importance of “*education as a tool of protection*”.

UNHCR is committed to the key principles of refugee participation, local capacity building, gender equality and addressing the specific needs of groups at risk.

In implementing education programmes, UNHCR will:

1. Safeguard the right of refugees to education and implement the six goals of Education for All (EFA) which include free access to primary education, equitable access to appropriate learning for youth and adults, adult literacy, gender equity and quality education.
2. Ensure the provision of basic education for refugees and other persons of concern, to ensure their protection and security and to enhance the possibility of durable solutions.
3. Guarantee the availability of primary education (standardised as the first eight grades of schooling) as a first priority including community-based initiatives providing early childhood and pre-school education, where these are prerequisites for formal education.
4. Support the provision of lower secondary education (standardised as grades 9 and 10). In addition, UNHCR will support the enrolment and retention of achieving students in higher secondary (grades 11 and 12) as a prerequisite to post-secondary education. Moreover, UNHCR will advocate for tertiary education and will support the effective use of resources donated for this purpose.
5. Provide low-cost adolescent and adult non-formal education linked to the psychosocial development and specific education needs of the groups. Where appropriate, this will include technical and vocational education.
6. Promote quality of education as a high priority commitment through teacher training and the development of quality teaching and learning materials.
7. Support innovative enrichment programmes in life skills and values education that improves the quality of education.
8. Ensure early intervention and development of education programmes in the earliest stages of an emergency and access to education programmes by children and adolescents upon arrival.
9. Coordinate local, national, regional and global inter-agency mechanisms and partnerships regarding refugee and returnee education issues including educational materials, certification of studies, teacher training and support for education. In addition, there will be inter-sectoral collaboration to ensure a cohesive and integrated approach.
10. Monitor and evaluate all refugee education programmes in line with the established standards and indicators, ensuring that these programmes receive the necessary human resources and appropriate funding at all levels and phases of UNHCR’s operations.

■ Access is limited and uneven

Access to education involves the ability to enrol in school and to continue one’s studies through to the end of a given level. The vision of UNHCR is to “[e]nsure the right to education for all people of concern to UNHCR by achieving universal primary education and creating increased opportunities for post-primary education (secondary, vocational training, non-formal and adult education) with special focus on girls, urban, and protracted situations” (UNHCR, 2009c, p. 4).

In 2009, the average primary school Gross Enrolment Ratio (GER) of 6 to 11 year-olds was 76%, across 92 camps and 47 urban settings reporting from 73 countries (see Box 3.2). The average secondary school GER of 12 to 17 year-olds was much lower at 36%, across 92 camps and 48 urban settings from 75 countries (UNHCR, 2010e, p. 3). As a point of comparison, in 2008, the global primary school GER was 90% (UNESCO, 2011, p. 40), and the global secondary school GER was 67% (UNESCO, 2011, p. 54) (see Figure 3.1). GER varies greatly by country; on average, refugee GERs are lower than national GERs, but there are exceptions (see Figures 3.2a and 3.2b).

Box 3.2. Gross Enrolment Ratio (GER)

Gross Enrolment Ratio is the total enrolment in a specific level of education, regardless of age, expressed as a percentage of the population in the official age group corresponding to that level of education. GERs can exceed 100% due to early or late entry into school or to repetition. It is not to be confused with the Net Enrolment Ratio (NER), which expresses the enrolment of the official age group for a given level of education, expressed as a percentage of the population in that age group.

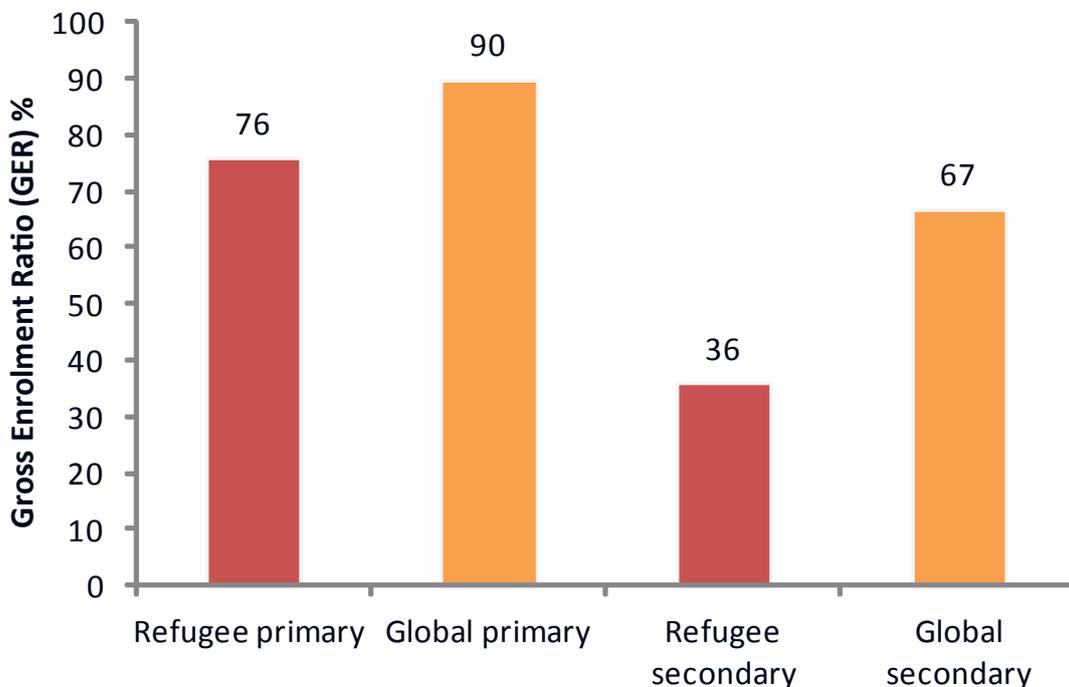


Figure 3.1. Refugee participation in primary and secondary school (2009) as compared to global participation (2008) expressed in Gross Enrolment Ratios (GER). Sources: (UNESCO, 2011; UNHCR, 2010e).

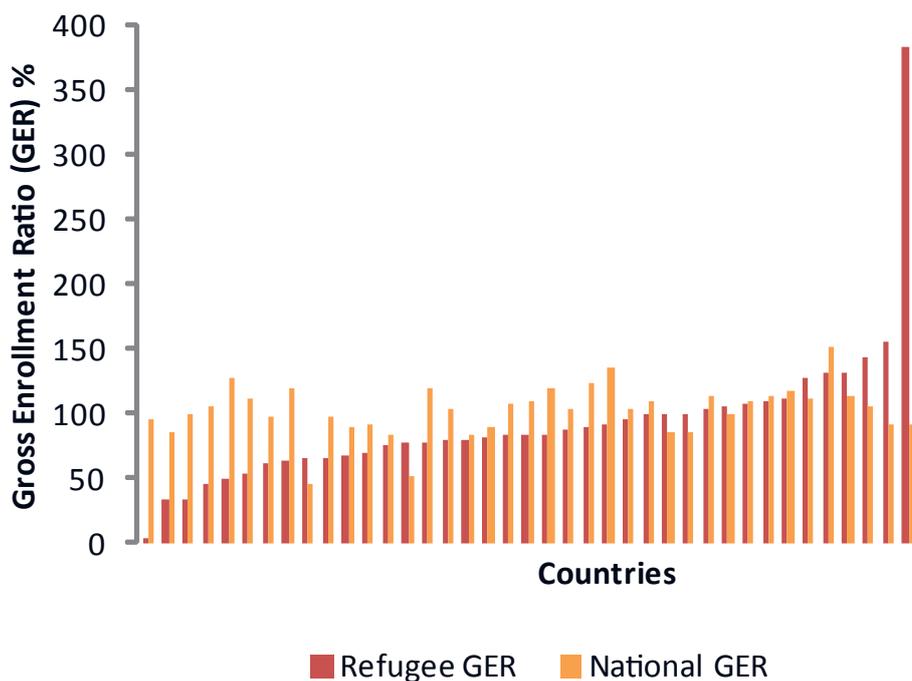


Figure 3.2a. 2008 Gross Enrolment Ratios (GER) for refugees and nationals in 39 refugee-hosting countries. Source: (UNESCO, 2011; UNHCR, 2008c).

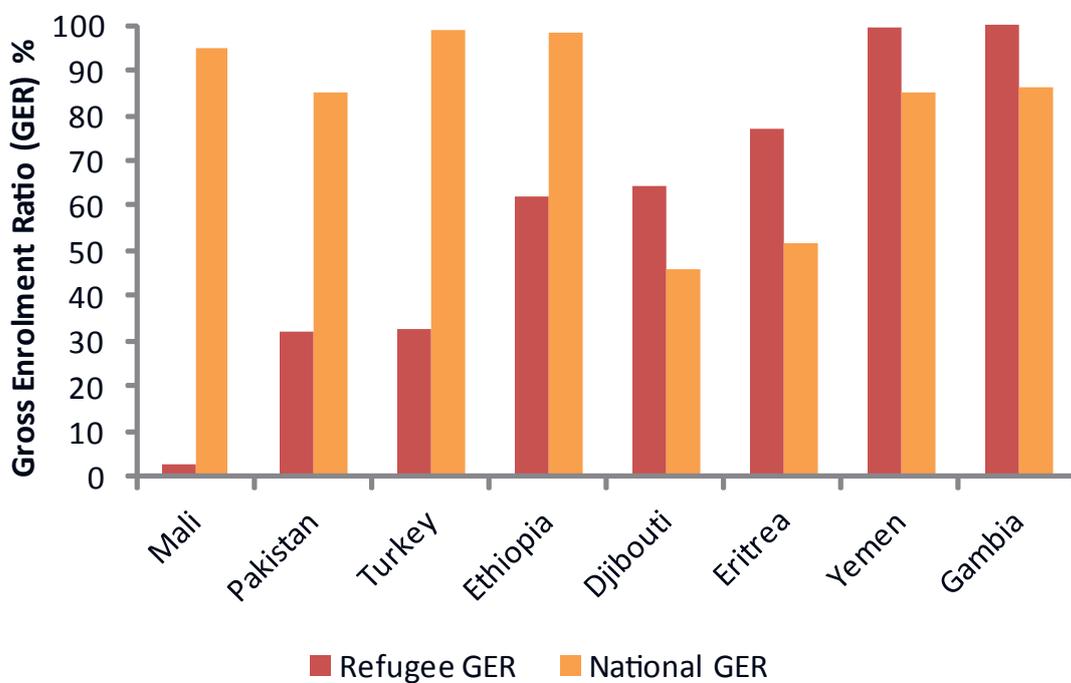


Figure 3.2b. 2008 Gross Enrolment Ratios (GER) for refugees and nationals in select refugee-hosting countries. Source: (UNESCO, 2011; UNHCR, 2008c).

Access to primary and secondary education is determined by many factors¹:

- *supply*, such as the nature and diversity of accessible schools, the location of formal schools, and the availability of sufficient classrooms and teachers;
- *demand*, such as social perceptions of schools, decision-making and strategies for school enrolment and attendance based on the direct and indirect cost of schools, and the role of children in households and family livelihoods;
- *exclusion along individual characteristics*, such as gender, age, social and economic position of the family, urban/rural residence, displacement, ethnicity/race, language, disability, and documentation/legal status;
- *discrimination in policies and practices*, such as certification and recognition of studies;
- *refugee governance*, such as asylum and settlement policies, and how the right to education is protected by law and in policy and practice;
- *security situation*, such as the physical destruction of educational infrastructure and the pervasive nature of violence and insecurity for children both inside and outside of schools.

These factors related to school access play out differently in different contexts, such that the global averages for refugee school participation mask large differences between camp and urban settings, across regions, between operations in the same national context, and by gender. Collecting reliable data on refugee enrolment rates is a difficult endeavour. Available data provide a general picture of these disaggregated school participation rates; however, numerous methodological problems in data collection mean that they must be interpreted with caution (see Box 3.3).

Nevertheless, several factors affecting access can be identified. Access to education is generally more difficult in urban areas. Globally, the primary school GER in camp settings is 78%, whereas it is 70% in urban areas. At the secondary level, the GER in camps is 37% and in urban areas it is 31% (see Figure 3.3). In countries where there are both urban and camp-based operations, the discrepancies between settings are often greater than these global averages suggest. In Central African Republic (CAR), for example, primary school enrolment is 96% in camps but 65% in urban settings, and in Uganda primary school enrolment is 73% in camps and 23% in the urban area. In Yemen, however, enrolment rates in the urban area are greater (93%) than in the camps (72%) (see Figure 3.4). In countries with both urban and camp-based operations, secondary school participation, on the other hand, can be higher in urban areas. While data are limited, secondary school enrolment in Kenya is 52% in urban areas but only 20% in camps (UNHCR, 2009d, 2009e, 2009f).

Access to education depends on regional differences. Striking is the variation between regions, especially in urban areas, where primary school GERs range from 46% across much of Africa to 90% in the Middle East and Northern Africa. At the secondary level, regional variation in camp settings is stark, with school participation at only 20% in Eastern and the Horn of Africa and at 86% in Western Africa. Urban secondary school GERs vary widely as well, with only 2% in Eastern and the Horn of Africa, 10% in Asia and the Pacific, and up to 47% in the Middle East and Northern Africa (see Figure 3.3).

¹ There is a wide body of literature on the factors associated with access to primary and secondary school, including on-going work by the Consortium for Research on Educational Access, Transitions and Equity (<http://www.create-rpc.org/>). The cutting edge of literature on access barriers is synthesised each year in the EFA Global Monitoring Report (UNESCO, 2011, pp. 40-64). For a review of the barriers to access in conflict-affected and displacement settings, see Dryden-Peterson, 2010.

Box 3.3. Limited data result in guessing games for policy and programmes

Collecting school enrolment data for refugees is difficult, and there is lack of capacity within UNHCR in the management of education data. This lack of reliable data can reduce forming policy and developing programmes for refugee education to a guessing game.

For example, primary school GERs in camps in Western Africa are reported at 120%. The cause of anomalies such as this one is unknown but is likely due to some combination of factors, including the following (see also, UNHCR, 2010e, p. 43):

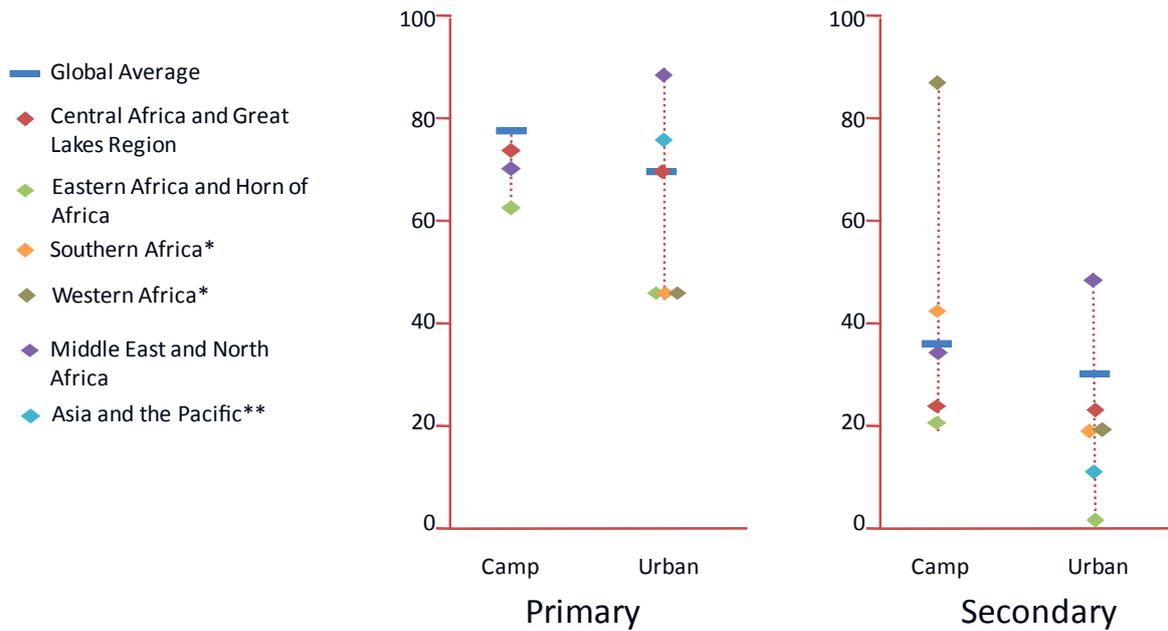
- refugee and national children often attend school together, and national children may be included in the number of children attending classes but not in the refugee population size
- there are over-aged children captured in the school attendance numbers due to high rates of repetition as well as interrupted education or new educational opportunities, but not included in the population of interest
- there are situations in which the calendar year does not mirror the academic year
- many children do not have birth certificates and their age is not known precisely
- teachers may distort school records to get more resources
- population data may be inaccurate
- on-going mobility of refugee families makes it difficult to count children in school accurately with static census-taking.

Despite the general picture of educational access that available data provide, these types of information gaps can lead to unreliable data. Interpretations must be formed with caution.

Further, the lack of institutional memory and inaccessibility of archives at both UNHCR Headquarters and country offices necessitate long learning processes that are counterproductive to continuous improvement of refugee education, especially for a field in which staff turnover is frequent.

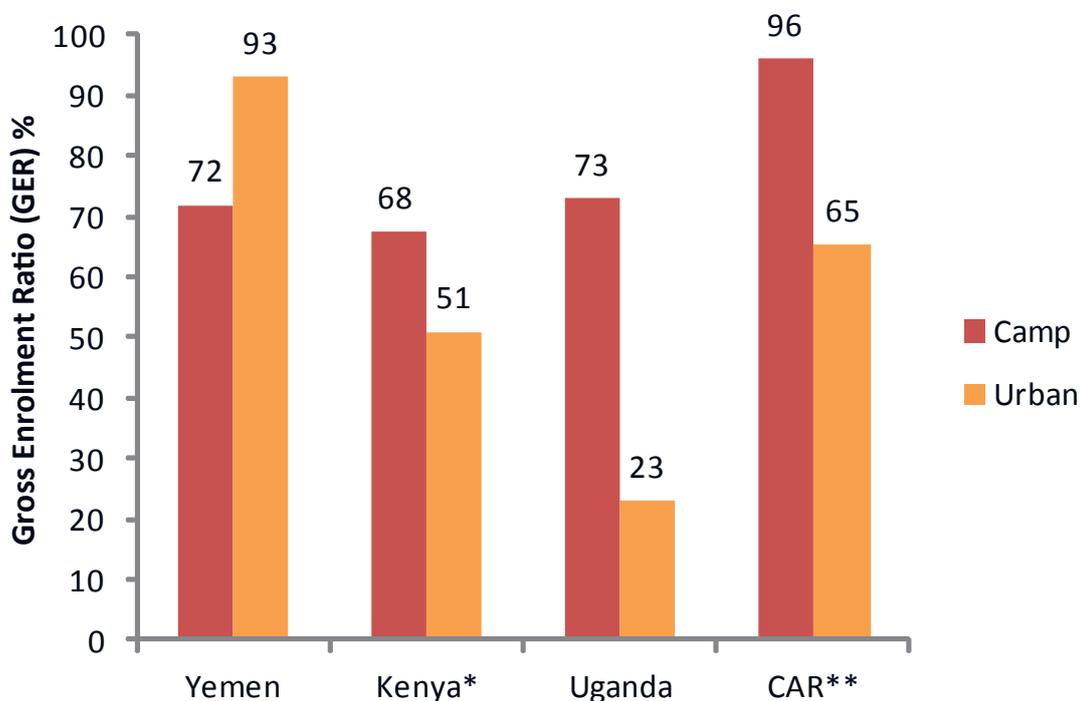
Access to education varies by the local context of the operation, even within the same country. In Kenya, for example, in 2009, primary school GERs were 51% in Nairobi, 56% in Dadaab camps, and 79% in Kakuma camp. At secondary level, GERs in Nairobi were 52%, in Dadaab camps 21% and Kakuma camp 19% (UNHCR, 2009d, 2009e, 2009f). National averages obscure even wider discrepancies in Pakistan, where some camps have gross enrolment ratios of 0% and others have GERs over 80%.² Similarly, in Chad, several camps have GERs of just under 40% and others over 100% (UNESCO, 2011, p. 155).

² These statistics may be obscured by the number of children enrolled in informal schools and madrasas.



* Primary camp enrolment rates in Southern and Western Africa are greater than 100% (see Box 3.3).
 ** Camp data for Asia and the Pacific are excluded due to lack of data for Pakistan.

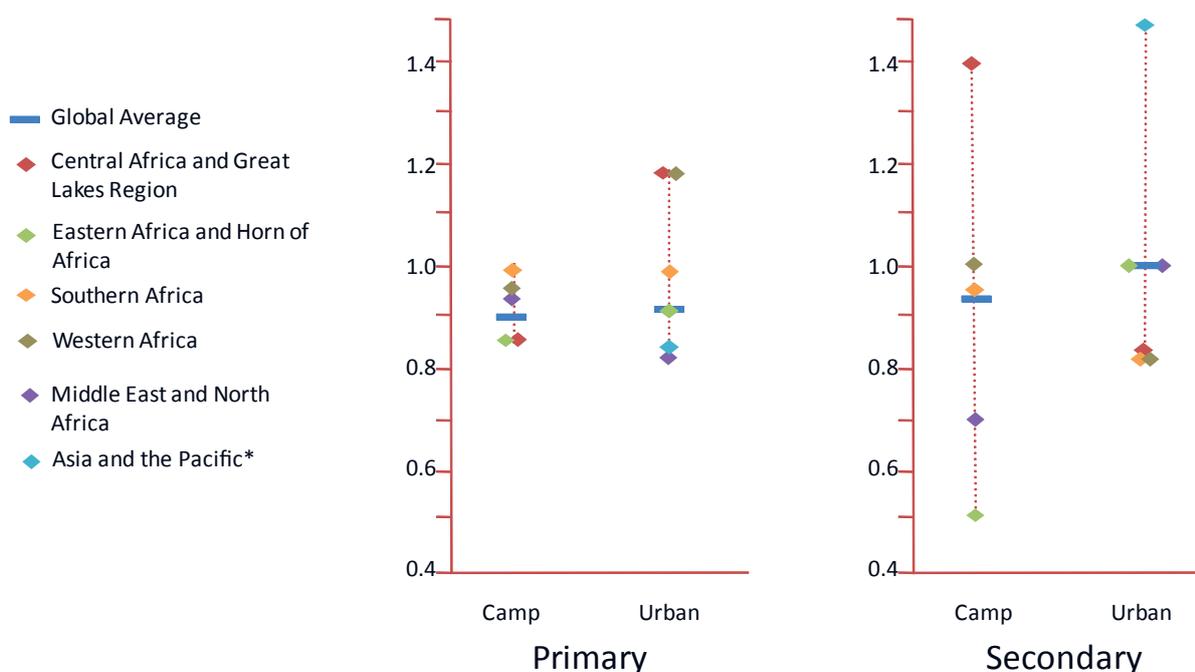
Figure 3.3. Primary and secondary school Gross Enrolment Ratios (GER) vary across regions and by camp vs. urban setting. Source for data: (UNHCR, 2010e).



* Camp participation rate is an average of Kakuma and Dadaab camps.
 ** Data from 2008

Figure 3.4. Primary school GERs (2009) in camp and urban settings within the same country operation. Sources: (UNHCR, 2008c, 2009j).

Access to education is more difficult for girls than for boys in most settings globally, with nine girls enrolled for every ten boys at primary levels in both camp and urban settings (see Figure 3.5). Gender gaps vary between regions, particularly in urban areas. Girls have less access to school in urban areas of Asia, the Middle East, and North Africa. In Southern and Western Africa, girls have greater access than boys. At secondary levels, the global average suggests near gender parity in access to school. However, this average masks massive disparities between regions. In camp settings in Eastern and the Horn of Africa, only five girls are enrolled for every 10 boys. On the other hand, in camps in Central Africa and the Great Lakes Region, 14 girls are enrolled for every 10 boys. There are similar regional differences for urban populations.



* Camp data for Asia and the Pacific are excluded due to lack of data for Pakistan.

Figure 3.5. Gender Parity Index (GPI) varies across regions and by camp vs. urban setting. Source for data: (UNHCR, 2010e).

There are two particularly urgent challenges in need of attention in order to address educational access for refugees in camps and urban areas, across regions, between operations in the same national context, and by gender. They will be explored in Section Four:

- Challenge #1: Urban refugee education requires an approach different from strategies used in camp-based settings.
- Challenge #2: Limited access to post-primary education for refugees in both camp and urban settings has immense economic and social consequences, for both individuals and societies.

■ Quality is defined and measured by ineffective standards

The quality of education involves the teaching and learning that takes place once children are enrolled in and in attendance at school. The Education Strategy 2010-2012 identifies quality as being “at the heart of education” and defines a quality education as one that “satisfies basic learning needs and enriches the lives of learners and their overall experience of living” (UNHCR, 2009c, p. 22).

The Education Strategy outlines three standards by which to measure the quality of refugee education. First is the number of students per teacher. The goal is 40:1 (UNHCR, 2009c, p. 22), however, 14 of the 26 reporting camp operations have average ratios above this level. The global range was wide in 2009, from a low of 18 students per teacher in Ghana to a high of 70 in Pakistan’s Northwest Frontier Province (NWFP). Reported data also mask common situations in which class sizes in lower primary school are very high and class sizes in upper primary are much lower. This standard is not measured in urban settings. Among the priority countries,³ the range was also wide in 2009, from 19 in Algeria to 68 in Bangladesh (see Figure 3.6).

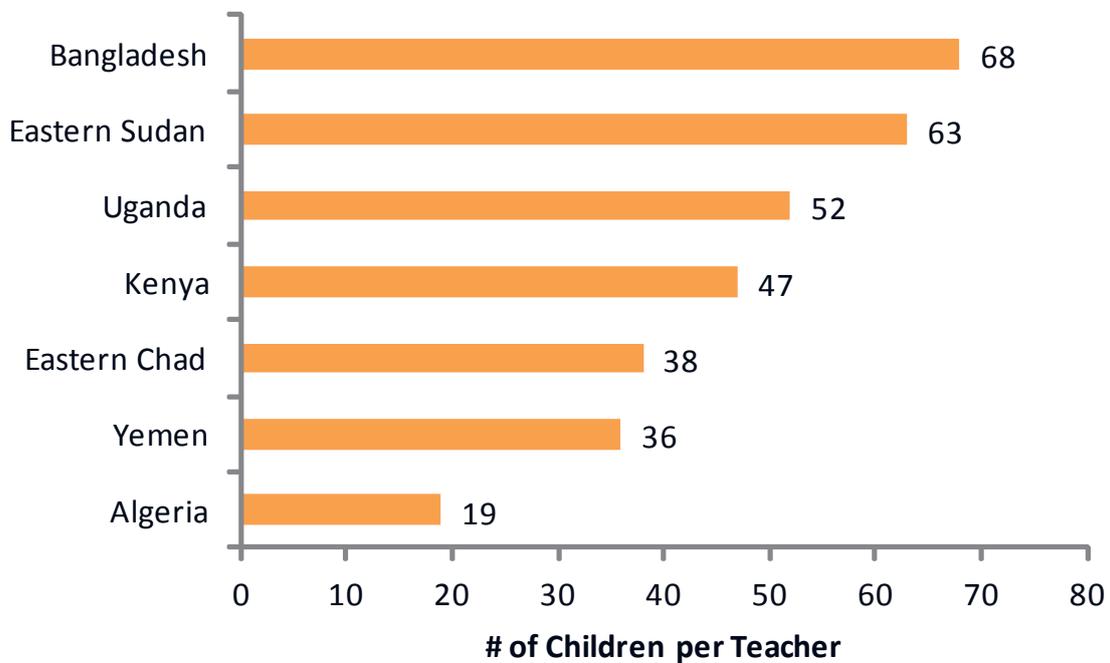
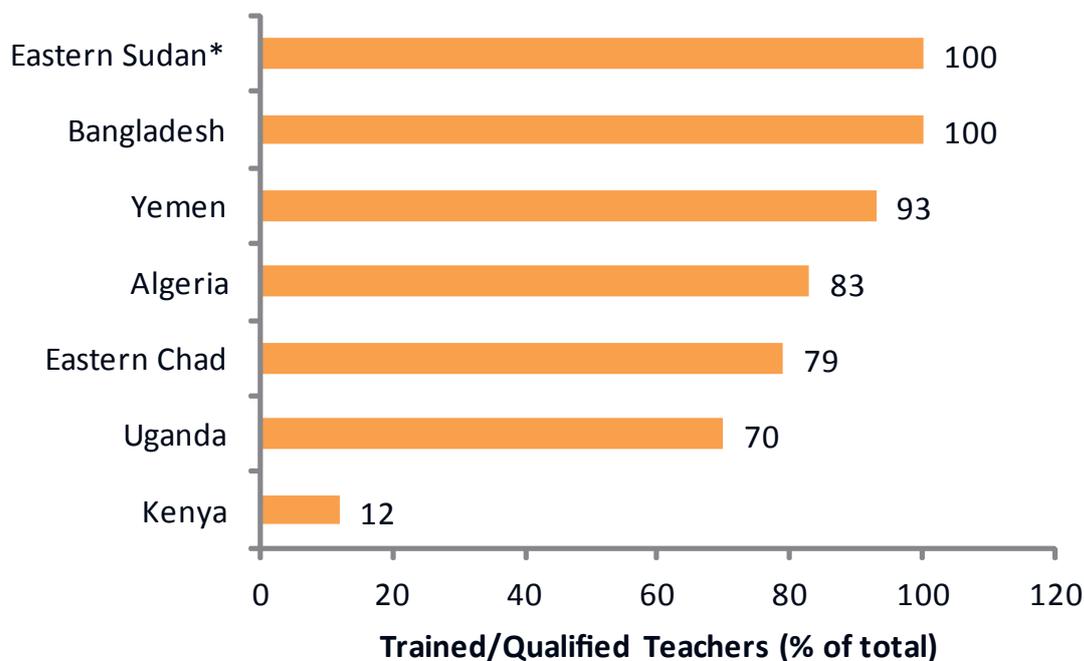


Figure 3.6. Number of students per teacher in camps in priority countries, 2009.
Source: (UNHCR, 2009j).

The second standard is the percentage of qualified or trained teachers, with a goal of more than 80% of the total qualified or trained. To be counted as trained, the minimum requirement is (only) 10 days of training (UNHCR, 2009c, p. 23), far below what would be reasonable for prolonged refugee situations or what is needed to prepare teachers to inculcate sustainable literacy and numeracy in rural students

³ The UNHCR Education Unit has piloted a strategy of identifying priority countries in order to target limited available resources, both financial and human, with the aim of demonstrating ‘what it takes’ to increase enrolment rates. The priority countries were selected in a consultative process with the Bureaux and Country Offices based on certain criteria: performance of the UNHCR standards and indicators; size and phase of the operations; office capacity and resources; accessibility and humanitarian space (UNHCR, 2009c, p. 37). For further discussion of priority countries, see the section of this review on Challenge #6: Lack of financial resources, and their inconsistency, as well as shortage of educational expertise may limit progress in refugee education.

from poor and often illiterate homes. The global range on this standard was again wide in 2009, from a low of zero qualified or trained in Djibouti to 100% in several countries, including Bangladesh, Eastern Sudan, Benin, Congo (data from 2007), Eritrea, Mozambique, and Pakistan’s NWFP. This standard is not measured in urban settings. Among the priority countries, the range was also wide in 2009, from 12% of the total number of teachers qualified or trained in Kenya to 100% in Eastern Sudan and Bangladesh (see Figure 3.7). Given the very limited provision or near total absence of textbooks and other teaching resources in many refugee schools, these figures are especially troubling.



* Given that teachers often go for extended periods of time without being paid by the government, UNHCR and Implementing Partners (IPs) organise additional trainings through which teachers can be paid and encouraged to remain in their posts.

Figure 3.7. Number of qualified or trained teachers as a percentage of the total, in camps in priority countries, 2009. Source: (UNHCR, 2009j).

The third standard is the extent to which refugee/returnee qualifications are recognised. In 2010, school diplomas and certificates from the country of origin were not recognised in 17 host countries (UNHCR, 2011b). Data on the recognition of diplomas and certificates obtained in exile upon return are not available. However, an extensive study of certification issues for refugees and IDPs by UNESCO International Institute for Educational Planning (IIEP) provides a broad view of the ways in which education pursued by refugees can be recognised, as well as the major challenges to recognition in most situations (see, Kirk, 2009). The main forms include cross-border examinations through which Southern Sudanese students living in Uganda, for example, have access to examinations from their home country; host country examinations through which refugees from Somalia, for example, access the national examinations in Kenya, their country of exile; and local certification boards such as the Inter-Regional Examinations Board initiated by Burundian and Congolese refugee educators in Tanzania in 2000 (Kirk, 2009, p. 46).

The main targets for quality in refugee education, as indicated in these three standards, are expressed in terms of service delivery and not in terms of outcomes, primarily student achievement. This is not incongruent with realities in the broader field of education, where the Millennium Development Goals for education are also expressed in terms of service delivery, stating “achieve universal primary education,” instead of in terms of outcome, stating rather something like, “reduce by two-thirds the number of children who cannot read fluently at age 12” (Chabbott, 2007, p. 72).

In recent years, the inadequacy of the service delivery model in terms of learning outcomes has become apparent in developing country settings generally. Major donor agencies have participated in the development and implementation of independent early grades testing of reading and arithmetic learning outcomes, notably the Early Grade Reading Assessment (EGRA) and the Early Grade Math Assessment (EGMA). The results are bleak and clear: even in non-emergency situations, many children fail to learn basic reading or arithmetic, or to show comprehension of written texts, despite regular school attendance. For example, among national, non-refugee students in Mali, 94% of children attending schools where French was the language of instruction were unable to read even a single word of French text, and 83% of children receiving instruction in Bamanankan could not read a single word in that language (Gove & Cvelich, 2011, p. 12).

These results have created nothing short of a revolution in thinking about the way in which educational assistance is delivered, particularly vis-à-vis the need for independent testing that focuses not on inputs but on learning outcomes. They present a critical challenge for UNHCR. Indeed, while data on learning outcomes for refugees are limited, the results are similarly low. One study, undertaken by the International Rescue Committee (IRC) in 2010, used the EGRA in two Eritrean refugee camps in Ethiopia. The study found that in both Kunama and Tigrigna the proportion of children with zero reading fluency in grade 2 was high, 38% among Tigrigna-speakers and 25% among Kunama-speakers; further, the number of children with benchmark scores was zero in both languages. By grade 4, only 5% of Kunama-speakers and 2% of Tigrigna-speakers had reached benchmark fluency (Anastacio, 2011; IRC, 2011).

By most metrics, low quality in refugee education is not a new phenomenon. Angolan refugees in Zaire in the mid-1980s did not find what they were learning in school sufficiently motivating and showed high absenteeism and drop-out rates; Guatemalan refugees in Mexico did not develop the necessary skills to compete for jobs or to facilitate self-employment and self-support (Kassay, 1987, as cited in Retamal, Forthcoming, p.18-19). The retention rate of Afghan refugees in Pakistan after five years of schooling was 18-26% between 1985 and 1989, despite a large education budget of US\$6,250,000, or US\$56 per student per year (Retamal, Forthcoming, p. 40).

In 1999, two Guinean teenagers were found dead in the landing gear of an airplane that had flown from Conakry to Brussels. With them, they had a letter that they had addressed to the ‘Excellencies and officials of Europe.’ In this letter, they wrote: “[w]e have schools, but we lack education.” This is a clear articulation of the necessity of not only the “hardware” of schools but the “software” of a high quality education. And yet the UNHCR Education Strategy 2010-2012 states that “[t]he need for quality services is beyond UNHCR’s existing capacity” (UNHCR, 2009c, p. 28).

In what ways can UNHCR address the need for quality in refugee education? There are two particularly urgent challenges that will be explored in this regard in Section Four:

- Challenge #3: There is a shortage of quality teachers and lack of structures, including remuneration and training, to retain them.
- Challenge #4: The quality of refugee education, and how it is recognised, does not help children to make connections between schooling and their future livelihoods.

■ Education is protective but only if it is of high quality

The protection role of education involves the ability of schools to provide a safe and secure space that promotes the well-being of learners, teachers, and other education personnel. The Education Strategy points out that, “[c]ontrary to expectation, schools are not always safe places for children” (UNHCR, 2009c, p. 24). Schools can be spaces of bullying; racial, ethnic, linguistic, and gender discrimination; sexual exploitation; natural and environmental hazards; corporal punishment; and attacks, including abduction and recruitment into armed forces. The UNHCR Executive Committee identified that “[c]ore protective factors in schools include adequate teacher/student ratios; elimination of humiliation, bullying and corporal punishment; and safeguards against sexual abuse and exploitation” (Executive Committee of the High Commissioner’s Programme, 2006, p. 6).

UNHCR uses four standards to measure the protective environment of schools: the percentage of students with specific needs attending Grades 1-6; the number of female teachers as a percentage of all teachers; the number of refugee teachers as a percentage of all teachers; and the presence of a School Management Committee (SMC). These standards are systematically reported on only in camps and not in urban settings.

These currently used measures of protection capture service delivery and not the protection outcomes of education. For example, in places where there are female teachers or classroom assistants, there is evidence that they can play a significant role in preventing violence against girls (Kirk, 2003; Kirk & Winthrop, 2006). However, their presence is usually not enough to be protective, especially in situations where they too face marginalisation or oppression based on gender dynamics (Kirk, 2005, p. 77). At issue is the quality of the teachers and their abilities to shape the contexts in which they work, which are not captured in UNHCR data. Notes such as “[s]tudents going to school face violence or bullying” are included in reports on education operations (e.g., UNHCR, 2009i), but these data are not systematically collected nor shared. Without measuring the extent of violence in schools, the impact of female teachers, refugee teachers, or SMCs on protection for refugee children cannot be gauged.

Data that are available on these problematic measures show uneven performance across operations. First, the percentage of students with specific needs attending Grades 1-6 measures the extent to which children with specific needs, including those with disabilities and those who are heads of household (UNHCR, 2009c, p. 27), have education available to them as a tool for protection. UNHCR reports that the inclusion of children with specific needs ranges from 3% in Burundi to 100% in several operations, including camps in Ghana, Liberia, Malawi, and Zimbabwe and in urban settings in Uganda, Senegal, India, and Costa Rica. However, as many children with disabilities are kept hidden and out of sight, reliable data are difficult to obtain (Bines, 2007, p. 12; Fast Track Initiative Secretariat, 2009, p. 5).

Second, the presence of female teachers can play a role in creating a secure environment for girls (Kirk, 2003; Kirk & Winthrop, 2006). The proportion of female teachers as a percentage of all teachers ranges from a low of 8% in Ethiopia to a high of 88% in Algeria. Data are only available for camps. Among priority countries, the range is also wide, with Eastern Chad, Kenya, and Yemen at or below 20% and only Eastern Sudan and Algeria above 50% (see Figure 3.8). The data do not differentiate between primary and secondary school and therefore obscure the frequent high proportion of female teachers in early primary school and the dearth of female teachers in secondary school, and the protection concerns related to this situation. Further, there are no UNHCR data available on the effectiveness of higher proportions of female teachers in protecting children.

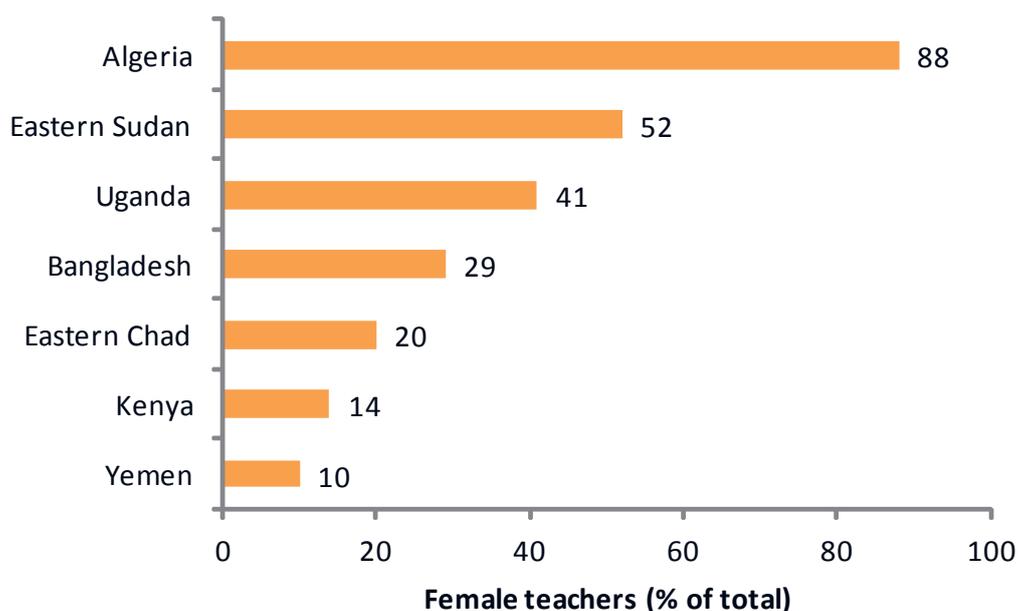


Figure 3.8. Female teachers as a percentage of the total number of teachers in camps in priority countries, 2009. Source: (UNHCR, 2009j).

The third standard to measure protection is based on an unproven assumption that the number of refugee teachers as a percentage of all teachers can play a role in protecting refugee children who may face discrimination on the basis of language, ethnicity, age, and other factors. The proportion ranges from a low of 8% in Zimbabwe to a high of 100% in several operations, including Thailand, Tanzania, Nepal, Namibia, Eritrea, and Algeria. The range is similarly wide in priority countries. Refugee teachers make up one quarter of the teaching force in Uganda and Eastern Sudan, where refugee children attend national schools; they make up over 87% of the teaching force in Kenya, Eastern Chad, and Algeria, some of the most protracted refugee situations globally (see Figure 3.9).

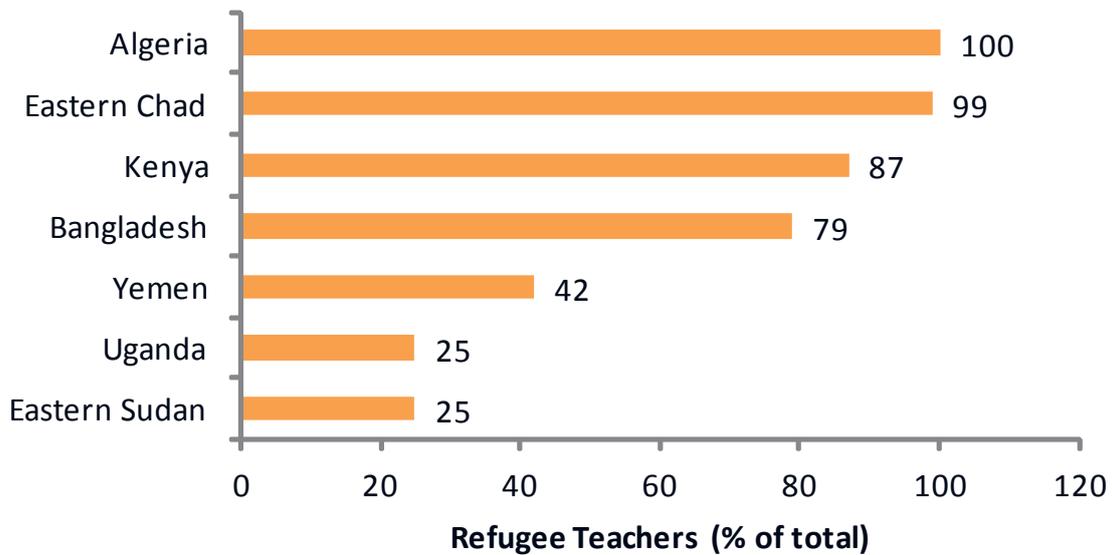


Figure 3.9. Refugee teachers as a percentage of the total number of teachers in camps in priority countries, 2009. Source: (UNHCR, 2009j).

Fourth, the presence of a SMC may have protective effects for refugee children through participatory and community-based supervision and monitoring of school staff, the drafting and enforcing of Codes of Conduct, and oversight of the budget and operating procedures; these effects, however, are unproven. In most operations for which there are data, there is a high if not universal reported presence of SMC. There are, however, no data systematically collected on what these SMCs do and what the specific protection dividends are.

The UNHCR Education Strategy, 2010-2012 as well as numerous protection documents such as the 2002 *Agenda for Protection* and the 2005 *Measuring Protection by Numbers*, conceptualise education as a space to achieve protection objectives that are not linked to the core mission of schools: teaching and learning (UNHCR, 2003a, 2006, p. 23). The 2010-2011 Global Appeal references education vis-à-vis protection only in relation to gender equality, sexual and gender-based violence (SGBV), and the security of older, at-risk learners (UNHCR, 2011e, pp. 31, 32, 33).

Education can be a tool related to these elements of UNHCR’s broad protection mandate for physical security. Unmeasured, however, are the ways in which education can provide other forms of protection, related to psychological and emotional well-being, sometimes called “psychosocial protection,” and to learning, sometimes called “cognitive protection” (Nicolai & Triplehorn, 2003).

Education can provide protection, but only when schools are physically safe, psychologically and emotionally healing, and cognitively transformative (see Boothby, 2008; Nicolai & Triplehorn, 2003). Protection is related to access, in that children will choose not to attend school or will drop out if they experience or perceive a lack of safety and security on any or all of these dimensions. It is also related to quality for only high quality education that physically, psychologically, and cognitively heals can be considered a tool of protection.

How can education for refugee children be protective, physically, psychosocially, and cognitively? This question is closely linked to Challenges #1 through #4, above, related to access and quality. There is one additional relevant and urgent protection challenge, relating to the inherently political nature of education, that will be explored in Section Four:

- Challenge #5: The inherently political nature of the content and structures of refugee education can exacerbate societal conflict, alienate individual children, and lead to education that is neither of high quality nor protective.

■ Refugee education faces large institutional, resource, and coordination constraints

UNHCR priorities for refugee education are to increase access, improve quality, and enhance protection. The challenges to these endeavours, outlined above, are situated within certain constraints, particularly related to institutional support and availability of resources.

The Education Unit at UNHCR Headquarters is shockingly small. It includes one Senior Education Officer (P4) for overall coordination, policy advice, and technical support to Field Offices; one DAFI Education Officer (P3), now called a Tertiary Education Officer, for management of UNHCR's main higher education scholarship scheme; and one DAFI Education Assistant (G6), the latter two supported by external ear-marked funding (see Figure 3.10). There is frequently, although not always, an Associate Education Officer (P2) position, occupied by a Junior Professional Officer (JPO). Until 2010, the Senior Education Officer was a rotated position within UNHCR; it is now held by an education specialist.

At the regional and country level, there have been no Education Officer posts since 2005, until one Associate Education Officer post (P2) was created in Chad in 2011. The education "focal points" in each regional or country office are usually Community Services Officers, Protection Officers, or Programme Assistants. At times, United Nations Volunteers (UNVs) take on responsibility for the education programmes. Under the 1994 agreement, the NRC provides Education Officers on short-term deployments of between three and 12 months; in 2010, there were nine such deployments. As of 2011, agreements have been made for similar deployments through Irish Aid and Save the Children.

Over 200 national and international IPs, under contract with UNHCR, deliver education programmes at the field level. Responses to the survey for this review indicate that there is wide discrepancy in the quality of services provided by these IPs, some bringing proven field experience and others not. Particularly problematic is the lack of consistent assessment to identify good partners in education. Even when genuine attempts are made to identify partners with the capacity to implement an education programme, UNHCR staff members often do not know what criteria on which to evaluate potential partners given their own lack of knowledge and experience in education. The monitoring of results by most IPs is focused on enrolment rates, without appropriate attention even to the inadequate metrics of quality currently in place.

There are dramatic consequences of UNHCR not having, or immediately deploying, dedicated education staff when an emergency strikes and of the lack of systematic incorporation of education into UNHCR's emergency response. For example, in Ethiopia, many months after the 2011 Horn of Africa crisis became evident, there was still not one Education Officer, even temporary, to coordinate the education response; and, although inter-agency plans existed, there was no school in the Dollo Ado region, where there were approximately 121,000 refugee children living in four camps (UNHCR, 2011a). In this situation, existing Community Services and Protection staff held responsibility for a large number of areas and could not be expected to focus on coordination and planning for education. Likewise, in Dadaab camp, there were two short-term secondments covering the education programme during this crisis, and no Education Officer. Education was not included in the July 2011 UNHCR appeal for the Horn of Africa.

Headquarters	Regional/country level	Secondments
<ul style="list-style-type: none"> • 1 Senior Education Officer (P4) • 1 DAFI Education Officer (P3) • 1 DAFI Education Assistant (G6) 	<ul style="list-style-type: none"> • 1 Associate Education Officer (P2), Chad (created 2011) • Education “focal points” are usually Community Services Officers, Protection Officers, and Programme Officers 	<ul style="list-style-type: none"> • 9 NRC secondments (2010), on average 6 per year

Figure 3.10. Education Staffing at UNHCR

The UNHCR education budget has increased over the period 2004 to 2012, with a peak of funding at US\$80 million in 2008 (see Figure 3.11). The rise in funding for education closely correlates with the 2003 Iraqi invasion, and particular countries account for much of this increase, notably those hosting Iraqi refugees. In 2008, for example, Jordan accounted for 29% of the total US\$80 million UNHCR education budget, and Syria accounted for 8% (Bulbul, 2008).

Since the introduction of the Comprehensive Needs Assessment (CNA)⁴ in 2010, it is possible to identify the funding gaps in education. In 2010, available funding (US\$75 million) covered 60% of the CNA (US\$126 million); in 2011, available funding (US\$58 million) covered only 39% of the CNA (US\$147 million) and, in 2012, available funding (US\$71 million) is again expected to cover 39% of the CNA (US\$180 million) (UNHCR, 2009c, 2010g, 2011c).

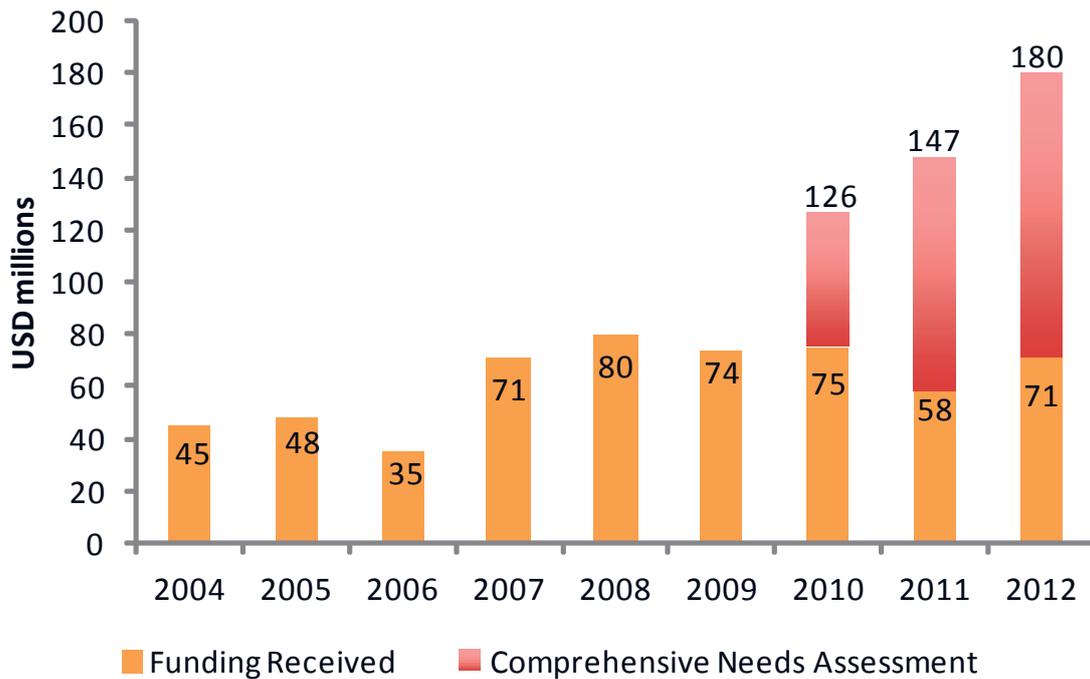


Figure 3.11. UNHCR education budget 2004-2012. Figures for 2010-2012 indicate funding received in relation to needs. Source: (UNHCR, 2009c, 2010g, 2011c).

⁴ The Comprehensive Needs Assessment (CNA) is a country-level process of assessing the needs of persons of concern to UNHCR in an inclusive way in order to design and implement more appropriate responses to those needs. More specifically, it is “a comprehensive analysis of gaps in protection, including assistance, a concise presentation of these unmet needs, agreement among all stakeholders on how to remedy the gaps and the development of proposed programmatic interventions with clear cost implications” (Allen & Rosi, 2010, p. 7).

The global education budget in 2010 represented 4% of the total comprehensive UNHCR budget (UNHCR, 2010g, p. 14), down from 8% in 2008 (UNHCR, 2009c, p. 16). Encouragingly, the 2012 budget anticipates that education will be more of a priority within UNHCR operations, with 13% of the CNA identified in education and the sector funded with an Initial Budget Target (IBT) of 14% (UNHCR, 2011c). As a point of comparison, in low-income Countries, education represents 18% of government expenditure, on average, and in conflict-affected settings, 13% (Save the Children, 2009). While UNHCR is clearly not a national government, the priority placed on education amid other competing sectors is a useful point of reference. A more comparable situation to UNHCR is the United Nations Relief Works Agency for Palestinian Refugees in the Near East (UNRWA), for which education comprised 59% of the total budget in 2008 (UNRWA, 2011, p. 44)(see Figure 3.12).

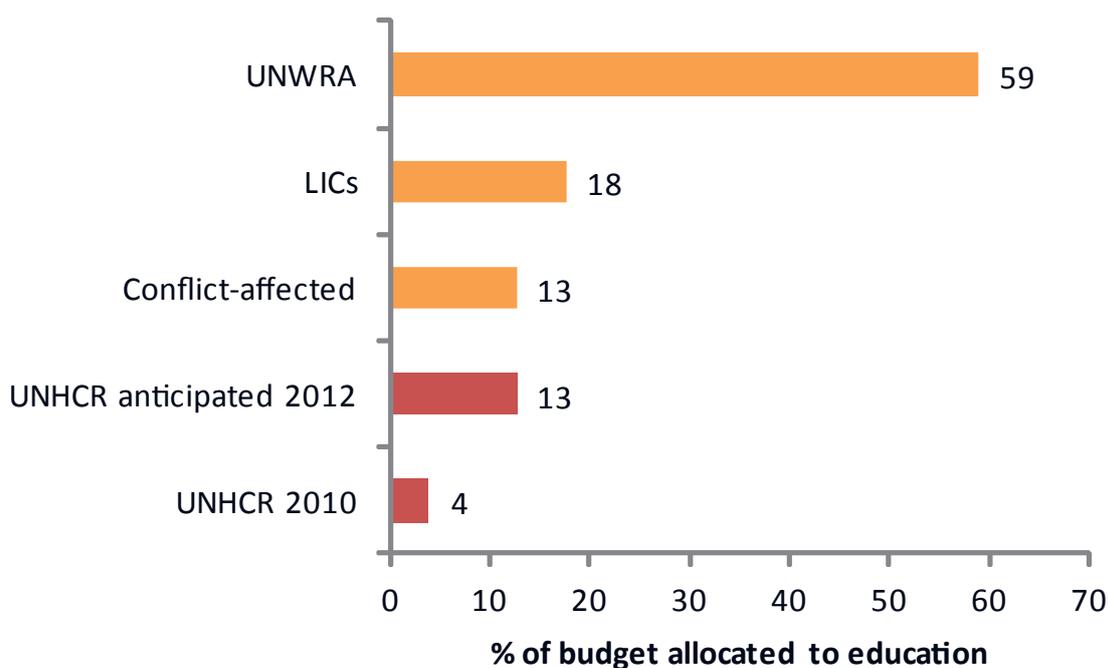


Figure 3.12. 2010 UNHCR budget allocation to education, as a percentage of total budget, in comparison with national budget allocations to education. Source: (Brannelly & Ndaruhutse, 2008, p. 6; Save the Children, 2009; UNHCR, 2010g).

Allocation of the education budget among outputs over time indicates the shifting of priorities in the education sector. Figure 3.13 depicts the 2012 education budget per prioritised output, data to which previous budgets are compared. Several important shifts have occurred between 2010 and 2012 (see Figure 3.14). First, significant resources have been allocated away from primary education and to post-primary activities. In 2010, primary education made up 27% of the comprehensive education budget; it makes up 17% of the budget for 2012. Post-primary activities include tertiary scholarships, vocational scholarships, secondary education, and vocational training, but these data do not include the centrally-managed DAFI higher education programme. These activities made up 20% of the education budget in 2010 and make up 29% of the budget for 2012. Importantly, resources allocated to secondary education in particular have increased from 7% of the budget to 14%, from US\$8.8 million in 2010 to US\$21.1 million in 2012. There are indications from UNHCR staff at Headquarters that this recent change in allocation of funds does indicate a global policy change; however, data over more years would be necessary to observe a true trend.

Second, there appears to be a noted decrease in priority on infrastructure, including the construction of educational facilities and the procurement of school furniture and materials (see Figure 3.14). While 26% of the education budget in 2010 and 27% of the budget in 2011 were allocated to this work, only 16% of the budget is thus allocated for 2012. Again, data over a longer period of time would be necessary to observe a trend in this regard. Finally, there are two areas of focus in the 2012 budget that represent a shift from recent years. Funding to promote girls' education increased 620% between 2011 and 2012, funding to provide early childhood education increased 414%, and funding to establish an education monitoring system increased 150% (UNHCR, 2009i, 2010f, 2011c).

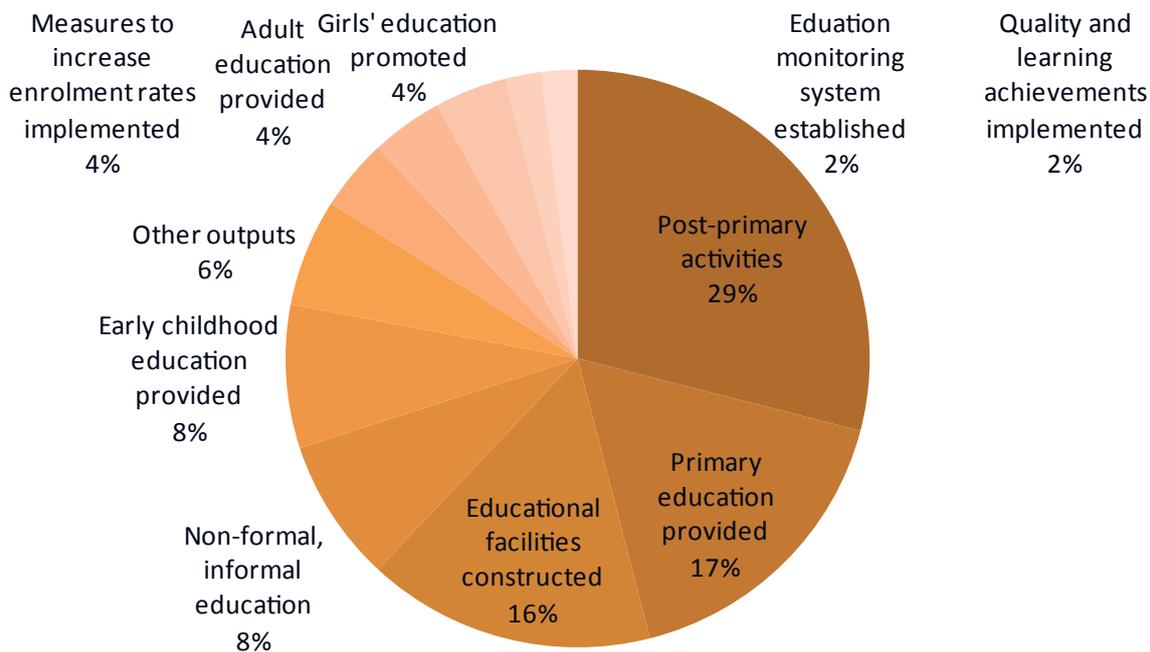
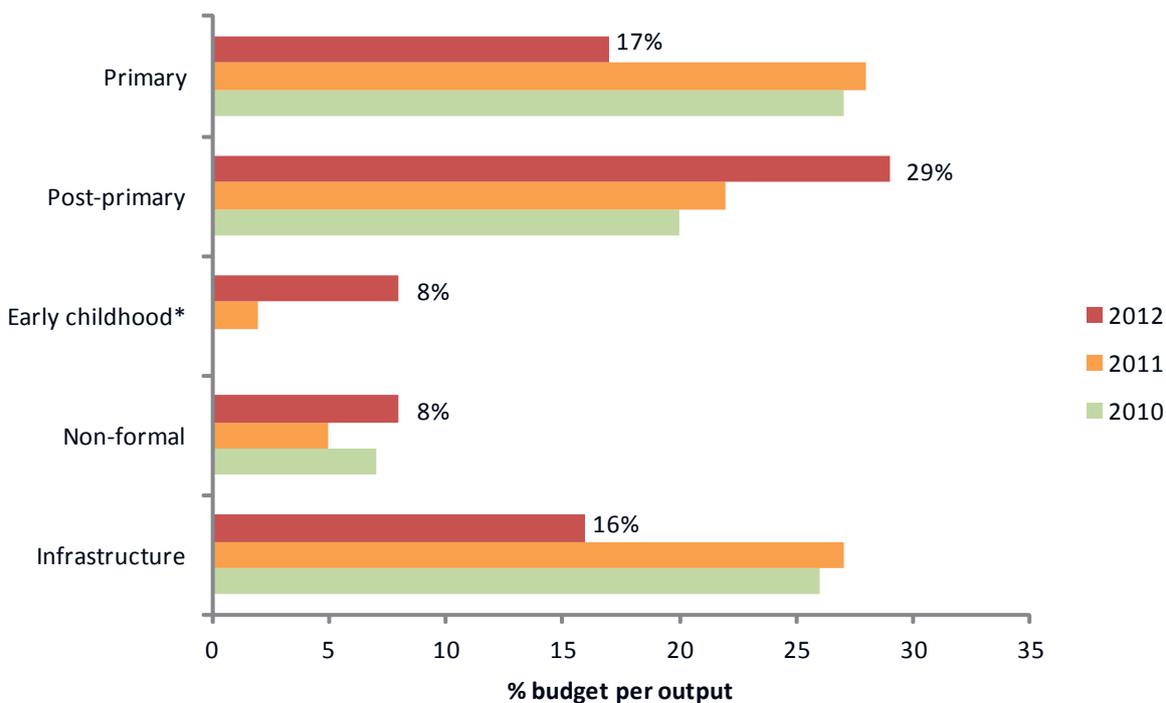


Figure 3.13. UNHCR Education budget as allocated per output, 2012 (UNHCR, 2011c).



*Data for early childhood not available for 2010.

Figure 3.14. UNHCR education budget as allocated per output, 2010-2012, with % indicated for 2012. Source: (UNHCR, 2009l, 2010f, 2011c).

Only 3% of UNHCR’s education budget funds activities in Europe and the Americas (see Figure 3.15). In these regions, access to free education is usually the norm for refugees, and UNHCR staff members generally assume that refugee children and young people are therefore going to school. However, these data are not available: refugee children’s school attendance is not monitored, and neither is their persistence in primary or secondary school. UNHCR offices in Central Europe have recently focused on education as a key element of integration and have identified key barriers to refugees accessing quality education, including lack of opportunity for language learning, uninformed grade placement, and inadequate supports in schools (UNHCR Regional Representation for Central Europe, 2011). Further analysis of these issues is needed in Europe and particularly in Latin America.

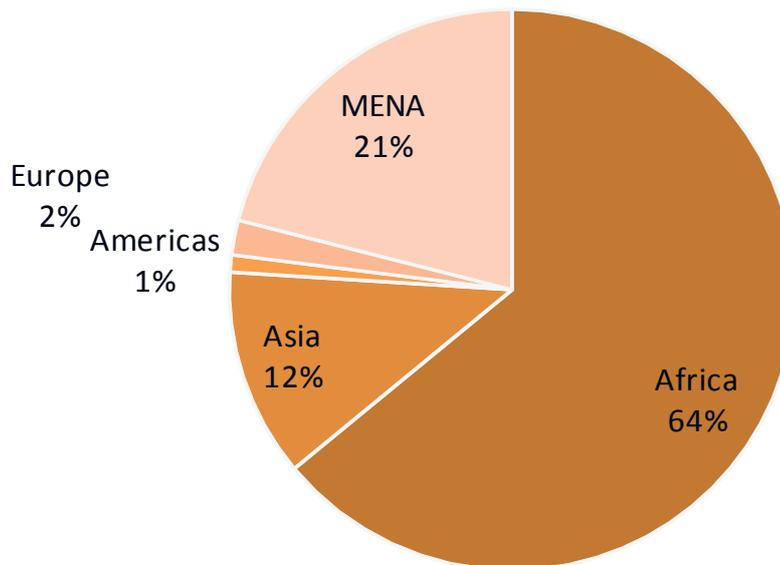


Figure 3.15. UNHCR education budget as allocated per region, 2012. Source: (UNHCR, 2011c).

Given the resource constraints on refugee education, both in terms of staffing and funding, coordination plays a central role for UNHCR’s Education Unit in delivering quality education to refugee children. This coordination is both internal to UNHCR and external.

Internally, the Education Unit has had several institutional homes over the past decade. Until 2010, it was within Operations, first within the Department of Operational Support (DOS) and then within the Division of Programme Support and Management (DPSM). The Unit was then moved to the Division of International Protection (DIP) on January 1, 2010. This move had its origins in the *2002 Agenda for Protection* and subsequent Action Plan approved by the Executive Committee, which emphasised the importance of “education as a tool for protection” (UNHCR, 2002). The documented protective role of education for children in conflict settings has been an effective tool for internal advocacy for the place of education within UNHCR’s core protection mandate, even if the protective outcomes of refugee education are not adequately measured, as described above.

Externally, UNHCR's mandate for refugee education, as it developed historically, is clear. The ability of UNHCR to deliver on this mandate, however, has increasingly come into question. In 2001, Margaret Sinclair wrote:

UNHCR's responsibilities for education cannot be abdicated, as they relate to its field presence. The international community expects UNHCR to be present in almost every location where refugees need protection and assistance, and equips the agency with field offices, field staff, vehicles and communications equipment accordingly. In most of these locations, therefore, it is cost-effective for UNHCR to be the lead agency for emergency educational response (Sinclair, 2001, p. 69).

In the past decade, much has changed in the field of emergency education, with the establishment of the INEE; the development of the *Minimum Standards for Education in Emergencies* (INEE, 2004, 2010b); the inclusion of education as a life-saving response within the IASC and the formation of the Education Cluster (2006); and the increasing rhetorical commitment of donors to education as part of humanitarian responses, even if not actual funding allocations. There has also been the emergence of professional leaders in this field and consolidation of expertise within NGOs such as the International Rescue Committee (IRC), Save the Children, Jesuit Refugee Service (JRS), NRC, and CARE, and within some UN agencies, especially UNICEF. While UNHCR does have a field presence in almost all situations where refugees are in need of education, UNHCR often does not have the educational expertise to mount an appropriate response. Further, UNHCR does not have the capacity to select qualified education Implementing Partners (IPs) nor to develop productive working relationships with national Ministries of Education (MoEs).

The common understanding within UNHCR, at Headquarters and in the field, is that UNHCR has the mandate for refugee education. The 2007 Third Edition to the UNHCR *Handbook for Emergencies* states that "UNHCR does not have the lead role in providing education in the new humanitarian reform" (UNHCR, 2007b, p. 414), meaning for IDPs. Many situations in which UNHCR is involved with education include both refugees and IDPs together. In these situations, there is a great deal of confusion over how to coordinate education responses that meet the needs of both target groups. UNHCR has been a member of the Education Cluster Working Group since its inception, and the Cluster strategic plan (2011-2013) includes joint activities for IDPs and refugees to be undertaken by the Cluster and UNHCR. At the field level, however, the appropriate role for UNHCR within the constellation of actors in refugee education is undefined and often contentious. The visibility, logistical capacity, and field presence of UNHCR writ large raise expectations for the organisation that are often disproportionate to its educational resources and expertise.

What are the impacts on refugee education of these institutional, resource, and coordination constraints and uncertainties? These are two particularly urgent challenges in this regard that will be explored in Section 4:

- Challenge #6: Lack of financial resources, and their inconsistency, as well as a shortage of educational expertise both within UNHCR and among Implementing Partners (IPs), limits progress in refugee education.
- Challenge #7: There are challenges to coordination in refugee education, including complex power dynamics, which limit the productivity of partnerships.



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Refugee education in urban settings requires different strategies than in camps



Urgent Challenges to Refugee Education

- **Challenge #1: Urban refugee education requires an approach different from strategies used in camp settings.**

That almost half of refugees live and seek to access education in urban areas is not a new phenomenon. What is new is the September 2009 UNHCR Policy on Refugee Protection and Solutions in Urban Areas. This policy recognises that education is a basic service to which refugees, no matter where they reside, have a right (UNHCR, 2009m, p. 18).

The 2010-2012 Education Strategy reflects this institutional policy change, away from a sole focus on the educational needs of camp-based refugees. The word 'urban' appears only twice in the 2007-2009 Strategy; in the 2010-2012 Strategy, it appears 51 times (see Figure 4.1).

The new urban policy states that UNHCR will prioritise “ensuring that children receive primary school education” in urban areas (UNHCR, 2009m, p. 19). What does it mean to provide educational services for refugees in urban areas? There are some ways in which educational access, quality, and protection are particularly challenging for refugees in urban areas; and there are some ways in which education for urban refugees is a fundamentally different endeavour than education for camp-based refugees.

The Urban Policy outlines several reasons why the right to education is difficult to realise in urban settings: the cost of schools and already over-stretched education systems serving local populations (UNHCR, 2009m, p. 18). Recent research on refugee education in Nairobi, Kampala, Amman, and Damascus (Dryden-Peterson, 2006a; UNHCR, 2009k) as well as the case study of Kuala Lumpur produced for this review identify further challenges.

Often there are legal and policy barriers for refugees in urban areas, which make access to education more difficult. In some cases, refugees do not have the legal right to live outside of refugee camps or settlements. In other cases, refugees are living in states that have not signed the 1951 Convention and face daily threats of arrest or detention. The case of Kampala demonstrates that removal of these barriers can have great effects on educational access in urban areas (see Box 4.1).

Many of the barriers to accessing education faced by refugee children in camps are exacerbated in urban areas. Financial constraints on refugee families due to legal and policy restrictions combined with high costs of living in cities mean that the direct and indirect costs of schools are even more prohibitive. Further, entering into a national system, refugee children often have less support than in a camp-based school in adjusting to a new curriculum, learning in a new language, accessing psychosocial support, and addressing discrimination, harassment, and bullying from teachers and peers. They may also encounter a lack of familiarity by local school authorities for the processes of admitting refugee children and recognising prior learning.

While some of the challenges of education for urban refugees are different in scope than those faced by camp-based refugees, education for urban refugees is also fundamentally different in critical ways from camp-based approaches. While camp-based approaches sometimes accord with national education policies, the UNHCR *Education Field Guidelines* and the original version of the *INEE Minimum Standards* recommend that education be as closely aligned as possible with the country of origin (INEE, 2004, p. 57; UNHCR, 2003b, p. 11). In urban areas, it is a necessity that refugee education is planned and implemented in collaboration with national and local level education authorities.

Box 4.1. Refugee governance in urban areas impacts school enrolment

Prior to 2006, refugees in Uganda were governed by the 1964 Control of Alien Refugees Act (CARA), under which freedom of movement for refugees was restricted and aid was contingent upon a refugee living in a designated rural settlement. In 2006, primary school enrolment rates were 77% in refugee settlements (UNHCR, 2009g) but very few refugees were able to access schools in Kampala. In 2006, the Ugandan Parliament passed the Refugee Bill, which protected refugees’ right to settle in urban areas. Compounding legal barriers to accessing education in Kampala was UNHCR’s opposition to the provision of services in urban areas on the grounds that these services would act as a pull factor away from the camps and to the city. In 2009, however, UNHCR made a major policy shift in adopting the Policy on Refugee Protection and Solutions in Urban Areas. This new policy paved the way for more widespread provision of assistance in urban areas and included a commitment by UNHCR to ensuring that refugees in urban areas have access to education. School participation rates in Kampala in 2008 were 9% and then jumped to 23% in 2009 (UNHCR, 2008b, 2009h). This evidence does not permit causal claims, and it is possible that what appears to be a change in enrolment rates is in fact simply due to better reporting. However, it is likely that the combination of new legal provisions and policy commitments have impacted refugee children’s access to education in Kampala.

This necessity is articulated in the recently released *Ensuring Access to Quality Education: Operational Guidance on Refugee Protection and Solutions in Urban Areas*, which takes as a main principle that “every effort should be made for urban refugees to participate in mainstream education along with local children and young people, with national authorities managing and coordinating the education response, supported by UNHCR and partners where needed” (UNHCR, 2011d, p. 4). The updated *INEE Minimum Standards* and the *INEE Guidance Notes on Teaching and Learning* reflect the more ambiguous and context-specific needs of urban areas, recommending that it is the *relevance* of curricula, for example, that is primary (INEE, 2010a, p. 1, 2010b, p. 78).

Historically, UNHCR provided scholarships for refugee students to study in government or private schools in urban areas. Yet the number of urban refugees and the demand for education today far outpace this individualised approach to education in urban areas. There are two options in urban areas: the creation of formal/non-formal/informal schools specifically for refugees or, preferably, local integration into public school systems.

Where legal and policy barriers exist to formal schooling for refugees in urban areas, non-formal/informal schools for refugees may be the only option. Such is the case in Malaysia, where there are approximately 90,000 refugees and asylum seekers registered with UNHCR, primarily from Myanmar but also from Somalia, Afghanistan, Iraq, and Sri Lanka. They are considered by the Malaysian government to be “undocumented migrants.” The 13,865 refugee children and young people (ages 5-17) living in Malaysia are unable to access public or private schools. Only 5,134, or about 37%, were attending any form of school at the end of 2010 (Kaun, 2011; Rahman, 2011, p. 36); as a point of comparison, national GER in Malaysia in 2007 was 97% (UNESCO, 2011, p. 305).

Refugee children in Malaysia attend seven NGO-run schools and 53 community-based schools, founded and managed by refugee groups and located mostly in apartments. While most of these schools use the Malaysian national syllabus, there is no formal certification of learning and no recognition of studies by any authority (Nirrengarten, 2010; Rahman, 2011).

Negotiation of access to the national system has been complicated in Malaysia, as in other countries that are not signatories to the 1951 Convention. In some individual cases, informal agreements between families and head teachers allow refugee children to attend public schools in Malaysia (see Box 4.2). In collaboration with UNICEF and its “Reaching the Unreached” campaign, and with the aim of fulfilling Malaysia’s commitment to EFA, UNHCR is working with a research team from the Malaysian Ministry of Education (MoE) to promote the inclusion of refugees in national schools. The 2010 UNHCR Malaysia education budget included US\$9,772 for “advocacy for admission to national education system,” however, this work comprised less than 1% of the total education CNA (UNHCR, 2010b). The high-level advocacy, which forms part of a broader advocacy for other refugee rights including the right to work and freedom of movement, has yet to produce results.

The situation in Amman, Jordan provides an example of how advocacy for access to national education systems can succeed, even in a non-signatory state, where the language of instruction is not a barrier. In the 2006-2007 academic year, approximately 14,000 of the 64,000 displaced Iraqi children in Jordan had access to school (Bulbul, 2008, p. 4). A royal decree in 2007, brought about in part through substantial advocacy by UNHCR and pressure to uphold the 1989 Convention on the Rights of the Child, opened Jordanian schools to Iraqi refugees. As a result, an additional 24,650 Iraqi children seized the opportunity to access school in academic year 2007-2008 (Bulbul, 2008, p. 4; UNHCR, 2009k, p. 37). However, existing school fees as well as fear and mistrust of public institutions continued to make it difficult for many Iraqi children to access education (Bulbul, 2008, p. 11). In 2009 when the European Union funded school fees for all Iraqis in Jordan, some additional 26,890 Iraqi children enrolled in public schools (Bulbul, 2008, p. 12; UNHCR, 2009k).

UNHCR made a commitment to supporting the Jordanian MoE in coping with this influx of students. In 2007-2008, UNHCR collaborated with the MoE to hire and pay salaries for 2,000 additional teachers and rehabilitated 30 classrooms with furniture and equipment (Bulbul, 2008, p. 4). This strategy of engagement with the Jordanian MoE was complemented by continuing support for informal/non-formal education to reach Iraqi children and young people who were unable to access the local system. This was an operation that had sufficient education staff, with a specific education team supervised by a Senior Programme Officer and included education experts from national staff and IPs as well as

Box 4.2. “I was attending a government school until last January... For right now... I’m not able to continue my studies”: The case of a 13-year old Rohingya boy in Malaysia (Rahman, 2011)

Abdul*, age 13 and a member of the Rohingya group, was born in Malaysia. Unlike most refugee children, he had the possibility of attending a governmental school. According to him, this was because he has a Malaysian birth certificate.

However, when he reached Form 1, the first year of secondary school, he was no longer allowed to attend school. His mother explains:

At the time when the former Prime Minister Mahathir was working, our children could study until Standard 6 in government school. We only needed a Malaysian birth certificate. It was possible only for those who were born in Malaysia. Then a new Prime Minister came, they stopped new registration in the school and the ones who were registered could study until the UPSR (Ujian Penilaian Sekolah Rendah) exam at the end of Standard 6. So my second son went until UPSR in a government school, then he couldn’t go anymore.

Abdul lives close to a refugee school. And yet when he could no longer attend the government school, he decided that he would not go to the refugee school either. He explains that his school level was too high:

After that I cannot study there. I come to this school, the UN school, but the teacher says ‘this doesn’t have what we teach at your school. This is only for small children’. So my mother says ‘don’t go’.

Abdul believed that the only possibility for him to continue his studies would be to be resettled to a third country:

I know I’m not allowed to study in Malaysia. So I think it’s better for me if I resettle in another country, then I can continue my studies there, in that country. So this is better for me. For right now, the situation in Malaysia, I’m not able to continue my studies.

* All names have been changed.

a NRC secondment. The operation was also well-funded; at the height of operations in 2007, it had a budget of over US\$12 million.

Funding rapidly decreased for education of Iraqis in Jordan from 2007 to 2010 (see Figure 4.2). However, the numbers of refugee children and young people aged 5-17 remained almost constant: 115,000 in 2007; 120,000 in 2008; 108,000 in 2009; and 120,000 in 2010 (UNHCR, 2008a, 2009a, 2010a).⁵ This lack of resources has left little role for UNHCR vis-à-vis the education of Iraqis in Jordan. As of 2010, all education activities for Iraqis in Jordan have been subsumed under regular UNICEF operations in the country and part of their overall goal of sustainably strengthening the national education system for all children.

⁵ All populations are estimates by the Government of Jordan. Estimate of the 2010 population aged 5-17 is based on the proportion of the total population in previous years.

Recommendation:

In its new work in urban settings, UNHCR should prioritise working with national governments for the integration of refugees into national school systems, building in the new operational guidelines (UNHCR, 2011d). Critical is to conceptualise education work as the strengthening of education systems and not only the achievements of individual refugee children. In this endeavour, both national Ministries of Education and UNICEF are central partners. It will require UNHCR staff with knowledge and experience of national education systems; moreover, time and resources should be dedicated to cultivating institutional and interpersonal relationships to facilitate this work and to ensure that national Ministries of Education take seriously the particular educational needs of refugee children and young people.

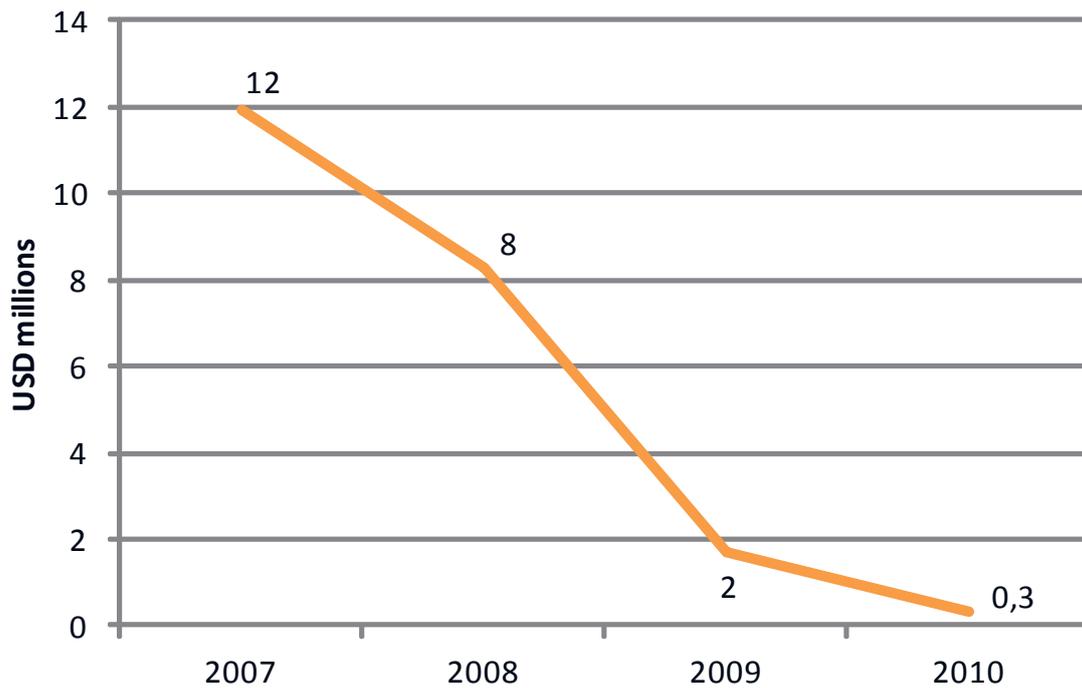


Figure 4.2. Funding to education activities in Jordan, 2007-2010. Source: (Bulbul, 2008; UNHCR, 2008a, 2009a, 2010a, 2010e, p. 29).



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Economic and social returns to secondary education are high, particularly for girls

■ Challenge #2: Limited access to post-primary education for refugees in both camp and urban settings has immense economic and social consequences, for both individuals and societies.

Access to post-primary education is a priority for refugee education at present. This priority is not new in terms of strategy within the UNHCR Education Unit. It has been emphasised as an overall goal, part of the long-term vision, and a component of immediate, reportable targets in both the 2007-2009 and the 2010-2012 Education Strategies (UNHCR, 2007a, 2009c). Further, the 2007 Executive Committee Conclusion on Children at Risk recognised the need to “promote access to post-primary education wherever possible and appropriate” (UNHCR Executive Committee, 2007).

Post-primary opportunities are also central to the EFA goals, specifically Goal 3: “Ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life-skills programs.” Nevertheless, the commonly held perception among some staff at Headquarters and predominantly in the field is that “we work on primary education.” There is great scepticism about investments in post-primary education when primary enrolment is not universal, specifically as post-primary opportunities are more expensive and difficult to coordinate.

Staff at UNHCR, other UN-agencies, and IPs describe how they “play with the words,” advocating for “early secondary” and “basic education and life skills” in lieu of post-primary opportunities. Often advocacy strategies for refugee youth sensationalise the need for education, adopting an overly negative tone and playing on fears that idle and frustrated young people pose security risks and terrorism threats, that they are “homogeneous blocks of potential menace” (Talbot, 2011), and that “[b]eing young, being uneducated, and being without dependents” may make one more likely to engage in political violence (Collier, 2007). Refugee youth must receive post-primary education; but

those advocating for it must avoid demonising those whom they seek to support. UNHCR has largely avoided negative rhetoric and should continue to advocate for refugee youth to receive post-primary education as a core component of UNHCR's responsibilities in fulfilling a right, rather than as a strategy to prevent disaffected youth from engaging in violence.

It remains difficult to secure funding for post-primary education for refugees, yet the tide is turning within UNHCR in terms of action on the challenge. The rhetorical commitment of the Education Strategies (2007-2009 and 2010-2012) is now being reinforced by the allocation of funds to post-primary refugee education, up from 20% of the education budget in 2010 to 29% of the budget in 2012 (see Figure 3.13). Resources allocated to secondary education in particular have doubled, from 7% in 2010 to 14% in 2012.

While encouragingly on the rise, these resources remain limited given that the rationales for post-primary investment are overwhelming. The most recent EFA Global Monitoring Report argues that secondary school is the "cornerstone of education for youth" and that "formal education is the most effective base for developing learning and life skills" (UNESCO, 2011, p. 54). Why is formal secondary school so critical? First, the existence of secondary school opportunities acts as a motivation to enrol in and complete primary school (Chaffin, 2010; Robinson, 2011). Without the possibility to pursue education beyond the primary level, many families and children decide that the investment of family resources in primary education is not justified.

Second, individual economic returns to secondary education are large. Each additional year of formal education on average adds about 10% to an individual's earnings, and secondary education adds 20% for low-income individuals. The rates of return for secondary education are particularly high in sub-Saharan Africa, at 25%, and in non-OECD Asia, at 16% (Psacharopoulos & Patrinos, 2002, pp. 2, 12).

Third, the economic returns to secondary education for societies are critical for the economic reconstruction and development of countries of origin and host countries. While private returns are often inequitably distributed, the economic growth generated by the skills cultivated through secondary education can also have widespread societal benefits. The social returns to secondary education in sub-Saharan Africa, for example, are 18% and to non-OECD Asia are 11% (Psacharopoulos & Patrinos, 2002, p. 12).

Fourth, secondary education affords greater opportunities for civic participation and quality of life and, in these ways, it is protective both for individuals and for societies (IIEP, 2011; INEE Working Group on Education and Fragility, n.d.). These opportunities provide refugees with the ability to think about the future (Winthrop & Kirk, 2008) and to imagine what is possible (Martone & Neighbor, 2006, p. 3; Waters & Leblanc, 2005) (see Box 4.3). Particularly in situations where entry into the labour market is limited for young people, "they need the stimulus and challenge of education to absorb their energies and lessen their frustrations and anxiety about the future" (IIEP, 2006, p. 2). A 17-year old Congolese boy who arrived in 2008 in Kyangwali refugee settlement in Uganda expressed the situation this way:

When we reached here in Kyangwali, life became really hard. Because there is nothing to do: in the morning you wake up, you are moving up and down, like someone who is looking to go somewhere but actually you are not going anywhere (Wettstein, 2011).

Finally, without continued investment in secondary education, the cadres of high quality future teachers for both primary and secondary education are limited, which poses a major challenge to post-conflict reconstruction (Buckland, 2005; Shriberg, 2007). In Southern Sudan, for example, a 2006 survey found that 19% of teachers had not completed primary school and 29% had no education beyond primary. The majority of teachers who had post-primary education were former refugees in neighbouring Uganda and Kenya (Government of Southern Sudan, Ministry of Education, Science and Technology/UNICEF, 2006 in Save the Children, 2008, p. 1). In NGO-run and community-based schools for Chin and Afghan refugees in Kuala Lumpur, Malaysia, one of the key barriers to establishing secondary education for refugees is the poor quality of education received by refugee teachers in their countries of origin and their resulting lack of capacity to teach the Malaysian curriculum (Rahman, 2011).

Box 4.3. Post-primary education gives young people “voice”

Hibist Kassa an Ethiopian refugee living in Ghana and recipient of a DAFI scholarship explains: “What does post-primary education offer a young person? This question means a lot in my life because I know the difference it can make. In most countries in the ‘developing world’, a life is more than a life. It is linked to an extended family and, ultimately, a community of people. Where states fail, these are the support networks people rely on. So why does a young person need to know more than how to read or write? A basic understanding of algebra should be enough, right? To the contrary, this only offers a person with what they need to interact in a very limited way in the social, political and economic life of their respective countries. How does a young person acquire the skills to develop informed opinions or views on the hardship that refugees and IDPs face daily? How does the community find its voice? Education gives a person a voice. Young people want education so that their voices can be heard. Education lays the basis for social and economic freedom to be achieved. As a young person this only means, we want to be free!” (INEE, 2010c, p. 9).

Post-primary education is a cornerstone of the global EFA movement in the lead up to 2015, has been identified as one of the three central strategies in addressing the global crisis of learning that afflicts developing countries (Robinson, 2011), and it is highlighted in the new USAID Education Strategy (USAID, 2011). Yet, for three central reasons, it remains difficult for refugees to access secondary education.

First, acceptable secondary school options are limited in many refugee settings. In some cases, the distances that refugees must travel to national secondary schools are prohibitive. This issue of supply is evident in returnee villages in Mauritania where one secondary school serves young people from approximately 20 surrounding villages as far away as seven kilometres, with few opportunities for boarding closer to the school. In these same settings in Mauritania, the quality of secondary education is also questionable, creating a demand-side barrier to secondary school access. Returned refugees generally felt that the quality of education, particularly secondary education, was higher in Senegal than in Mauritania. Some families therefore chose to pursue cross-border educational strategies, with parents returning to Mauritania and children staying in Senegal to continue their studies (Rezzonico, 2011).

In refugee camps in Chad, there were supply- and demand-side barriers to secondary education. Of particular concern to Darfuri refugees was the lack of opportunities to pursue secondary education that would lead to a recognised diploma. Although UNICEF and the Chadian regional authorities signed primary school certificates, those certificates provided no access to secondary schools in Sudan. A NRC secondment noted that this lack of recognition was discouraging and resulted in learners dropping out prior to the end of primary school, so much so that the last year of primary school ceased to be taught in some camps (Voll, 2009). To address this situation, the Refugee Education Trust (RET), implementing for UNHCR, negotiated with the University of Khartoum in 2006 to allow refugee young people in the camps to pursue a formally recognised secondary education course by distance; in 2009, a Memorandum of Understanding between RET and the Sudanese MoE agreed to official Sudanese recognition of both the primary schools and the first formal secondary schools in the Chadian camps (Mauoubila, Matabaro, & Servas, 2011). This programme serves only a limited number of students, and others return to Sudan seeking further educational opportunities, despite the protection risks posed.

Second, secondary school opportunities can be prohibitively expensive for refugees, both in terms of direct fees and opportunity costs such as the loss of household labour, especially for girls. In Uganda’s Kyangwali refugee settlement, the extent of this barrier of cost is evident in the practice of secondary school students from Democratic Republic of Congo (DRC) returning to primary school in order to sit Primary School Leaving Exams (PLE) that would allow them to qualify for free Universal Secondary Education (Wettstein, 2011).

Third, secondary education is, of course, only accessible to those refugee young people who complete primary school. Girls are at particular disadvantage here, with nine girls enrolled in primary school for every ten boys (see Figure 3.5). For those who do not complete primary school, other options for further education and training are needed.

The *Minimum Standards* advocate attention to the education that each individual learner needs (INEE, 2010b). These needs are defined by the abilities and desires of refugees as well as by available livelihood opportunities. According to Chernor Bah, a former refugee from Sierra Leone and a Women's Refugee Commission youth advisor, "[e]specially in crisis-affected situations, people are looking for skills to survive and while young people value learning and want a good education, we are not excited by education that does not prepare us for the job market" (INEE, 2010c, p. 2).

Alternative schooling mechanisms, such as accelerated learning, are effective though usually expensive policy options for refugee young people who have not had the opportunity to pursue formal education (Charlick, 2005, p. 41; INEE, 2009a, p. 19). For example, the Complementary Rapid Education Programme for Schools (CREPS) in Sierra Leone condensed six primary grades into three years, and the Complementary Opportunities for Primary Education (COPE) Programme in Uganda condensed seven grades into three years (Nicholson, 2006, p. 8). The most effective of these programs use brain-based research on how learning happens and how it can be accelerated. Despite some success, there remain several key challenges to these programmes. The efficacy of these programmes is generally unknown, as the literacy and numeracy skills the graduates are rarely measured. There are also difficulties in providing accreditation, certification, or recognition, and lack of links to formal education (Echessa, n.d.), resulting at times, as in the case of Sierra Leone, in a parallel system that parents perceive as an alternative to primary school.

For some refugees, the relevant post-primary opportunity is secondary school, gaining a recognised educational qualification. Refugees also participate in other forms of education, most notably technical and vocational skills development (TVSD). These opportunities can be post-primary in nature or can target young people who did not have the chance to complete primary school and who are either unable or unwilling to re-enter the formal education system.

Vocational training makes up just over 20% of the 2012 budget for post-primary education (US\$10 million), and there is an additional US\$7 million allocated for vocational scholarships (UNHCR, 2011c); there is slightly less emphasis on this sub-sector than in previous years. Vocational training can be even more expensive per refugee than secondary education, given the extensive infrastructure often required.

TVSD should include both "hard" and "soft" skills, "developed within a 'joined-up,' integrated development and delivery framework that seeks to improve livelihoods, promote inclusion into the world of work and that supports community and individual agency" (Conflict and Education Research Group, 2007, p. 2; see also, Lyby, 2003). This kind of training is varied: in the city of Kuala Lumpur, Malaysia it includes baking and computer classes; in the settlement of Kyangwali, Uganda, there is a tailoring centre; and in the returnee context of Mauritania, there are short (three-week) baking, tailoring, hair-dressing, and mechanics trainings (Rahman, 2011; Rezzonico, 2011; Wettstein, 2011).

An important partnership for UNHCR in vocational training is the Youth Education Pack (YEP) programme of the NRC, a one-year full time programme focused on literacy/numeracy, life skills, and basic vocational skills (NRC, n.d.). The YEP was launched in Dadaab camps and Dadaab town (host community) in October 2007; enrolment rates have been high, with 570 students as of August 2010 and less than a 10% drop-out rate in three of the four sites (Umbima, Koelbel, & Hassan, 2010, pp. 29-30). Importantly, the programme includes a follow-up of students six months after they graduate to assess how the young people are functioning in their work and to offer advice (NRC, n.d.). The most comprehensive evaluation of the success of graduates of the YEP programme in Liberia found that few of the youth trained with YEP could sustain themselves on the income from the new skills they learned in this programme. Part of the problem was that although the skills were relevant to the local economy, the market was over-saturated with YEP graduates and diversification of training was needed (Moberg & Johnson-Demen, 2009). Market constraints are the limiting factor on how many young people can and should be absorbed in TVSD.

As the YEP evaluation underscores, critical to any successful TVSD is market analysis, which is often difficult and time-consuming to complete (Chaffin, 2010). The Women's Refugee Commission has developed a useful toolkit for market assessment (Women's Refugee Commission, 2009a, pp. 304-308), however, in many cases, this kind of analysis is not done in refugee settings, given logistical constraints and the time and budget involved. Moreover, a market analysis cannot create opportunities which simply do not exist on a large scale in low purchasing power communities. "Skill mismatch" results from the tendency to train more students year after year in the same skills, as in the case where plumbers were trained in Liberia. A former child soldier trained as a plumber reflected: "it's not easy to find work in plumbing, you know?... because most of Liberia doesn't have plumbing" (Conflict and Education Research Group, 2007, p. 13). This mismatch between skills, job opportunities, and expectations can lead to false hope, breeding immense frustration among refugee young people, and to recruitment into armies and armed militias when that is seen as the more secure livelihood options (G. K. Brown, 2010; Sommers, 2006).

Refugees who have completed secondary school almost universally voice the desire to attend university (Women's Refugee Commission, 2009b). Opportunities for higher education for refugees, however, are severely limited. UNHCR supports higher education for refugees predominantly through the DAFI Programme (the German acronym for the Albert Einstein German Academic Refugee Initiative), which provides scholarships for study at colleges and universities in host countries. Created in 1992, the DAFI programme has funded approximately 5,000 students from 70 countries of origin in 71 host countries (Morlang & Watson, 2007, p. 18). Demand for these scholarships far outstrips the number of scholarships available: UNHCR generally receives between 10 and 30 applications for each available scholarship. In some countries, acceptance rates for DAFI scholarships are 2% (Morlang & Watson, 2007, p. 17; Women's Refugee Commission, 2009b, p. 6).

The UNHCR Education Strategy, 2010-2012 states that "there is a need to expand the scope of scholarships and the number of beneficiaries through the future establishment of similar programmes" (UNHCR, 2009c, p. 21). Several higher education programmes for refugees have developed outside of UNHCR, including through the World University Service of Canada (WUSC) and the Windle Trust. More recently has been growth in higher education opportunities that combine scholarships and distance education, including by the JRS in East Africa and the Australian Catholic University on the Thai-Burma border. Despite the new initiatives, higher education remains low on the agenda for most donors, perceived as a "luxury" for an elite few, especially in contexts where access to primary and secondary education is not universal.

Higher education for refugees is not a luxury. It is important both for individuals and for society in terms of rebuilding lives and fostering leadership in both protracted settings and post-conflict reconstruction (see, Dryden-Peterson, 2011b). A study of the DAFI programme for Afghan refugees demonstrates "a direct link between a refugee programme focused on tertiary education and national reconstruction." The study shows that refugees who had access to higher education moved back earlier in the repatriation process, with 70% taking up work as civil servants or as NGO managers, filling much needed roles in a society in the process of rebuilding (Morlang & Stolte, 2008, p. 63).⁶ Importantly, in 2008 approximately 6% of DAFI students were engaged in teacher training activities, assisting in the creation of a cadre of teachers to assist in rebuilding the education system (UNHCR, 2009b, p. 20).

6 It is important to note that the results of this study are affected by selectivity bias, with refugees who have experienced successful employment post-graduation more likely to be contactable and more likely to respond to the survey.



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Vocational training should provide refugees with skills that match the needs of the local market

Recommendation:

Given the individual and societal benefits that accrue to secondary education, and within the framework of EFA, UNHCR needs to support education up to the end of secondary school. UNHCR's new budgetary emphasis on post-primary education, particularly secondary education, is to be commended. In order to overcome the challenges to secondary school access, especially for girls, UNHCR needs to actively pursue strategies that augment the supply of formal and accredited secondary school programmes, enhance the quality of available secondary schooling, and combat school dropouts at the primary level. Simultaneous strategies of non-formal programmes for overage learners and technical and vocational training, linked to real market needs in the countries of asylum and of eventual return and to post-graduation seed grants, will help to meet the needs of refugee young people for whom secondary school is not an option, based on ability, desire, or previous opportunities. Higher education plays a critical role for individual refugees and for societies in terms of leadership in protracted settings and in post-conflict reconstruction, and UNHCR should explore partnerships that augment these opportunities.



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The qualification of teachers matters more for the quality of refugee education than class size

■ Challenge #3: There is a shortage of quality teachers and lack of structures, including remuneration and training, to retain them.

Teachers matter more than any other single factor for the quality of learning in schools (Hanushek, Kain, & Rivkin, 2004; Reimers, 2006). Teachers are the central aspect of refugee education. Sometimes there is no building, no administration, but there is a teacher. It is these teachers who determine the effectiveness of refugee education: “[w]hile schools can provide safe environments where structure, stimulation and opportunities for learning healthy socialisation with peers and adults can help mitigate the trauma of war, it is teachers who determine the availability and quality of these programs daily” (Shriberg, 2007, p. 8). Poor quality education reduces demand and thus enrolment and persistence (Winthrop & Kirk, 2008); investment in the supply of quality teachers is therefore critical to achieving the goals of access and quality outlined in the UNHCR Education Strategy.

Currently, the first UNHCR indicator of quality for refugee education is the number of teachers per student (UNHCR, 2009c, p. 22). While class size matters, a large class of up to 60 children, for example, can also be an effective learning environment with a skilled teacher (Lockheed & Verspoor, 1991; Nakabugo, 2008). Indeed, it is not so much the number of teachers that matter, but their quality. The second indicator of quality in refugee education is the percentage of qualified or trained teachers (UNHCR, 2009c, p. 22), which is a better, though not perfect, proxy for quality. This indicator is especially problematic given the range of experiences that “trained” may represent, from a low of 10 days of low-quality training to more advanced and intense training that may span years.

In Kyangwali refugee settlement, the variability of teacher quality across trained teachers was evident in classroom observations: while some trained teachers used examples, charts, drawings, and songs in their teaching, other trained teachers simply wrote the lessons on the blackboard without giving any further explanation (Wettstein, 2011). Investment in teacher training is critical to any reforms designed to improve quality (UNESCO, 2004b, p. 161). However, the level of training and qualifications is just one way to measure teacher quality, and an input measure at that.

What does quality teaching in refugee education look like, and how is it best fostered? The *Joint Education Needs Assessment Toolkit* produced by the Global Education Cluster provides a helpful starting point to examine quality in any refugee context. Many of the indicators in the core education domains in the categories of teaching and learning and teachers and other personnel are focused on inputs, which may be easy to count but have not been documented to correlate with quality teaching. The Toolkit is most useful in terms of the quality of teacher pedagogy. The classroom observation form outlines five spheres of pedagogy that are evident in high-quality classrooms (Global Education Cluster, 2010, pp. 106-107):

- participatory teaching methods
- the use of a variety of methods
- the use of teaching materials
- non-violent discipline
- inclusion of all children

Observing these methods in classroom settings is more reliable than self-reported data from teachers on the use of these methods. The *IRC's Guide to Design, Monitoring and Evaluation* suggests that an effective indicator in measuring actual teacher performance in the classroom would be "90% of teachers observed in the classroom satisfactorily demonstrate use of appropriate child-centred methodologies" (IRC, 2005, p. 47). Any observations, however, are snapshots, capturing one moment in time, with an observer present, whereas teaching is an on-going process.

An important way to corroborate classroom observations is through the perspectives of children and their parents who experience teaching over long periods of time. Focus group discussions with children and parents, instruments for which are included as part of the Education Cluster's *Joint Education Needs Assessment Toolkit*, could cover questions that ask about the use of these methods, probing for specific examples. In Uganda, for example, a refugee girl in Primary 5 commented on the absence of participatory methods in her classroom, through the example of lack of feedback. She said: "The teachers, after just writing an exercise on the blackboard, they just tell you if you want to write down, just do it, but they don't give you explanations." Parents also question the interactive nature of teaching that happens at their children's schools. One father commented that he did not understand how the teachers were teaching. "For example," he said, "even when children have failed, they write 'good' in their exercise books" (Wettstein, 2011). While pedagogy is essential, it can only be effective when paired with high-quality and on-going training on the content of the curriculum.

The use of non-violent discipline also can be assessed through conversations with refugee children. In Uganda, a refugee girl in Primary 3 described her experiences:

Sometimes, they cane too much and then I feel unhappy. For example, after canning you, you are crying but at the same time you have to laugh and play with others when you are still crying. Yesterday, they were teaching us how to write, I was very much happy but then the teacher caned and I forgot about this happiness. When you fail again, they add more (Wettstein, 2011).

At times, corporal punishment and verbal abuse also can be measured through time-limited observations in classrooms. In Mauritania, for example, a researcher was witness to teachers using a strap on children's bodies and faces in punishment for chatting, making mistakes, being disrespectful, and falling asleep in class. Teachers were also observed calling children "ânes" (donkeys), telling them that they cannot think, or that they would be more useful if they remained at home to help their mothers (Rezzonico, 2011).

Three strategies can be effective in augmenting the supply of quality teachers and retaining them: training, on-going supervision, and compensation and certification. First, while training is not by itself a good measure of quality teachers, in the right form teacher training can be a productive mechanism to improve the quality of teaching. The teacher training most commonly used in refugee situations is in-service training organised by NGO IPs: short courses of three months or less often conducted during school holidays and long courses also often conducted during school holidays but over multiple years. At present, the minimum recommended length of training is 10 days (UNHCR, 2009c, p. 23), but this limited training can be for an initial start up period only. Given the new research that shows widespread failure to learn in primary schools, a more adequate standard is needed.

A Save the Children evaluation in conflict settings, but not with refugees, found that short courses can be effective in transforming teacher pedagogy toward a child-centred approach. Teachers trained during three month courses in the “basic skills and knowledge needed to teach,” including child-centred pedagogy, subsequently had better relationships with their learners, as measured by listening to learners, helping learners to solve problems, addressing individual learners by name, and giving praise (Save the Children, 2008, pp. 11-13). This training, however, had no noticeable effects on learning outcomes (Save the Children, 2008, pp. 14-15). On the other hand, the experience of IRC in Guinea showed that cumulative teacher training can help build teachers’ knowledge and teaching skills, and Save the Children’s Literacy Boost programme had similar results in a pilot study in Pakistan (Dowd, Ochoa, Alam, Pari, & Afsar Babar, 2010; D. Jones, 2009).

UNRWA has sought to address the issue of learning outcomes by developing a longer-term strategy for teacher training, specifically focused on partnerships with local universities in Jordan, the West Bank, Gaza, Syria, and Lebanon. Similar to UNHCR, UNRWA faces the challenge of short-term funding cycles in a protracted situation but, as staff describe, it has prioritised long-term planning, developing an education strategy that covers six years, even though the mandate of the organisation must be renewed every three years.

Second, and related, on-going teacher training in the form of supervision and on-going observations of teaching can play an important role in improving teacher quality. The *INEE Minimum Standards* recommend performance appraisals, including “developing criteria to support classroom observations and evaluations; providing feedback; and setting goals and targets to measure growth and progress” (INEE, 2010b, p. 102). To ensure sustainability, head teachers need to be the first line of support in this work; however, they often have little more training than the teachers they oversee and are usually not in the practice of classroom observation. In situations where refugees are integrated into national systems, both refugee and national teachers may benefit from National Inspectors. However, Inspectors are over-worked and often lack funds for transportation to school sites, especially those that are remote (Moloi, Morobe, & Urwick, 2008, p. 613); further, they often focus on administrative rather than pedagogic matters. The innovative ‘Be a better teacher/ Le bon enseignant’ programme used with Sudanese refugee teachers in Chad uses video assessment as a form of in-service supervision to allow teachers to teach more confidently and competently (INEE, 2010a, p. 22). Funding for mobile or multi-school trainers, the deployment of “resources teachers,” and the use of new technologies can facilitate this kind of support for teachers in cost-effective and sustainable ways (T. Brown, 2003).

Third, in order to improve the supply of quality teachers, incentives to retain teachers are needed. Without compensation and certification structures in place, “[t]raining more teachers is like pouring water into a bucket with holes in it” (Shepler, 2011). In Dadaab camp in Kenya, there is a total of 870 teachers, but an average of 30 leave the sector each month (UNHCR & CARE, 2009, p. 6), with feelings of frustration at not being paid a salary commensurate with their experience and with prospects of finding a better-paying job in another sector or a less demanding job with similar pay. Teachers’ salaries represent by far the largest expenditure within education budgets in low-income countries. On average, they make up two-thirds of education budgets, and in some cases the figure is over 90% (Brannelly & Ndaruhutse, 2008, p. 6). In some refugee situations, teachers are underpaid, not paid on time, or not paid at all, although in some situations they are paid more regularly than local teachers. This is no simple challenge; Sommers notes that “[a]mong the most vexing and widespread operational challenges in field co-ordination for education during emergencies is devising an appropriate and affordable payment structure for teachers” (Sommers, 2004, p. 74); this challenge continues well after the emergency phase.

The *INEE Guidance Notes on Teacher Compensation in Fragile States, Situations of Displacement and Post-Crisis Recovery* highlight several issues particularly relevant to retaining high quality teachers in refugee education. Teacher compensation involves multiple actors, including government, community, NGOs/UN agencies, donors, and teacher unions, the constellation of which is context-specific (INEE, 2009b, p. 5). These multiple sources of authority result in particular challenges in a country like Uganda, where refugee education depends on teachers being paid by national governments, and there is little recourse by UNHCR or IPs to ensure timely delivery of salaries (Wettstein, 2011). Even careful, phased-in approaches to integrating refugee schools with national systems can suffer from similar issues of late payment (see Box 4.4), requiring intense commitment on the part of UNHCR to coordination and high-level advocacy.

Box 4.4 Sustainable teacher compensation in Ethiopia: A phased approach

USAID in Ethiopia built the capacity of district education offices by encouraging a Memorandum of Understanding (MoU) between IRC and the district education office that agreed on a phased approach to outside funding. It was agreed that after the first year, the district regional education office would cover 25% of the teachers' compensation, 50% after year 2, 75% after year 3 and 100% after year 4. It has not been easy to achieve, as the contribution of many education offices is still not at the agreed level. The main challenge faced is that when the local education office takes over the payment of teachers' salaries, payments are often irregular and unpredictable. Maintaining a regular policy dialogue and follow-up to secure the timely payment has been one way that IRC has tried to overcome this challenge (INEE, 2009b, p. 11).

The absence of adequate teacher compensation results in lowered teacher morale, teacher absenteeism, and a lack of interest in the profession (INEE, 2009b, p. 1). Indeed, in the varied cases of Uganda, Mauritania, and Malaysia, teachers report the lack of sufficient income to sustain their families. While education authorities, in the form of national governments or NGOs, often blame teacher absenteeism on lack of supervision, teachers point to meagre compensation to explain their absences. One teacher in Kyangwali refugee settlement in Uganda said, “[y]ou know when you get very little money and you do so much, you may not be able to get motivated so much.” Another teacher explained the necessity of a strategy of absenteeism in order to secure his family’s livelihood: “[i]f you are wise enough, you come one day to school and the other day you go and dig so you can eat at the end of the month.” Teachers may also recover their salaries by pressuring students to provide money or labour, to the detriment of quality education. This is not only a problem for teachers in refugee-hosting areas but for all teachers in Uganda. UNHCR Malaysia drew on the *INEE Minimum Standards* to devise a scheme to pay refugee teachers in community schools in Kuala Lumpur; teachers noted that this compensation has renewed their commitment to teaching, led to an improved quality of instruction, and fostered a more positive reputation of teachers within the community (Kaun, 2011).

Constraints on resources and inefficiencies of host country compensation systems necessitate creative thinking about other forms of compensation that can serve to motivate teachers in their work and retain them. In some cases, relief assistance in the form of food, health care, and shelter can supplement modest financial compensation (INEE, 2009b, p. 13). Certification can be another form of investment in teacher professionalism and well-being. A cornerstone of the IRC’s refugee education programme in Guinea from 1990 to 2007 was the training and certification of teachers. Recognition of these credentials in home countries has had a long-term impact on the livelihoods of these teachers in that two thirds of them were employed upon return to Sierra Leone and Liberia as teachers, often at their old schools (Shepler, 2011).

Recommendation:

The *INEE Guidance Notes on Teaching and Learning* describe teachers as “the lynchpin of education,” requiring “real investment” (INEE, 2010a, p. 19). For most refugee children, the education received in exile is their one shot at education, and the quality of their teachers is critical. There is an urgent need to think beyond short-term, emergency trainings and toward more extensive investments in teacher quality for refugee education. A new standard is required for UNHCR which incorporates the idea of sequential training that aims, over a period of years, to complete a basic qualification, recognition of which can hopefully be negotiated with home and/or host country governments. Strategies should include the development of indicators that measure teacher quality in terms of pedagogy and students’ learning outcomes; investment in more extensive teacher training initiatives, focused on both pedagogy and content, in partnership with local institutions that allow formal recognition of teacher qualifications; and engagement with issues of teacher compensation and certification through coordination and high-level advocacy to promote the retention of quality teachers.



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Education for refugees is a way to lessen their frustrations and anxiety about the future

■ Challenge #4: The quality of refugee education, and how it is recognised, does not help children to make connections between schooling and their future livelihoods.

Humanitarian aid advocacy and policy documents emphasise the role that education plays in restoring normalcy for refugee children. The implication of this line of thinking “is that it would almost be enough to get the children back into school and that the routines of schooling are as important as its content” (Davies & Talbot, 2008, p. 513). For example, the new USAID Education Strategy of February 2011 separates a goal for access to education in crisis and conflict environments from the other two goals related to the content and relevance of learning (USAID, 2011).

Education for refugees is “something to do” in the present, a way to “absorb their energies.” At the same time, it is a way to “lessen their frustrations and anxiety about the future” (IIEP, 2006, p. 2). Indeed, the world over, refugee children are clear that while access is a critical first step, it is the learning that happens in the classroom that matters to them. In particular, they connect learning well with the ability to hope for a better future (Winthrop & Kirk, 2008, p. 646), including the skills they are able to acquire that will allow them to enter into jobs and decision-making within the community (Davies & Talbot, 2008, p. 513).

A 50-year old returnee mother in Boungyel Thily, Mauritania describes the specific connections she sees between education and future livelihoods:

I have seen certain people who were studying and who were poor, but after their studies they have had opportunities for good jobs. And, in the end, they have become rich and forgotten all of the suffering that they endured early on, and they have been able to rid their families of poverty. I have also seen that if a person does not study, she can become a hooligan or even a crook or a thief. And a person who has studied is more open-minded than a person who has not studied. This is why I allow myself to bear my thirst and my hunger in order to see that my children get an education (Rezzonico, 2011).

Many refugee children and parents share this abiding faith in the role that education can play in securing prosperous, happy, and healthy futures.

Yet what do school experiences of refugee children and parents indicate about the accuracy of this faith? There are no global data on the learning outcomes of refugees or of the pathways between primary and secondary school and secure adult livelihoods for refugees. As mentioned earlier, there is clear evidence that most children in low-income countries are learning little in school, and often even less in conflict-affected countries (Das, Pandey, & Zajonc, 2006; Gove & Cvelich, 2011; Save the Children, 2008, pp. 14-15; Young Lives, 2009). And there is no reason to believe that outcomes would be different among refugees, on average.

The perceptions of refugee children and parents support the claim of poor quality education for refugees. Numerous case studies indicate that many refugee children and parents become disillusioned by the quality of the education available to them and begin to question the true links between schooling and future livelihoods (see Box 4.5).

The actions of refugee children and parents also support this claim. For example, in some settings, refugee parents and young people are creating alternatives to the available UNHCR-supported education. In Kyangwali refugee settlement in Uganda, five Congolese refugee youth started a community school called COBURWAS (Congo Burundi Rwanda and Sudan). They began this school in the hopes of providing a higher quality of education that would allow refugee children to progress to and succeed in secondary school, with the aim, as one of the founders stated, “that children in Kyangwali would [no longer] need to suffer in their education as much as [we] did.” Refugee parents described taking their children out of the government school in the settlement in order to enrol them in this community school. Parents noted their children learning more, especially in the English language, than at the government school. One parent also commented that “[t]he difference [at COBURWAS is that] the teachers care about our children. And in case there is a problem or a challenge, they invite us to come to discuss, we discuss how to improve” (Wettstein, 2011).

Box 4.5. Learning “very little” will not allow Annette to become a nurse

“When asked to draw her school, Annette looks at me blankly. I had observed her in classes in Kyaka [refugee settlement in Uganda] for two years, and she had told me about the secondary school she used to attend in DRC. I was curious as to what Annette considered her school and how she would describe it. She breaks the silence, but her blank look does not dissipate: ‘I study under the trees,’ she says in monotone. The emergency situation in the settlement resulted in a tripling of the school population without any new construction. That she was studying under the trees was to Annette a symbol of how unimportant her education was to others, to her teachers and to those in power. Indeed, weeks of observation in her classes convinced me that Annette was not exaggerating to say that she was learning ‘very little’ at school. At this time, Annette parroted what she heard from her parents in terms of a rationale for continuing her studies: ‘...studying is important because it will help me find a job and make money.’ But she had lost her daily desire to attend school and to learn, and her dream of the fulfilling work she hoped to do as a nurse had disappeared” (Dryden-Peterson, 2011a).

In Dadaab refugee settlement in Kenya, 62% of school-aged children were enrolled in primary school in 2009 (Umbima, et al., 2010, p. 20). An additional 3% of the school-aged population was enrolled in 6 private schools that had opened in the camps over the previous two years (Umbima, et al., 2010; UNHCR & CARE, 2009). By 2010, the number of private schools in the camps had increased to 11 (Umbima, et al., 2010). According to refugee parents, this rapid expansion of private alternatives to the UNHCR-sponsored education in Dadaab is a direct response to the poor quality education previously available in the camps.

There are many examples of low-quality private schools in poor communities around the world; in this instance, however, the development of private education alternatives was a direct response to low-quality within the UNHCR-sponsored schools. Parents cite several reasons for their preference for private schools in this situation, including strong discipline, the integration of religious and secular studies, and quality in terms of smaller classes and trained teachers who are motivated due to on-time payment and opportunities for professional development. In terms of quality pedagogy, one student stated about the private school in Dadaab: “[t]eachers explain more here. In the other school, the teacher just wrote on the board and didn’t ask questions.” In terms of outcomes, another student explained that “[w]hen I was in that (CARE) school, I couldn’t speak English. Now I can.” Teachers and school management of the private schools also highlighted the difference in quality:

Maintaining standards are (*sic*) not just about passing students on from one class to another, but rather about competency of the students. In simple terms, it’s not about whether my child passes from one class to another, but rather what he or she actually *learns* along the way. One example of this can be illustrated by a Standard 7 student who came from an agency [CARE and UNHCR] school and transferred to one of the private schools. As with any school, new students from outside are given an assessment for placement. However, the teachers giving the assessment noted that the student was unable to even write his name. The child was subsequently enrolled in Standard 2 and is at the same level as his classmates (UNHCR & CARE, 2009, p. 11).

Further, as in Kyangwali, the importance of home-school connections was highlighted. Parents in Dadaab also noted greater communication with teachers at private schools than at UNHCR-sponsored schools. One parent described how she was only informed that two of her children were not attending school at the end of a term, when it was too late to act on the situation. At the private school, on the other hand, she found teachers collaborating more with parents both on absenteeism and on performance, and she was more satisfied that her children were well-looked after, in terms of protection and learning (UNHCR & CARE, 2009, pp. 10, 17). This collaboration is critical when class size, school hours, and teaching culture prevent individual students from practicing reading, instead chanting together and learning the reader by heart.

UNHCR and Implementing Partners (IPs), in collaboration with host and home country Ministries of Education (MoEs), have taken action on certification in many operations as one critical way of addressing accountability for learning outcomes and the recognition of achievements. The IRC in Pakistan, for example, worked closely with the IRC in Afghanistan, the Afghan Consulate in Peshawar, and the MoE in Kabul to ensure smooth registration and certification of learning for Afghan refugees upon their return to Afghanistan (Kirk, 2009, pp. 133-134). Similarly, RET in Chad worked closely with the Sudanese MoE to ensure recognition of primary and secondary schools in the camps, as described above under Challenge #2 (Mauoubila, et al., 2011).

Certification reflects summative or cumulative assessment, designed to determine whether students have met the learning outcomes for a complete course of study. In the Education Cluster *Joint Education Needs Assessment Toolkit*, the indicators to assess learning are similarly limited to summative/cumulative assessment, measuring the process of how learning is assessed, validated, and locally certified (Global Education Cluster, 2010, pp. 51-52). Absent are indicators that address formative assessment that would capture the on-going learning needs of refugee children.

The *INEE Guidance Notes on Teaching and Learning* do make the link between assessment and learning outcomes, stating that “[q]uality education relies on accurate and timely gathering, sharing, and use of information” (INEE, 2010a, p. 43). The guidance notes encourage support for teachers in three areas: ensure greater understanding of the value of assessment data and analysis; support flexibility

and local adaptation of tools; and ensure information collected informs and influences the teaching and learning process. In refugee settings, these notes should be carefully considered in order to build accountability regarding learning outcomes at the level of students, teachers, parents, communities, and education authorities. Further, the possibility that assessments are based on rote learning of the textbook should also be taken into account. For this reason, independent assessments of learning, such as that promoted by EGRA, are essential, in addition to ways of teaching and learning that foster sustainable literacy, numeracy, comprehension and life skills as well as satisfying national examination requirements.

Education that is not quality education is not meaningful or useful, to individuals or to society; it can be detrimental. If refugee children and young people leave school with few skills, their education will not translate into the future livelihoods they imagine for themselves or into social and economic dividends for their societies. An education strategy that is built on the connections between education and livelihoods – both social and economic – would necessarily prioritise learning outcomes and would provide a much-needed catalyst for addressing gaps of quality in refugee education.

Indeed, policy and programming in refugee education need to be conceptually linked to livelihoods. In order to be a durable solution, education needs to prepare refugee children for futures in which they can be economically productive, physically healthy, and civically and politically engaged. Refugee education that is of high quality and protective is essential to these outcomes. The quality of this education is tightly linked to its relevance, particularly how well it is aligned with the limited opportunities for employment in local labour markets and with its portability, which enables graduates to be flexible given probable high rates of mobility.

Recommendation:

The Education Strategy 2010-2012 states that “[t]he need for quality services is beyond UNHCR’s existing capacity” (UNHCR, 2009c, p. 28). This simply cannot be accepted if UNHCR is to uphold its mandate to protect and assist refugees. There is an urgent need to devote resources to ensuring access to high quality and relevant education for refugees. Monitoring and evaluation will be central to this work. The data currently collected for education are not appropriate; it renders progress toward quality education both illusory and disappointing. In order to measure whether education is of high quality and is protective, outcomes need to be measured rather than inputs. It is not enough for refugee children to be in school with an acceptable teacher-pupil ratio. For education to be a durable solution, they must be learning meaningfully. In order to improve the quality of education, we need to know whether children are learning, *what* they are learning, and *why*. Summative learning assessments can provide a basis for understanding whether children are learning and point to areas in which learning is particularly difficult. UNHCR needs to require annually independent sample testing of student learning, beginning with reading abilities. Further, UNHCR needs to ensure that teachers are well-trained in formative assessments of children in order to develop on-going strategies to promote in-class learning.



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What refugees learn in exile shapes how they think and how they imagine the future for themselves and their societies

- **Challenge #5: The inherently political nature of the content and structures of refugee education can exacerbate societal conflict, alienate individual children, and lead to education that is neither of high quality nor protective.**

Deeply-rooted assumptions that children transcend geo-political differences have shaped the ways in which refugee education is conceived. And yet as a system of knowledge production and a tool of socialisation, education must take account of the structural and cultural conflicts, the languages, worldviews, ethnicities, and accompanying power structures, which have caused the persecution and flight of refugees.

The links between education and conflict have been clearly documented theoretically and, increasingly, empirically as well. Education has been described as having “two faces,” one that increases the risk of conflict and one that mitigates those risks (Bush & Saltarelli, 2000). Recently, this framework of “two faces” has been problematised toward notions of the multiple and intersecting ways in which education can prevent, assuage, and exacerbate conflict (Davies, 2011; IIEP, 2011; King, 2011).

While education in conflict settings, including refugee education, is understood as increasingly politicised, the education response by UNHCR is often not sensitive to critical political factors that impact the ways in which refugee children can participate in and experience education. UNHCR has typically focused on the “hardware” components of education, including school construction and equipping classrooms with materials (UNHCR, 2009k, p. 47), a focus which may be changing as indicated in the decreased proportion of funds allocated for infrastructure (see Figure 3.12). This approach is a “problem-solving” one, which “is to accept the broader status-quo as given and seek to focus in on a particular ‘problem’ – abstract it from its broader social relations – and attempt to make this situation run more smoothly” (Novelli & Lopes Cardozo, 2008, p. 481; see also, Pingel, 2010, p. 121).

Yet in order for refugee education to be of high quality and to be a tool of protection, the inherently political nature of the content and structures of education worldwide must be recognised. In so doing, a critical approach is useful to locate ‘the problems’ of access, quality, and protection within a broader and more complicated context. In conceptualising ‘parts’ as connected to ‘larger wholes’, critical theory leads to problematising the roots of the problems. It “has less of a system maintenance bias, and allows for the possibility of imagining alternatives to the status-quo” (Novelli & Lopes Cardozo, 2008, p. 481).

The political nature of the content and structures of refugee education and the need to transcend the status quo is particularly evident in five spheres: curriculum, language, social integration, relationships between schools and families, and repatriation policy.

First, the selection of what will be taught in schools – the curriculum – is often a difficult and contentious undertaking as it is a process of defining and selecting legitimate knowledge (Tawil, Harley, & Braslavsky, 2004, p. 19). However, the basic concern, for students and parents as well as agencies, is that a recognised national curriculum is the basis for what is taught, leading to nationally recognised qualifications. The 2003 *UNHCR Education Field Guidelines* advocate that the curriculum in refugee education programmes should be the curriculum of the country of origin, where the expected durable solution is voluntary repatriation, and where numbers, and/or the language of instruction mean that local schools cannot absorb the refugee students. This approach to curriculum was emphasised due to examples where host governments insisted that refugees study in a language that bore no relation to refugees’ futures, either with good intentions or on the basis of national pride. More experiences at country-level indicate acceptance of both political and pragmatic reasons for which other decisions may be made. As stated in the *INEE Guidance Notes on Teaching and Learning*, “[t]eaching and learning in emergencies never takes place in a vacuum,” and there are reasons to make context-specific curriculum choices, including following a curriculum from a country of origin, from a host country, and enriching the curriculum with specific priority areas such as lifeskills or peace education (INEE, 2010a, p. 1). Where urban refugees are integrated into national systems, for example, they by necessity follow curricula of host countries, whether or not the most probable durable solution is local integration or repatriation.

The content of what is included in curricula shapes what children know and how they think about themselves and imagine the future both for themselves and their society. It can be difficult for teachers to cope with curriculum topics that are controversial, and recent conflict-related topics are often omitted from curricula, such as in the case of history teaching in Rwanda (Freedman, Weinstein, Murphy, & Longman, 2008; King, 2011). In Mauritania, for example, the omission of study of the 1989 crisis from the curriculum contributes to strained relations between Moors and Black Mauritians. Rather than a comprehensive understanding of the events leading up to the returnees’ exile in Senegal, Black Mauritanian children’s only source of information on the ethnic groups and their relations is their parents’ discourse and a politicised version of the 1989 crisis learned in refugee schools in Senegal, which were supervised by politically engaged refugee teachers. A negative image based on racial stereotypes, such as that Moors are dirty and stinky, is thus transmitted to children and reproduced by them (Fresia, 2009; Rezzonico, 2011).

Stereotypes run in both directions. A high school student from Houdallaye, Mauritania, says, “[t]he Moor [teachers], if we ask them to translate, they don’t do it, because they don’t like black heads, they are just looking at their friends, their children, those who have Moorish heads, but black heads, they don’t respect them” (Rezzonico, 2011). This perceived exclusion runs counter to an inclusive environment, alienates learners from the content of learning, and acts as a barrier to accessing education of

quality and that is protective. Since many teachers come from one side or the other of a civil conflict or ethnic divide, it is important to improve the duration and content of teacher training and to include tolerance/peace education topics, so that they can avoid stereotyping and bias in the classroom.

Second, the choice of language of instruction impacts the quality of education that refugee children are able to access. Research is clear that children are better able to acquire literacy initially in their first language and then to transfer those skills to the target language of instruction (Abadzi, 2006; August & Hakuta, 1998; Brock-Utne & Holmarsdottir, 2004; Rolstad, Mahoney, & Glass, 2005). The education available to refugees in exile is often neither in their first language nor in the language in which they have previously studied. Children face not understanding what the teacher or their peers are saying. In this situation, children are often demoted to lower classes not as a result of their cognitive development or content knowledge but instead as a result of their lack of proficiency in the language of instruction (Dryden-Peterson, 2006b).

In addition to impacts on quality, these actions have protection implications, impacting negatively on the social development of refugee children, and access and retention implications through lack of interest in enrolment and dropping out. Unfamiliar languages pose such a significant barrier that refugees at times initiate their own informal education in order to offer education in a familiar language. For example, a significant number of refugees in eastern Sudan chose not to attend the schools set up by UNHCR in which teaching was conducted in Arabic but instead elected to attend informal schools under the trees in which teaching was in Tigrinya. On the other hand, there may be quality and protection benefits to the use of new languages in exile. In Malaysia, for example, refugee parents see the utility of learning English in light of their resettlement possibilities, and they see the protection benefits of learning Bahasa Melayu as it promotes integration and might reduce the risk of arrest (Rahman, 2011).

Political in nature, the choice of language of instruction is often contentious, perceived to benefit some while marginalising others (see Box 4.6). Language decisions highlight for refugee children the power dynamics of their situation. Many Congolese refugees in Uganda wish to study in French, but they do not have that option. Refugee parents and children fear that because of lack of skills in French, they will face great difficulties once they repatriate to DRC, worried that they will be “just useless people” or that “children will not be employed because they don’t know the language spoken in DRC” (Wettstein, 2011). Some returnee children in Mauritania conceive of Arabic, which is used in the majority of their classes, as the language of the oppressor, drawing on the rhetoric of their parents. They perceive the language as oppressive because they are unable to understand and succeed in classes, which translates to feelings of marginalisation in their society. Some children chose to rebel against the imposition of the Arabic language; one girl in sixth grade described children in her class who refuse to write in their notebooks when they have classes in Arabic, saying that she cannot do it and thus it is not worth wasting pages (Rezzonico, 2011).

Third, in some situations, the physical integration of children – refugees and nationals, returnees and stayees, and those of different ethnic and linguistic backgrounds – takes place without sufficient attention to the social aspects of living together. Policy and programme responses to integration of refugees and national hosts have been limited to the integration of services, including through the zonal development approach of the 1960s, refugee aid and development strategies of the late 1970s and early 1980s and the recent ‘The Targeting of Development Assistance’ (TDA) (Dryden-Peterson & Hovil, 2004; Rowley, Burnham, & Drabe, 2006). Where different groups are living in the same environment, the integration of services in education can create important possibilities for social integration, but only if the content of education is conducive and explicitly addresses issues related to causes of conflict, good citizenship, social cohesion, human rights, etc.

Box 4.6. Language of instruction is political and contentious (Rezzonico, 2011)

Among the returnee population in Mauritania, and particularly among parents, there are three types of discourse about language within the national education system.

First, some returnees believe that French-Arabic bilingualism is well-adapted to the Mauritanian context, even if they are conscious of their children's troubles with Arabic. A village chief points out:

These two languages are the languages that have always been taught in this country and if you master only one or the other, you will have problems... If you don't learn Arabic, you will not be able to advance because it is used all over the country, it is a big, widespread language.

Second, some returnees are resigned to the language of instruction in Mauritania. A returnee father in Houdallaye said:

We are governed and the powerful are stronger than the poor, so we have no alternative than to accept the system.

Third, some returnees believe that rulers have deliberately designed the current language policies in education to disadvantage "negro-Africans" and that "white Moors" want to keep Black Mauritians ignorant in order to continue dominating them. This view is not exclusive to returnees, but is shared by other Haalpulaaren people including teachers, and should be understood as a continuation of on-going protests since 1966 that have denounced Arabisation of the country. An old refugee woman in Ndioum, Senegal argued:

Education in Senegal and Mauritania. I know something about that. In Mauritania, education is very good, but what makes it different from Senegal is the segregation. Here [in Senegal], is it only maybe the child who does not want to learn, but he is nonetheless on the same equal footing as the others... In Mauritania, because there are two ethnic groups – Moorish and Haalpulaar – and it is the Moors who are in power and they have more power than the others... In the schools, it is the same, just as it is in the hospitals and the clinics.

Some parents focus their attention on the dysfunction of the language policies in general, with concerns that it disadvantages all children; others argue that the current system disadvantages only Black Mauritians, and particularly returnees.

Davies argues that most schools in most countries do not uphold the UNESCO four pillars of education for the world in the 21st Century – 'learning to know, learning to do, learning to be and learning to live together' (Davies, 2005; UNESCO, 1996a). Especially in settings of conflict, including refugee settings, she asserts that many schools instead foster the following:

- *Learning to be different:* through selective and stratified education – reflecting 'ability', social class and language – which produces and reproduces the diverse pathways into further education and jobs;
- *Learning to mistrust:* through ethnically and religiously segregated schools, and through various constructions of 'we' and 'others';
- *Learning to accept aggression:* through militaristic or 'defence' education, through the experience of mental or physical violence from teachers and peers, from punishment regimes which uphold an ethos of revenge rather than reparation, and from a masculine ethos which celebrates toughness;
- *Learning to fear:* through competitive, individualistic and examination-oriented education which feeds a culture of anxiety (Davies, 2005, p. 43).

Peace education programmes were developed and used by UNHCR, particularly in refugee camps in Kenya, in the 1990s and into the early 2000s. These programmes provided sustained focus on the social aspects of living together, yet they were mostly discontinued after 2005 due to administrative difficulties and budget constraints, despite being positively evaluated (Obura, 2002). An extensive review of education and peace/conflict including impact assessments concludes that the question remains open as to whether “the established impact of [peace education] on the micro level is also able to have a sustainable impact on the macro-structural roots of ethnopolitical conflict and violence” (Seitz, 2004, p. 75). Education is of course only one factor that can drive conflict or contribute to peace, with many other factors also having to be in a positive configuration to achieve the desired results. One limitation to peace education is the isolated ways in which it may be taught: in an extra period that is squeezed into the timetable or as an extracurricular activity. While this approach can be effective in initial attempts to bring peace education into schools (Sinclair, 2004), in these forms, ‘good practice’ in peace education cannot fully address the ‘bad practice’ of the whole of education experience (Davies, 2005, p. 43) or mitigate negative messages received from the wider society. Nevertheless, initiatives such as the INEE-Peace Education Programme (PEP) introduce the skills and concepts needed to consider peaceful alternatives (UNHCR, UNESCO, & INEE, 2005) and, if embedded in broader structural interventions related to ensuring educational access and quality, may undermine sources of conflict. Protective education identifies features of both micro- and macro-systems that together can form “a protective shield around children, not eliminating risks and vulnerabilities but protecting children from their full impact” (Boothby, 2008, p. 502).

The case of Mauritania demonstrates the need to focus on systemic issues of living together in order to achieve educational goals of access, quality, and protection (see Box 4.7). Some of the difficulties of living together may be traced to lack of a common language. While there is only a small amount of data from the field-based component of this review (Rezzonico, 2011), the Haalpulaaren children who could speak Hassaniya and thus communicate with Moors described having Moor friends; the others who did not share a common language did not have Moor friends. Beyond language, teachers noticed that among returnees and long-time residents, there is not only a general lack of cohesion but outright animosity and a lack of will to develop relationships. One long-time resident girl in 5th grade in Tantane described how the climate at her school fostered these negative relationships:

*One time I had an argument with a [returnee] girl over our places on the bench.
 And what happened afterwards?
 The teacher hit me but she did not hit the other girl.
 And why did she do that?
 She said that the ones from Boungyel Thily [returnees] are foreigners and we mustn't fight with them.*

One long-time resident boy in 6th grade described similar situations in which he and returnee children could not understand each other. His solution: “We just told them to come and play football!” (Rezzonico, 2011). These spontaneous interactions are critical and yet not sufficient. Schools must find ways to bridge these divides for refugee children more formally and systematically, specifically through concentrated efforts in assisting children to build relationships with each other (Sinclair, Davies, Obura, & Tibbitts, 2008).

Fourth, unequal power relationships between schools and refugee families foster miscommunication, misunderstandings, and lack of collaboration among these critical stakeholders in refugee education. Community participation in the management of schools is a cornerstone of strategies to improve access, quality, and protection in refugee education (INEE, 2010b; UNHCR, 2009c). Yet just as in the larger humanitarian field, the rhetoric of participation and the practice of genuine participation often diverge.

In Kyangwali refugee settlement in Uganda, policies indicate that UNHCR, implementing partner Action Africa Help-International (AAH-I), national and refugee teaching staff, and refugee families collaborate through Parent Teacher Associations (PTAs) and School Management Committees (SMCs) (Wettstein, 2011). Participation by refugee stakeholders, however, is limited. UNHCR and AAH-I attribute the lack of participation of refugee parents who hold positions on the PTA and the SMC to under-developed knowledge and skills about how to participate. Refugee parents have a different interpretation. A refugee chairman on one SMC explained his ideas for how funds should be spent, one

Box 4.7. Words can hurt you, and society (Rezzonico, 2011)

Building positive relationships between the different members of the population in Mauritania is critical to the durable integration of returnees. Reflecting this idea, one of the principles of action shared by all partners in the operation is that the population living in the surrounding areas of returnee villages is included in assistance activities.

The terminology used by humanitarian organisations and authorities to refer to different groups of people, however, runs counter to this integration. The governmental organisation created to address the issue of returnees is called ANAIR in which the “R” in the acronym stands for Réfugiés, rather than the correct Rapatriés (Agence Nationale pour l’Appui et l’Insertion des Réfugiés). Returnee villages are called sites de rapatriement (repatriation sites) and the surrounding communities are known as villages d’accueil (host villages). This terminology is very similar to that used in refugee situations. Villages established for returnees are referred to as “sites,” which gives the impression of a place more artificial and less human than “villages,” and promotes a conception of “temporary” that is not coherent with the aim of durable integration. Moreover, people living in the area to which returnees are arriving are considered “hosts,” underlying a representation of returnees as “guests.” Reflecting these understandings, some local authorities continue to refer to returnees using the term “refugees.”

of his responsibilities in this position. However, although he signs official documents to approve expenditures, he is not involved in the allocation or management of funds. When asked if he discussed with the Headmaster about the ways in which Universal Primary Education (UPE) funds were spent, he said: “He is a national, I am a refugee [he laughs], and that is why I keep quiet.”

Refugee parents in Kyangwali participate in schools in much the same way as this refugee parent participates in the SMC. The locus of power is with national school staff, UNHCR, and AAH-I. Those in power share information with parents and invite them to be present at events, but there is little opportunity for the building of meaningful relationships, trust, and a sharing of decision-making (see Box 4.8). In order for the benefits of parent engagement in schools to be realised in terms of access, quality, and protection, a transformation of these relationships must occur.

Finally, education can serve political goals of influencing human mobility in the context of asylum and refugee assistance, especially repatriation. In many operations, host countries, donors, and UNHCR agree to withdraw from the provision of education once a peace agreement is signed. The rationale is that education in exile will act as a pull factor, dissuading refugees from returning to their countries of origin. For example, schools have been prematurely closed for Sierra Leoneans in Guinea; Mauritians in Senegal; and Burundians in Tanzania. The consequences are wider than loss of years of schooling for children who do not repatriate immediately; among Burundians in Tanzania, SGBV in the camps increased markedly once the schools had been closed. Education programmes need to be maintained during repatriation, at least until education can be offered in areas of return.

Recommendation:

Understanding of the conflicts out of which refugees come and the political situations in settings of exile must impact the design of appropriate educational interventions in order for education to protect children rather than fuel poor quality learning and on-going intolerance, prejudice, injustice, and conflict. In order to be adequately addressed, these analyses cannot be left to Implementing Partners (IPs) but must be guided by UNHCR education specialists in the field and at Headquarters. Some of the principles that can be put into action include: requiring needs assessments that include situational analyses applying lenses of conflict and power to assess the content and structures of education, including curriculum, language, and relationships between actors; supporting peace education in all operations; and maintaining education programmes during repatriation, at least until education can be offered in areas of return.

Box 4.8. The role of power in community participation (Wettstein, 2011)

UNHCR implementing partner AAH-I organised a “school opening day” in each school in Kyangwali refugee settlement in western Uganda. Parents were invited to visit their children’s school to see what they are learning. They visited each classroom where teachers were demonstrating how pupils learn to count or read. After the visits, the headmaster, the AAH-I education adviser, the PTA and SMC chairmen, and the Assistant Settlement officer of the Office of the Prime Minister, one after the other, made speeches to parents to remind them of the importance of education.

In many of these speeches, parents were identified as the root causes of children’s late coming or their non-enrolment at school. Parents were asked to better support the education of their children by providing scholastic material and by not giving them work in the morning, so that they might arrive at school on time.

After the speeches, would there be a moment for parents to ask questions or make any comments? “No, it is not in the programme and, anyway, there is the PTA who has spoken on behalf of the parents,” said the AAH-I education advisor. The chairman of the PTA had not met with parents ahead of time to solicit ideas.

Because we are refugees, a refugee father commented, “there is nowhere to pass our thoughts, our views, our words. There is nobody to understand us.” A refugee teacher explained that parents did not get the opportunity to speak because the school administration did not want them “to throw bad words, because if a parent would have talked, he would have only complained, speak about the negative aspects and it cannot please.” One refugee father yearned for more genuine participation; he said, “at least if they may give us the possibility to ask five question or so, so that we are also participating. But they didn’t give us a chance. If they don’t allow you to speak, then you keep quiet. There is nothing to do since we are considered as inferior people.”

■ **Challenge #6: Lack of financial resources, and their inconsistency, as well as a shortage of educational expertise both within UNHCR and among Implementing Partners (IPs), limits progress in refugee education.**

[E]ducation is like a lamp – if you don’t provide sufficient paraffin, the lamp won’t function (UNHCR & CARE, 2009, p. 10).

For refugee education, paraffin is in short supply. This paucity of resources, both human and financial, is outlined in Section 3. What are the effects of these constraints on educational outcomes related to access, quality, and protection? Results-based management aims to provide answers to important operational questions such as this one. However, appropriate data for education are largely unavailable. Further, the lack of meaningful outcome measures for quality and protection, as outlined previously, render this type of analysis moot.

Is access to education for refugees related to adequate financial resources allocated to education in a given operation? Piecing together various sources of data on primary school enrolment ratios and available resources renders a rough picture of the connection between financial resources and refugees’ access to education. There is a medium-strength, positive correlation between Gross Enrolment Ratio (GER) and percent of education needs funded; however, this correlation is not statistically significant ($r=0.35$, $p=0.07$). This exploratory analysis indicates that when funding needs are met there is a greater likelihood that GER will be higher (see Figure 4.3).

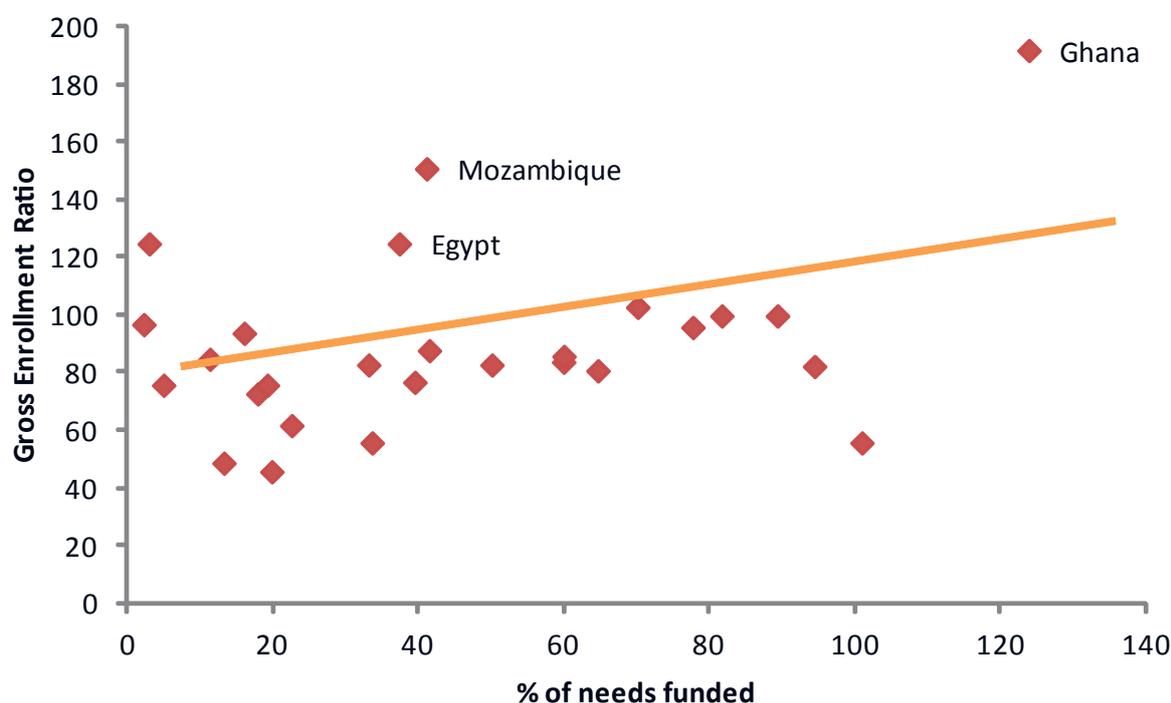


Figure 4.3. Gross Enrolment Ratio (2009) as related to the percentage of education needs funded (2009, 2010). Source: (UNHCR, 2008c, 2009j).

This analysis, however, is limited for a number of reasons. First, the allocation of budgets to education and to various operations not only reflects real needs but depends on multiple factors including the size of the operation, the process by which needs are identified, successful advocacy, and donor earmarking. Using CNA data in combination with actual budget allocations allows for the computation of the degree to which the educational needs in a given operation are met by the allocated budget. CNA data are available only from 2010, so budgets before 2010 provide little by way of data toward



understanding whether outcomes of enrolment are related to financial needs being met. Second, since CNA data are available only from 2010 and enrolment data are available only until 2009, there is no way of examining whether needs being met in one year is connected to improved enrolment in that year or the next. Third, given these constraints, a central assumption is necessary in order to attempt initial analyses of the connection between school enrolment and adequate financial resources: that the CNA, had it been done, would have been the same in 2009 as it was in 2010. This is a clear limitation of available data; once 2010 enrolment data become available, this analysis could be repeated for more reliable results. Finally, the correlation between GER and percent of needs funded is likely driven by inflated GERs in operations such as Egypt (125%), Mozambique (151%) and, most importantly, Ghana (192%), as indicated on Figure 4.3. This limitation only emphasises the need for more reliable data (see Box 3.3).

Another financial constraint on refugee education, raised repeatedly by UNHCR staff, is the lack of consistency and predictability of funds. Among 31 operations for which there are data in 2009 and 2010, 48% were funded in 2010 below the rate at which they were funded in 2009; and 52% were funded at a larger amount (see Figure 4.4). What is remarkable is the discrepancy in changes in funding from one operation to the next. For example, Botswana received in 2010 just 1% of the funding received in 2009; whereas Tanzania received in 2010 720% of the funding received in 2009. Despite this massive decrease in funding, the population of children ages 6-17 in Botswana decreased by only one quarter. In Tanzania, where funds increased so massively, the population of children ages 6-17 decreased by over half. Constantly changing and unpredictable funding levels make planning for provision of quality education near to impossible. Particularly problematic is the practice of reducing budgets throughout the year, not only in education but often across all programmes. To some extent these fluctuations from year to year and during a given year reflect the lack of an education professional at country level, with the technical expertise and the institutional standing to advocate for needed funds and their consistency.

To address the lack of financial resources, UNHCR has piloted a strategy of identifying priority countries in order to target available resources toward meaningful impact. These resources have included technical missions, secondment of staff, trainings, fundraising, advocacy, and monitoring. Priority countries between 2008 and 2010 included: Algeria, Bangladesh, Eastern Chad, Eastern Sudan, Jordan, Kenya (camp and urban), Malaysia, Mauritania (urban, 2008 only, and returnee), Sudan (urban, 2008 only), Syria, Turkey, Uganda (not 2008), and Yemen (camp and urban). These countries were selected on the basis of four criteria: performance on the UNHCR standards and indicators; size and phase of the operations; office capacity and resources; accessibility and humanitarian space (UNHCR, 2009c, p. 37). Despite these criteria, UNHCR staff members describe what appears to be an arbitrary nature to country selection: for example, why is Pakistan, with 1.7 million refugees, not on the list? In Kenya, why is only Dadaab a priority and not Kakuma?

This targeting of limited resources to key countries has been common practice by UN agencies and bilateral donors. What effects does this priority status have on educational outcomes? Percentage change in primary GER from 2007 to 2009 for priority countries can provide some sense of these effects. For several countries, there is marked change in GER from 2007 to 2009 (see Figures 4.5 and 4.6). In camp settings, GER increased 36% in Eastern Sudan and 27% in Algeria; there was less progress in Dadaab camp in Kenya at 6% increase and in Bangladesh at 2% increase. In Yemen, Uganda, and Eastern Chad, on the other hand, GERs fell, 9%, 14%, and 22% respectively. In urban settings, positive change in GERs was even larger in Malaysia (67%), Yemen (50%), and Turkey (36%). In cities in Syria and Kenya, on the other hand, there was a decrease in GERs, 3% and 19% respectively.

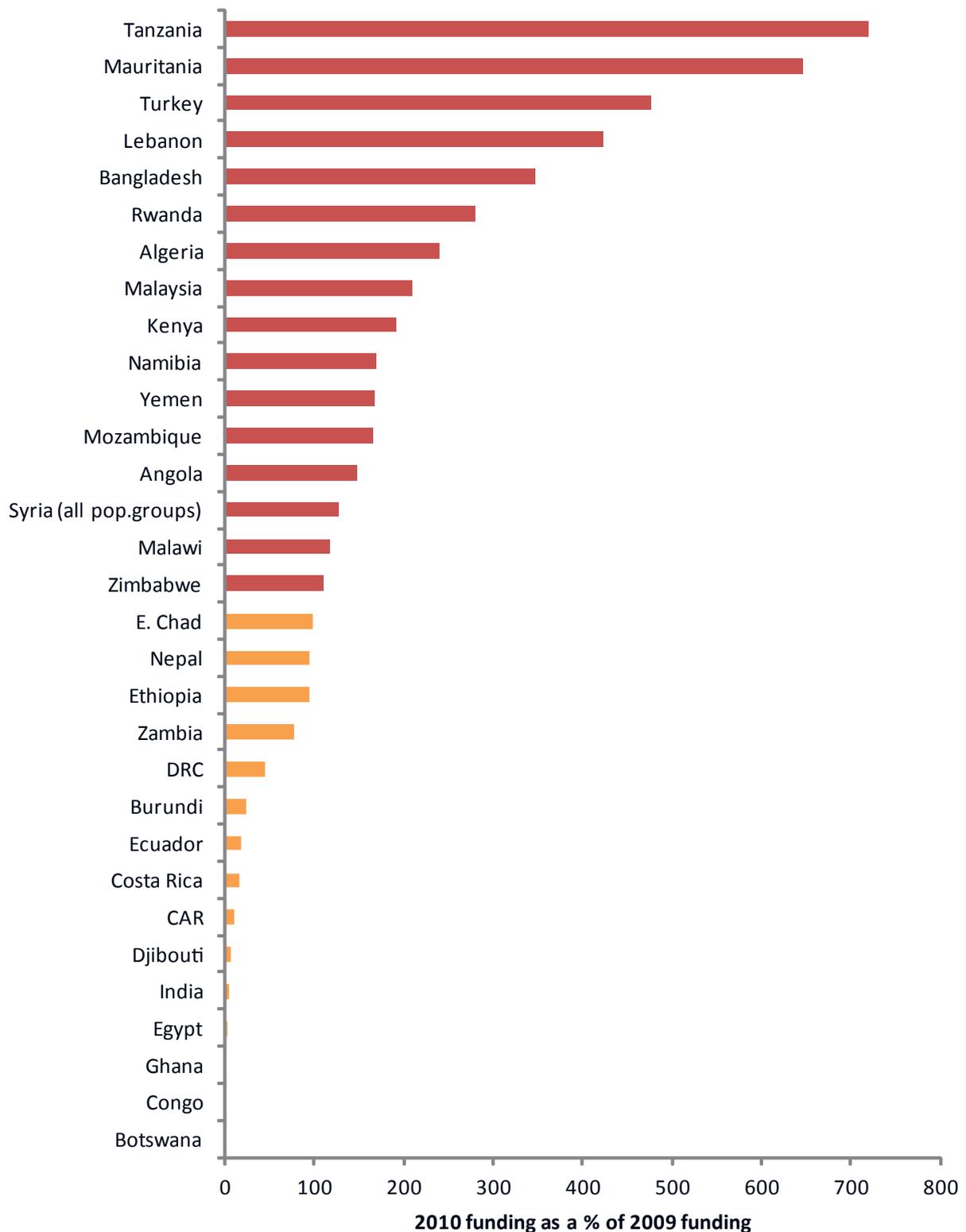


Figure 4.4. Funding in 2010 expressed as a percentage of 2009 funding for 31 operations. Sources: (UNHCR, 2008c, 2009j).

This analysis is exploratory, based on the limited amount of data available; in particular, it does not consider the multiple explanations for any change, nor impact over time. While the changes in GER could be related to the priority status of the country, they could also be related to changes in refugee governance (Syria, for example), population changes (Dadaab, for example), or any other number of factors, including the commitment of field offices to education and staff turnover. Comprehensive evaluation of the effects of the strategy of concentrating resources on priority countries in order to

positively impact enrolment ratios with limited financial resources goes beyond the data currently available. It would require further analysis on financial commitments in each country, focus group discussions with children and parents to understand access barriers, and situational analyses of population characteristics and refugee governance.

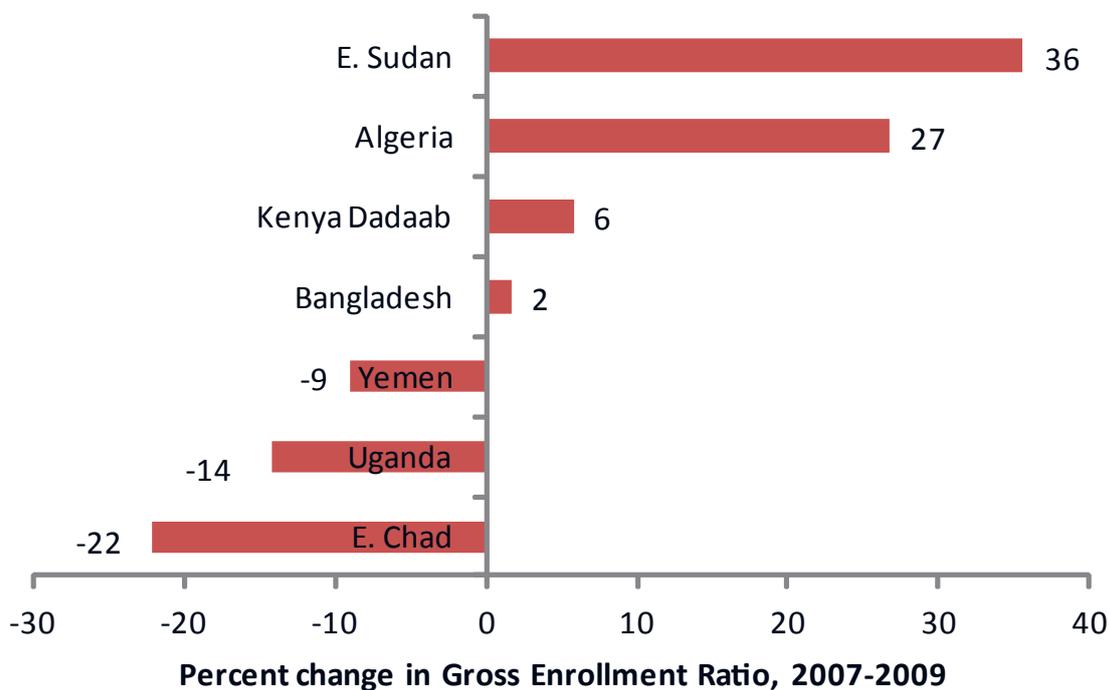


Figure 4.5. Percent change in Gross Enrolment Ratios, 2007-2009, in camp settings in priority countries. Source: (UNHCR, 2008c, 2009j).

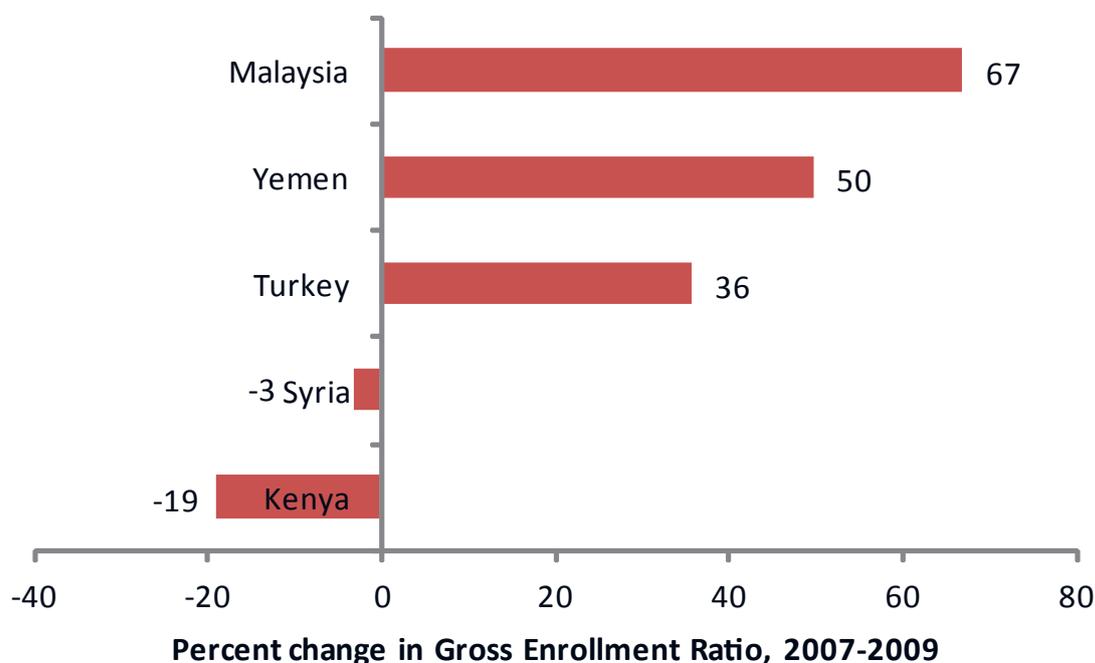


Figure 4.6. Percent change in Gross Enrolment Ratios, 2007-2009, in urban settings in priority countries. Source: (UNHCR, 2008c, 2009j).

As described in Section 3, human resources allocated to education are minimal. In 2004, 0.1% of UNHCR's total budget was allocated to education staff (Kelley, Sandison, & Lawry-White, 2004, p. 27). At the field level, there is only one education officer post, an Associate Education Officer position created in 2011 in Chad (see Figure 3.10). The general assumption from Headquarters that dominates the discourse on how UNHCR can “do” education without education staff, as stated by one staff member, is that education is “like football: everybody is an expert.”

Most field-based staff vehemently disagree. On the survey for this review, field-based staff described education “focal points” as having some education background or having been teachers previously. For the most part, UNHCR staff members who work in 51 operations and who self-identify as being in charge of education within their offices described the expertise and training on education among staff in their country offices as follows: “low,” “none that I am aware of,” “limited, education has not remained a priority area,” “no training,” “no specific expertise in education available.” A few survey respondents described having some knowledge of refugee education from “access to the *INEE Minimum Standards*,” even if they had had no particular training on them. Some also described comfort in working on education due to their “on the job training” over many years. The rotation of field staff and the fact that education focal points are sometimes Community Services Officers, sometimes Protection Officers, sometimes Programme Assistants makes the targeting of education training difficult. Education is one of the Global Strategic Priorities, however, “it is sheer luck if [a field office has] anyone who has previously worked on education.”

To compensate for this shortage, refugee education has been outsourced, a practice not uncommon in humanitarian and development work generally. Most commonly, expertise in education is located within IPs, and UNHCR field staff commonly report that they “depended greatly on IPs’ expert staff.” Staff in 14 out of 51 responding operations identified IPs as “in charge” of refugee education. Even in operations where UNHCR staff members perceived the responsibility for refugee education to be within UNHCR, design of programmes, decision-making, and daily implementation about education resides with the IP. Only five survey respondents described any kind of education training provided by UNHCR to IPs, while many of the other 74 respondents specifically stated that no training was provided. The relationships between UNHCR and education IPs are typically described as ones in which UNHCR provides “support and advice” and “consultation,” and IPs report back through mechanisms defined by UNHCR. Substantial field-level data collection would be necessary to evaluate the effectiveness of IPs as *de facto* UNHCR Education Officers.

In some cases, Community Services Officers or other UNHCR staff members in charge of education do have experience and expertise in the sector. Yet even when this is the case, education is often neglected given that the Community Services portfolio usually includes health services, community development, case management, and outreach activities, in addition to education (UNHCR, 2009k, p. 46). In some cases, there are IPs in the education sector with deep technical expertise. Yet even when this is the case, there remains a gap in overall programme management and monitoring, jeopardising appropriate levels of accountability for quality refugee education. In some countries, there are several IPs, and UNHCR lacks the technical capacity for coordination.

Without a clearly defined locus of oversight for refugee education at the field level, there are also few channels for technical support from Headquarters. Some survey respondents indicated productive partnerships between the Education Unit at Headquarters and field offices, usually as follow-up from field missions and in particular around specific projects such as discreet negotiations to introduce education for Rohingyas in Bangladesh and funding school supplies for refugees in urban Malaysia. Most survey responses, however, illuminate the missing link between useful working relationships between Headquarters and the field: given their position within the office, education focal points usually communicate with Headquarters only through their supervisors.

The need for well-trained staff to fill education posts at the field level is clear, especially to monitor the quality of education activities and to manage, from a technical perspective, partnerships with other UN agencies, NGOs, the donor community and increasingly important relationships with national MoEs.

Recommendation:

The widespread assumption that the lack of positive outcomes in refugee education is caused by lack of adequate financial resources has a strong basis. However, lack of funding is compounded by limited to non-existent expertise in education at the field level. Given the immense challenges to access to a high quality and protective education for refugees, the augmentation of educational expertise at field level is essential to the productive use of existing and additional resources. This should be done in several ways: the creation of Regional Education Advisors who can support several education programmes at country level, develop strategies, and strengthen local capacity; the creation of field-level Education Officer positions in country offices, where possible; institutionalisation of hiring and rotation policies that place staff with education expertise in appropriate Community Services and Protection posts, specifically in regional offices and in operations with large education programmes; and the careful assessment of the capacities of IPs, with assistance from regional offices and/or Headquarters, to ensure that they are technically strong in education.



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Education expertise at the field level is central to the provision of high quality and protection education for refugees

■ Challenge #7: There are challenges to coordination in refugee education, including complex power dynamics, which limit the productivity of partnerships.

Despite the rhetorical commitment to aligning education with the core protection mandate of UNHCR and despite the external advocacy by UNHCR Senior Education Officers within the broader field of education in emergencies, there is little evidence of tangible organisational commitment by UNHCR to guaranteeing the right to quality education for refugee children.

Yet, what was true a decade ago remains true today: “UNHCR’s responsibilities for education cannot be abdicated” (Sinclair, 2001, p. 69). The evidence is abundant, however, that UNHCR alone cannot meet the needs for quality and protective refugee education. Coordination is a critical opportunity for UNHCR in order to meet the challenges to refugee education. What forms of coordination are most effective in meeting these needs?

The decentralisation of decision-making to UNHCR country offices generally has been critical in the ability of individual operations to make decisions that effectively respond to the unique context of the operation. This decentralisation has been particularly problematic, however, for education, given the lack of expertise at the country level. In addition to field-level partnerships with IPs, under contract to UNHCR, there are several coordination relationships that define UNHCR’s education work at the field level.



First are relationships with national Ministries of Education (MoEs). In most cases, UNHCR has no ongoing contact with the MoE. UNHCR-government contacts are with Commissioners of Refugees, Offices of the Prime Minister, Ministries of the Interior, or Ministries of Disaster Preparedness, for example. In a few situations, usually in a repatriation context, MoEs are perceived to be “in charge” of refugee education and even serve as IPs. In between are the two most common forms of interaction between UNHCR and MoEs: issue-based advocacy and general advocacy. Issue-based advocacy is often quite specific and time-bound. In Rwanda, for example, UNHCR successfully negotiated with the Rwandese MoE to adapt for refugees their policy of assigning primary school graduates to secondary schools anywhere in the country. Given the challenge posed for UNHCR and IPs to follow the progress of refugee children in schools spread across the country and far from the camps, and the protection risks of this situation especially for refugee girls, the MoE agreed to assign refugee children to schools in the areas surrounding the camps.

UNHCR also advocates with MoEs on broader issues of access to education, curriculum choice, certification, and of including the educational needs of refugees in national sector planning. In Malaysia, for example, UNHCR attempted to build the awareness of MoE staff on the educational needs of refugees through facilitating visits to informal refugee schools, laying the groundwork for higher-level advocacy for refugee access to national schools. The MoE has collaborated with UNHCR in selecting Malaysian textbooks for refugee schools, made opportunities available for some limited training, and participated in UNHCR education planning meetings for 2012-2013. Refugee children nevertheless continue to be barred from accessing national schools.

As there is greater need to integrate refugees into national systems, both in the case of urban refugees and protracted refugee situations, this kind of coordination with MoEs is essential. Even in situations where IPs are the principal actors in refugee education, they are requesting that UNHCR take up the coordination role with MoEs (UNHCR, 2009c, p.13). Key informants both internal and external to UNHCR indicate that national authorities are indeed more responsive to advocacy efforts led by UNHCR than to those initiated by NGOs.

Second is coordination with UNICEF, as the UN Children's *Emergency Fund*, has a long history of work in emergency situations. From its inception as a humanitarian agency, it has transformed into a development agency and, more recently, into a human rights advocate with a focus not narrowly on "children in emergencies" but on "children in need" (P. W. Jones, 2006, p. 600). Education is but one of the many components of UNICEF's work. *Vis-à-vis* this sector, the mandate of UNICEF is that every child gets an education, including in situations of disaster preparedness, emergency response, and early recovery. The lever for coordination between UNHCR and UNICEF is present, in this shared interest in children in need in crisis situations. The UNICEF 2010 *Core Commitments for Children in Humanitarian Action* expresses UNICEF's commitment to ensuring that "girls and boys access safe and secure education" in crisis settings; however, refugees are not explicitly mentioned, not once in the more than 50 page document (UNICEF, 2010a, pp. 36-39).

The issue of mandate here is central. The language of the 1996 MoU between UNHCR and UNICEF reaffirms that UNHCR has the mandate for refugee education. Yet it also opens space for "jointly determin[ing]" how UNICEF might support UNHCR efforts in the provision of education for refugees (UNHCR & UNICEF, 1996, p. 7). UNICEF has more than 300 education officers in the field and, in each country in which they work, has established relationships with the national MoE. Given the immense unmet needs in refugee education, coordination with UNICEF has become paramount.

In 2010 UNICEF and UNHCR published a note and consolidated work plan, as an addendum to the global MoU of 1996. It aimed at strengthening cooperation between the two agencies at the global level and bolstering support for existing field-based MoUs. It recognises the need for "predictability of partnership and bilateral cooperation for the protection and assistance of children of mutual concern, i.e., refugees, returnees, IDPs, and other affected local host populations" (UNICEF & UNHCR, 2010, p. 2). The three Result Areas for joint activity include joint assessments and information sharing; the provision of pre-primary and primary kits and basic learning materials; and collaboration in advocacy initiatives to address refugee issues within national education systems. These global MoUs are of use only as a catalyst for operational work at the field level. Any field-level outcomes of this addendum to the MoU remain to be seen. A joint needs assessment was conducted in Dadaab, Kenya in 2010, as per Result Area 1; unfortunately, UNHCR developed a follow-up action plan largely in isolation, without direct involvement of the MoE or UNICEF, contradicting the goals of the MoU and the vision of the joint needs assessment. This can largely be attributed to the absence of any dedicated, experienced education personnel in Dadaab, dependency on a non-continuous rotation of short term deployments, and the ensuing lack of continuity and consistency in programme orientation.

Existing relationships between UNHCR and UNICEF are governed by the 1996 global MoU and the 2010 addendum and also by regional and country MoUs as well as local practice. They are vastly different depending on the context. With returnee populations in Mauritania, for example, there are frequent miscommunications between UNHCR and UNICEF, with one cause being the lack of overlap in their day-to-day work, with UNICEF engaged in capacity-building at a central level and UNHCR operating at the field level (Rezzonico, 2011). On the survey for this review, UNHCR staff members in Brazil described close relationships between UNHCR and UNICEF in the capital but note UNICEF's absence from the field. On the other hand, UNICEF has collaborated with UNHCR in Botswana in providing school materials and in Dadaab, Kenya in organising teacher training. In Peninsular Malaysia, UNICEF activities are targeted exclusively toward the local population, although UNICEF does assist in the education of refugees in Sabah and Sarawak (Malaysian Borneo). UNICEF has assisted UNHCR more broadly in Malaysia in an advocacy role, raising the issue of refugee access to school with national authorities (Rahman, 2011).

There is wide consensus both within UNICEF and within UNHCR that inter-agency partnerships are personality-driven and depend largely on the individuals involved. Absent are strong institutional rela-

tionships and structures through which productive and long-term cooperation could take place. At a global level, the INEE has been this space for UNHCR and UNICEF to communicate.

Third is the Global Education Cluster, which holds promise as a site for field-level cooperation between UNHCR and both national MoEs and UNICEF. The Education Cluster is co-chaired by UNICEF and Save the Children. Formally, there are no education clusters in refugee settings, as UNHCR has the clear and sole mandate for refugee education. In practice, given the fluidity of IDP and refugee situations and the unmet needs in refugee education, education clusters do operate in some refugee settings. UNHCR has participated in the Education Cluster at the global level since its inception in 2006.

At the field level, UNHCR's participation in education clusters is uneven, undefined and, at times, contentious. A UNICEF staff member described a situation in Uganda in 2008, in which the Education Cluster mobilised educational materials and tents to create learning spaces in response to a massive influx of refugees from DRC. UNHCR was not involved in this action and criticised the Cluster for acting beyond its mandate. There was a genuine confusion of roles and responsibilities. In Eastern Chad, a MoU between UNHCR and UNICEF established UNICEF as the lead agency for refugee education, although this MoU is currently being revised. UNICEF organises coordination meetings once a month in which UNHCR participates. UNICEF also organises Cluster meetings in which national educational authorities play a central role but in which UNHCR does not participate. Without a presence, UNHCR is not part of essential policy dialogue related to sector plans; one consequence is that UNHCR cannot advocate for the inclusion of refugee children in these national plans. There is an urgent need to clarify and formalise UNHCR's role within field-level education clusters. Supposedly the lead agency in refugee education but without a co-chair role in the cluster, UNHCR staff members in some cases have eschewed participation. Without a *bona fide* seat at this table, UNHCR is unable to play its critical and mandated role in refugee education.

Recommendation:

Field presence in refugee situations remains, as it was historically, the principal value-added that UNHCR brings to refugee education. Given UNHCR's limited capacity and expertise in education, especially at the field level, formal and operational partnerships between UNHCR and national MoEs and UNICEF are essential in all refugee situations; partnerships with the Education Cluster are particularly relevant to emergency situations. The relationships must be strengthened not only by the rhetoric of MoUs but by mutual engagement at the field level and by joint implementation of jointly developed action plans.



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“The only inheritance you can give a child is education” (A refugee from Kenya)



Education as Durable Solution: Conclusions and Recommendations

The current state of the field of refugee education is “education for ultimate disappointment.”

This review makes seven recommendations in response to seven urgent challenges to refugee education (see Table 1). These concrete ways forward are necessary to address the immediate and dire state of access to high quality and protective education for most refugees globally.

Table 1.: Urgent Challenges in and Recommendations for Refugee Education

Challenge	Recommendation
<p>1. Urban refugee education requires an approach different from strategies used in camp-based settings.</p>	<p>In its new work in urban settings, UNHCR should prioritise working with national governments for the integration of refugees into national school systems, building in the new operational guidelines (UNHCR, 2011d). Critical is to conceptualise education work as the strengthening of education systems and not only the achievements of individual refugee children. In this endeavour, both national Ministries of Education and UNICEF are central partners. It will require UNHCR staff with knowledge and experience of national education systems, and time and resources should be dedicated to cultivating institutional and interpersonal relationships to facilitate this work and to ensure that national Ministries of Education take seriously the particular educational needs of refugee children and young people.</p>
<p>2. Limited access to post-primary education for refugees in both camp and urban settings has immense economic and social consequences, for both individuals and societies.</p>	<p>Given the individual and societal benefits that accrue to secondary education, and within the framework of Education for All (EFA), UNHCR needs to support education up to the end of secondary school. UNHCR's new budgetary emphasis on post-primary education, particularly secondary education, is to be commended. In order to overcome the challenges to secondary school access, especially for girls, UNHCR needs to actively pursue strategies that augment the supply of formal and accredited secondary school programmes, enhance the quality of available secondary schooling, and combat school drop-outs at the primary level. Simultaneous strategies of non-formal programmes for overage learners and technical and vocational training (linked to real market needs in the countries of asylum and of eventual return) and to post-graduation seed grants, will help to meet the needs of refugee young people for whom secondary school is not an option, based on ability, desire, or previous opportunities. Higher education plays a critical role for individual refugees and for societies in terms of leadership in protracted settings and in post-conflict reconstruction, and UNHCR should explore partnerships that augment these opportunities.</p>
<p>3. There is a shortage of quality teachers and lack of structures, including remuneration and training, to retain them.</p>	<p>The <i>INEE Guidance Notes on Teaching and Learning</i> describe teachers as “the lynchpin of education,” requiring “real investment” (INEE, 2010a, p. 19). For most refugee children, the education received in exile is their one shot at education, and the quality of their teachers is critical. There is an urgent need to think beyond short-term, emergency trainings and toward more extensive investments in teacher quality for refugee education. A new standard is required for UNHCR which incorporates the idea of sequential training that aims, over a period of years, to complete a basic qualification, recognition of which can hopefully be negotiated with home and/or host country governments. Strategies should include the development of indicators that measure teacher quality in terms of pedagogy and students’ learning outcomes; investment in more extensive teacher training initiatives, focused on both pedagogy and content, in partnership with local institutions that allow formal recognition of teacher qualifications; and engagement with issues of teacher compensation and certification through coordination and high-level advocacy to promote the retention of quality teachers.</p>

<p>4. The quality of refugee education, and how it is recognised, does not help children to make connections between schooling and their future livelihoods.</p>	<p>The Education Strategy 2010-2012 states that “[t]he need for quality services is beyond UNHCR’s existing capacity” (UNHCR, 2009c, p. 28). This simply cannot be accepted if UNHCR is to uphold its mandate to protect and assist refugees. There is an urgent need to devote resources to ensuring access to high quality and relevant education for refugees. Monitoring and evaluation will be central to this work. The data currently collected for education are not appropriate; it renders progress toward quality education both illusory and disappointing. In order to measure whether education is of high quality and is protective, outcomes need to be measured rather than inputs. It is not enough for refugee children to be in school with an acceptable teacher-pupil ratio. For education to be a durable solution, they must be learning meaningfully. In order to improve the quality of education, we need to know whether children are learning, what they are learning, and why. Summative learning assessments can provide a basis for understanding whether children are learning and point to areas in which learning is particularly difficult. UNHCR needs to require annually independent sample testing of student learning, beginning with reading abilities. Further, UNHCR needs to ensure that teachers are well-trained in formative assessments of children in order to develop on-going strategies to promote in-class learning.</p>
<p>5. The inherently political nature of the content and structures of refugee education can exacerbate societal conflict, alienate individual children, and lead to education that is neither of high quality nor protective.</p>	<p>Understanding of the conflicts out of which refugees come and the political situations in settings of exile must impact the design of appropriate educational interventions in order for education to protect children rather than fuel poor quality learning and on-going intolerance, prejudice, injustice, and conflict. In order to be adequately addressed, these analyses cannot be left to Implementing Partners (IPs) but must be guided by UNHCR education specialists in the field and at Headquarters. Some of the principles that can be put into action include: requiring needs assessments that include situational analyses; applying lenses of conflict and power to assess the content and structures of education, including curriculum, language, and relationships between actors; supporting peace education in all operations; and maintaining education programmes during repatriation, at least until education can be offered in areas of return.</p>
<p>6. Lack of financial resources, and their inconsistency, as well as a shortage of educational expertise both within UNHCR and among Implementing Partners (IPs), limits progress in refugee education.</p>	<p>The widespread assumption that the lack of positive outcomes in refugee education is caused by lack of adequate financial resources has a strong basis. However, lack of funding is compounded by limited to non-existent expertise in education at the field level. Given the immense challenges to access to a high quality and protective education for refugees, the augmentation of educational expertise at the field level is essential to the productive use of existing and additional resources. This should be done in several ways: the creation of Regional Education Advisors who can support several education programmes at country level, develop strategies, and strengthen local capacity; the creation of field-level Education Officer positions in country offices, where possible; institutionalisation of hiring and rotation policies that place staff with education expertise in appropriate Community Services and Protection posts, specifically in regional offices and in operations with large education programmes; and the careful assessment of the capacities of Implementing Partners (IPs), with assistance from regional offices and/or Headquarters, to ensure that they are technically strong in education.</p>

7. There are challenges to coordination in refugee education, including complex power dynamics, which limit the productivity of partnerships.

Field presence in refugee situations remains, as it was historically, the principal value-added that UNHCR brings to refugee education. Given UNHCR's limited capacity and expertise in education, especially at the field level, formal and operational partnerships between UNHCR and national Ministries of Education and UNICEF are essential in all refugee situations; partnerships with the Education Cluster are particularly relevant to emergency situations. The relationships must be strengthened not only by the rhetoric of MoUs but by mutual engagement at the field level and by joint implementation of jointly developed action plans.

To address the central discrepancy between the priority that refugees place on education and the status of this sector within UNHCR requires much bolder thinking and action. It requires a reconceptualisation of the role of education for refugees within UNHCR's response.

A refugee from Kenya explains that “[i]n Africa, in the olden times, you could give your children land as an inheritance.... Now in Africa... there's no land, people are many. So the only inheritance you can give a child is education” (Dryden-Peterson, 2009). Future security – economic, political, and social – is therefore less connected to where one is geographically and more to skills, capacities, and knowledge that can accompany an individual no matter where that future may be. In other words, future security – the durable solution – is tied to education.

Yet high quality and protective education is not only a durable solution for the future. It is also durable in the present. Unlike other durable solutions of repatriation, local integration, and resettlement that are not immediately realisable for most refugees, the durability of education for refugee children does not depend on resolution of the political and legal uncertainties that drive continued exile. Refugees who are educated are more likely than those who do not have these opportunities to be economically, politically, socially, cognitively, and psychologically resilient in all stages of their refugeehood – in exile, upon repatriation, upon resettlement, *and* in intervening times (Nicolai & Triplehorn, 2003; Tapscott, 1994). They are also more likely to regain legal, physical, and material protection by themselves and through their own means.

This is not a particularly new line of thinking. Indeed, the 1997 evaluation of UNHCR's refugee education activities described education as “the most critical element in bridging the gap between relief assistance and durable solutions. Whether the refugees eventually repatriate voluntarily, settle locally or resettle in a third country, basic education will be essential for their successful integration and future development” (UNHCR Inspection and Evaluation Service, 1997, p. 1). While not new, the linking of education to durable solutions is increasingly urgent.

The need for new thinking around durable solutions is evident, especially given that conflicts between 1999 and 2007 lasted, on average, 12 years in low-income countries and 22 years in middle-income countries (UNHCR, 2007b, p. 417). Given the protracted nature of most conflicts, the durability of any solution needs to begin during these long periods of exile. Further, given the uncertainty of the future for refugees, the increasingly globalised realities that most of them face, and the promise of knowledge-based economies, durable solutions need to be flexible and portable. Education can be both.

In order for education to be a durable solution for refugees, UNHCR should:

- Prioritise integrating refugees into national education systems, particularly in urban areas, working closely with Ministries of Education and UNICEF to strengthen national systems for the benefit not only of refugees but also host communities;
- Support education up to the end of secondary school for all refugees, with emphasis on access for girls and other marginalised groups;
- Seek additional opportunities for higher education for refugees, both scholarships and site-based programmes that use open and distance learning;
- Invest in sequential training for teachers that cultivates high quality skills related to both pedagogy and content and that leads towards a basic qualification that is recognised in home and/or host countries;
- Develop new standards and indicators to measure progress towards a quality and protective education, specifically focused on learning outcomes, and that include both formative in-class assessments and summative independent sample testing of student learning, drawing on the Early Grade Reading Assessment (EGRA) and on partnerships with UNESCO IIEP and national Ministries of Education;
- Institute conflict-sensitive analyses to all education policy and planning through the development of tools to assess the content and structures of education, including curriculum, language, and relationships between actors, and reinstitute peace education as a core component of refugee education;
- Ensure that the funding needs for high quality and protective education are met consistently, in keeping with education as a durable solution and a core element of UNHCR's mandate;
- Augment educational expertise at the field level through the creation of Regional Education Advisors; the creation of Education Officer posts in country offices, and the hiring of Community Services and Protection Officers with training in education; and the selection of Implementing Partners (IPs) with proven technical capacities in education;
- Formalise operational, field-level partnerships that establish clear lines of responsibility between UNHCR and national Ministries of Education and UNICEF in all situations, and with the Education Cluster in the event that both are involved in a refugee response.

Institutional arrangements need to be aligned with UNHCR's mandate for the provision of refugee education, as a basic right and as an enabling right for all refugee children. At present, UNHCR is in essence a funding mechanism for refugee education with little operational and organisational capacity to act on this mandate. At the same time, the visibility, logistical capacity, and field presence of UNHCR as an organisation raise expectations in education that are not aligned with resources and expertise in this sector. A commitment to education as durable solution means mainstreaming education into UNHCR's response, not rhetorically but with the resources – both human and financial – to make this possible in practice. Of course overall UNHCR staff costs have been reduced drastically over the past several years (DFID, 2011, p. 47), and it will remain a priority within UNHCR to improve efficiency. Yet the most important investments in the education sector are in human resources. Investment in partnerships with national Ministries of Education and UNICEF, including through the Education Cluster, and with Implementing Partners (IPs) who are technically skilled in education are critical to the expansion of capacity for refugee education. However, in order for UNHCR to be responsible and accountable for refugee education, these partnerships cannot replace the creation of education expertise within UNHCR at the field level, in Regional and Country Offices.

While education does hold promise as a durable solution, it is not a panacea. In the rhetoric around education as a tool for protection, education is described as a “space” to identify other protection issues (UNHCR, 2003a) and to protect rights related to gender, sexual and gender-based violence, and

older learners (UNHCR, 2011e, pp. 31, 32, 33). Schools do provide important spaces for a myriad of protection issues. Yet neglected in the re-orientation of education within UNHCR toward protection is the core mission of education: learning. Education – not as a “space” but as learning – is itself protective, especially as a mechanism for enabling present and future durable solutions. “If we choose between food and education,” said a refuge PTA member in Dadaab camp in Kenya, “we choose education. Ignorance is what destroyed our country” (UNHCR & CARE, 2009, p. 5). For refugee children and parents, it is for this promise of learning that they prioritise education over other critical spheres of UNHCR assistance. A renewed focus on refugee education – not as a stand-alone service, not as a peripheral mandate, but as a durable solution – cannot neglect this core.

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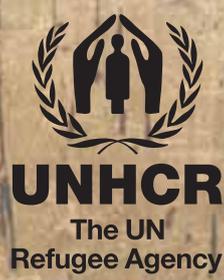
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School and Community-Based Interventions for Refugee and Asylum Seeking Children: A Systematic Review

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Abstract

Background: Research for effective psychological interventions for refugee and asylum-seeking children has intensified. The need for interventions in environments more easily accessed by children and families is especially relevant for newly arrived populations. This paper reviews the literature on school and community-based interventions aimed at reducing psychological disorders in refugee and asylum-seeking children.

Methods and Findings: Comprehensive searches were conducted in seven databases and further information was obtained through searching reference lists, grey literature, and contacting experts in the field. Studies were included if they reported on the efficacy of a school or community-based mental health intervention for refugee or asylum-seeking children. Two independent reviewers made the final study selection, extracted data, and reached consensus on study quality. Results were summarized descriptively. The marked heterogeneity of studies excluded conducting a meta-analysis but study effect-sizes were calculated where possible. Twenty one studies met inclusion criteria for the review reporting on interventions for approximately 1800 refugee children. Fourteen studies were carried out in high-income countries in either a school ($n = 11$) or community ($n = 3$) setting and seven studies were carried out in refugee camps. Interventions were either primarily focused on the verbal processing of past experiences ($n = 9$), or on an array of creative art techniques ($n = 7$) and others used a combination of these interventions ($n = 5$). While both intervention types reported significant changes in symptomatology, effect sizes ranged from 0.31 to 0.93 and could mainly be calculated for interventions focusing on the verbal processing of past experiences.

Conclusions: Only a small number of studies fulfilled inclusion criteria and the majority of these were in the school setting. The findings suggest that interventions delivered within the school setting can be successful in helping children overcome difficulties associated with forced migration.

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Introduction

The stressful experiences that many refugees and asylum-seekers are exposed to during forced migration, be that during persecution, flight and resettlement or in the changes they experience in their family, community and society make them vulnerable to a range of psychosocial problems [1]. As more is understood about the potential psychological sequelae of traumatic events experienced by refugees, research for effective interventions conducted in different settings has intensified [2]. These interventions can be delivered to individuals, families or groups and in either clinical or non-clinical/community settings. The intervention can either be focused on previous potentially traumatic events or can be multi-modal and comprehensive in design, concurrently addressing a number of issues in the child's environment and social networks as well as past experiences [3,4]. The choice of potential interventions can therefore be limitless and so developing a coherent evidence-base is crucial to ensure that those interventions that are effective can be replicated and those that are not effective, discontinued.

The UNHCR estimated that at the end of 2012 there were 10.5 million refugees worldwide, of which approximately half were under the age of 18. Only a small proportion of all refugees reach high-income countries amounting to less than half a million in 2011 [5]. A substantial proportion of those forcibly displaced from their homes move within their country of origin and are designated as internally displaced persons (IDPs) of which there were 17.7 million in 2012 [5]. Under the UN Refugee convention, the term 'refugee' is defined as someone who has fled their country of origin due to a well-founded fear of persecution because of race, religion, nationality, membership of a particular social group or political opinion [6]. An 'asylum-seeker' is waiting for their refugee status to be granted.

Mental Health Issues in Refugee Populations

The prevalence of psychological disorders varies amongst refugees across studies, although high rates of post-traumatic stress disorder (PTSD) appears to be a common finding. A study which compared rates of psychological problems among 300

school children living in the UK showed that refugee children scored significantly higher than two control groups on the teacher-rated Strengths and Difficulties Questionnaire with one quarter of refugee children showing serious difficulties. The refugee children, when compared to non-refugee children from ethnic minorities and indigenous white children, had significantly more total difficulties ($p < .01$) [7]. Unaccompanied and separated children are often subject to increased risk not only of potentially traumatic events during their migration journey, but also of significant psychological difficulty after arrival [8]. In a recent study of war-exposed adult refugees resettled in Europe, high rates of mood disorders (43%), anxiety disorders (44%), and PTSD (33%) were reported. Stressful resettlement conditions were found to be significant contributing factors [9]. This suggests support is needed not only to tackle the traumatic events experienced pre-migration but also to address the on-going psychosocial stress in resettlement.

When refugee and asylum-seeking children arrive in a resettlement country, they might have experienced a host of potentially traumatic events depending on the conflicts they have left and the manner in which they have travelled to their new home. These experiences can be further confounded by post-migration events, such as stringent border controls, discrimination and social isolation which can raise the risk of developing psychological disorders [10,11]. Furthermore, children have to negotiate a vast number of new challenges in a resettlement country such as learning a new language and understanding the educational and cultural environments of a new school. This process can be disrupted by changes in accommodation resulting in further school changes and low school attendance [12]. These stressors can be mirrored in their neighbourhoods and communities impacting on the natural resilience of families by further disrupting their environment. The post-migration environment, however, can play a crucial role in supporting refugee and asylum-seeking children and it is also an environment which is amenable to supportive interventions, such as those in the school or community-setting. It is for this reason that we conducted a systematic review to determine the evidence-base and possible effectiveness of such interventions.

Refugee Camps

The 2011 UNHCR Global Report highlighted that one third of all refugees are living in camps or camp-like settings, with many likely to remain in them for several years [13]. Refugee camps present challenging living conditions where basic survival needs can become the overriding focus for families delaying restoration of the community and social milieu needed for healthy development [14]. It is estimated that vast numbers of children living in camps have significant psychological difficulties, exacerbated by the numerous adversities they can potentially experience, such as on-going insecurity, malnutrition, limited access to education, lack of work for parents, poor health and exposure to further violence and abuse [15]. Needless to say, mental health services in such settings are poorly available. There is a movement towards developing multimodal approaches to address mental and emotional health problems in these settings. For example, artistic activities in refugee camps have been used to engage recipients into 'constructive action' [14].

The School Context for Mental Health Interventions

Schools could provide an ideal setting to implement interventions to address the mental health needs of refugee children. In disrupted environments, schools are often one of the earlier institutions to be introduced and, throughout the world, most children can attend school. Therefore the school is an

environment that can potentially access children and their families. Schools can facilitate early identification and provide interventions to maximise cognitive, emotional and social development. Teachers and other school staff can identify children with difficulties as they observe children's behaviour in a range of settings, both structured and unstructured; over a long period of time and with different peers and adults [16]. School-based interventions delivered in a safe and informal setting potentially offer non-stigmatizing services which families may be more likely to accept given the increased likelihood of building relationships with school staff and the relatively easy access to children within school [17].

Birman *et al.*, noted the school context is where the process of acculturation develops and therefore providing support either on an individual basis or using a multimodal approach may serve to enhance socialization and support psychological adjustment and development [18,19]. Working with groups of children who have come together naturally in the school context can strengthen the child's relationship to the group through shared responsibilities, non-competitive activities and team work while simultaneously providing practical support [12].

Drawing on the Literature

Investigation into successful mental health interventions for this population is warranted [1] as little is known about which theoretical models or implementation strategies are most appropriate [20–22]. Few programmes have been evaluated in the real-world setting of schools with even fewer designed for immigrant or refugee children [22–25]. Creative activities in the classroom that provide opportunities for children to construct personal accounts of their lives, interact with others and express emotion have consistently been found to have a beneficial effect on self-esteem, conflict resolution and problem solving [26,27]. However, a literature review of interventions for refugee adults with PTSD and depression found trauma-focused cognitive behaviour therapy (TF-CBT) to be superior to other treatments [3]. A review of mental health interventions for children affected by war reported that creative-expressive, psycho-educational and recreational activities were most studied. Only a few studies had targeted specific PTSD symptomology using either TF-CBT or narrative exposure therapy (NET) [28]. This review was therefore conducted to systematically gather data on tested interventions to guide the development and understanding of the field.

Aims of the Study

To conduct a systematic review of mental health interventions that had been evaluated in school or community-settings for refugee and asylum-seeking children.

Methods

Search Strategy

Seven databases were systematically searched: CINAHL; Embase; ERIC; PsycINFO; Scopus; Sociological Abstracts and Web of Science. Studies of mental health interventions in school and community-settings for asylum-seeking and refugee children reported from January 1987 to December 2012 were identified. The search was completed in January 2013. Searches of similar terms were combined such as "refugee", "asylum-seeker", "migrant", "immigrant", "displaced" with "school" "community" and "intervention" or "treatment". The searches were limited to participants aged 2 to 17 years inclusive, and adaptations to the search terms were made in accordance with the requirements of each database. Additionally, grey literature was searched (WHO

database), article reference lists and the authors of significant papers were checked for other relevant articles and experts in the field were consulted. There were no language restrictions.

Criteria for Inclusion

Studies selected for inclusion were based on the following criteria:

- (1) Evaluation of a mental health intervention programme that addressed emotional, social or behavioural difficulties of the sample using a controlled or within-subjects experimental design
- (2) The population was inclusive of IDPs, asylum-seekers and refugees
- (3) Target age: 2 to 17 years inclusive
- (4) Intervention delivered in schools, refugee camps or the community as opposed to clinic and hospital-based settings
- (5) Intervention outcome was evaluated with a clinical psychometric measure

Studies for exclusion

Studies selected for exclusion were Interventions that:

- (1) Evaluated educational performance or language acquisition
- (2) Aimed to change the overall school environment without specific measures taken on the asylum-seeking and refugee children
- (3) Evaluated non-displaced children and adolescents in areas of on-going conflict
- (4) Reported single case studies

Quality of Ratings Scale

Following a broad review of quality rating scales [29] the Yates Scale was chosen to evaluate the quality of the studies as it was comprehensive and has been used in similar reviews [30]. As a quality rating scale it has face, content and construct validity with good reliability however, its criterion validity and internal consistency are not strong [29]. The Yates scale focuses on the quality of two main areas: Quality of design and methods and Treatment quality. The quality rating of each study was assessed independently by each author (RT and MF) and any discrepancies in results discussed.

In the Yates Scale, the evaluation of quality of design and methods includes questions on study sampling, minimisation of bias, outcome measures, control groups and statistical analyses. Scores range from 0 to 26 and cut-offs determined in another study were used (0–8: ‘not fulfilled’; 9–17: ‘partially fulfilled’; 18–26: ‘fulfilled’) [31]. The evaluation of treatment quality includes questions on the rationale and explanation of the treatment, whether it is manualised, therapist training and patient engagement. Scores range from 0 to 9 (0–3: ‘not fulfilled’; 4–6: ‘partially fulfilled’; 7–9: ‘fulfilled’).

Effect Size

Effect sizes of the study interventions were either obtained from the publications when provided or calculated for this review using a procedure outlined by Thalheimer and Cook [32] and cross-checked against a web-based calculator [33]. Cohen’s *d* effect sizes were computed for symptom change to try and present data in a manner that could be compared across studies, given the high clinical heterogeneity of the sample [34]. The calculations were conducted using the average standard deviations between two

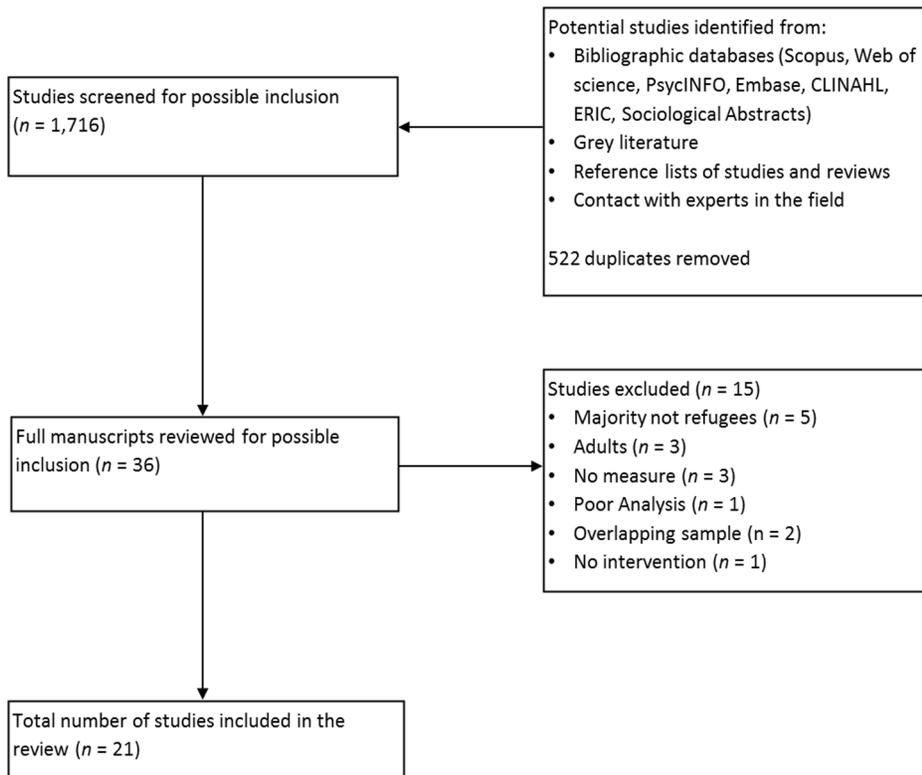


Figure 1. Flow Diagram to show the process of Study Selection.
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Table 1. Summary of included studies.

First Author	Setting	Country	Intervention focus	Intervention	Instrument used	Study type	Target population	Selection criteria	Sample size*	Age yrs	Quality of design and methods	Treatment quality
STUDIES from High-income settings												
Baker 2006 [52]	School	Australia	Creative arts (music therapy)	Group	BASC	CCT: Cross-over design	Newly arrived refugees	Present at school for following two terms	31 (31)	11–16	Partially fulfilled	Not fulfilled
Barrett 2003 [56]	School	Australia	CBT (FRIENDS)	Group	SEI, RSES, RCMAS, TSCL, BHS, KHS	Case-control study: classes grouped together	Mixed migrant population, approx. half refugees	ESL class	166	6–19	Partially fulfilled	Fulfilled
Beehler 2012 [17]	School	USA	CBT, TF-CBT, comprehensive (CATS)	Individual, Group	CAFAS, PTSD-RI	Cohort study: two school districts	Mixed migrant population, small proportion refugees	Referred by staff, nurses or parents	149	6–21	Not fulfilled	Partially fulfilled
Birman 2008 [40]	Community	USA	Comprehensive (FACES), Counselling, therapy, creative arts	Individual, Family & Group	CAFAS, HTQ	Cohort study: attending specialist service	57% Refugees and asylum seekers, 43% other types of migrant	Needing further intervention	97 (68)	6–18	Not fulfilled	Not fulfilled
Dura-Vila 2013 [36]	School	UK	Individual, family & supportive therapy.	Individual, Family	SDQ	Cohort study: referred to specialist service	Refugees and asylum seekers	Referred by teachers & social workers	92 (74)	3–17	Not fulfilled	Not fulfilled
Einholt 2005 [12]	School	UK	CBT	Group	R-IES, DSRS, RCMAS, WtQ, SDQ	CCT	Asylum-seekers	Referred by teachers	15	11–15	Not fulfilled	Fulfilled
Ellis 2013 [35]	Community	USA	Comprehensive, Skill-based groups +/-TST	Individual, Group	WTSS, PWA, PTSD-RI, DSRS	Cohort study: attending a school	Somali refugees	All Somali ESL children	30 (26)	11–15	Fulfilled	Partially fulfilled
Fazel 2009 [41]	School	UK	Supportive therapy & creative arts	Individual, Family & Group	SDQ	Cohort study: referred to specialist service	Refugees and asylum seekers	Referred by teachers	69 (47)	5–17	Partially fulfilled	Not fulfilled
Fox 2005 [54]	School	USA	CBT	Group	CDI	Cohort Study	South-East Asian refugees	All those attending a school	58	6–15	Not fulfilled	Not fulfilled
Kalantari 2012 [44]	School	Iran	Exposure through writing	Group	TGIC	RCT	Afghan refugees	High score on traumatic grief measure	29 (29)	12–18	Partially fulfilled	Partially fulfilled
Möhlen 2005 [55]	Community	Germany	Trauma-focus therapy and Creative arts	Individual, Family & Group	HTQ, K-SADS, DYSIPS, CGAS	Cohort study	Kosovo-Albanian refugees	In refugee accommodation.	10 (10)	10–16	Not fulfilled	Partially fulfilled
Rousseau 2005 [45]	School	Canada	Creative arts (CEW)	Group	TRF, CSCS, Dominic Interactive	RCT: whole classes randomly assigned	Mixed migrant, mainly Asian & South American	Students in special integration and normal classes	73 (73)	7–13	Partially fulfilled	Not fulfilled

Table 1. Cont.

First Author	Setting	Country	Intervention focus	Intervention	Instrument used	Study type	Target population	Selection criteria	Sample size*	Age yrs	Quality of design and methods	Treatment quality
Rousseau 2009 [46]	School	Canada	Creative arts (CEW-sandplay)	Group	SDQ	RCT: whole classes randomly assigned	Predominantly South Asian (28% refugees)	All students	52	4–6	Fulfilled	Partially fulfilled
Schotteikorb 2012 [47]	School	USA	TF-CBT vs. creative arts (CCPT)	Individual vs. group	UPID, PRPS	RCT	Refugees	Referred by teachers	31 (26)	6–13	Partially fulfilled	Fulfilled
STUDIES from REFUGEE and IDP CAMPS												
Ager 2011 [48]	School in IDP camp area	Uganda	Creative arts (PSSA)	Classroom	Modified BEI	RCT: schools randomly assigned	Ugandan IDPs	Referred by teachers	203 (191)	7–12	Partially fulfilled	Partially fulfilled
Bolton 2007 [49]	Camp	Uganda	IPT vs. creative arts (CP)	Group	APAI	RCT	Ugandan IDPs	High score on depression scale	210 (210)	14–17	Partially fulfilled	Fulfilled
Catani 2009 [50]	Camp	Sri Lanka	KIDNET vs. meditation relaxation	Individual vs. group	UPID, authors' functioning scale	RCT	Sri Lankan IDPs	Children in new camps with preliminary PTSD diagnosis	31 (31)	8–14	Partially fulfilled	Fulfilled
Ertl 2011 [51]	Camps	Uganda	NET vs. academic catch-up and counselling	Individual	CAPS, MINI, VWAES, adapted stigma scale	RCT	Ugandan former child soldiers	PTSD diagnosis	57 (57)	12–25	Fulfilled	Fulfilled
Gupta 2008 [43]	Camp	Sierra Leone	Creative arts (Rapid-Ed)	Group	IES	Cohort study	Sierra Leonean IDPs	Randomly selected from school registration lists	315 (306)	8–17	Not fulfilled	Partially fulfilled
Onyut 2005 [42]	Camp	Uganda	KIDNET	Individual	PDS, HSCL, CIDI	Cohort study (pilot)	Somali	PTSD diagnosis	6	13–17	Partially fulfilled	Fulfilled
Thabet 2005 [53]	Schools in camp area	Gaza	Creative arts (modified CISM) vs. teacher psycho-education	Group	CPTSD-RI, CDI	CCT	Palestinians residing in camps	High PTSD symptom scores	69	9–15	Fulfilled	Partially fulfilled

*Sample size calculated excluding non-active controls; brackets indicate final number used in evaluation, if reported.

APAI: Acholi Psychosocial Assessment Instrument; BASC: Behaviour Assessment System for Children; BEI: Brief Ethnographic Interviewing; BHS: Beck Hopelessness Scale; CAFAS: Child and Adolescent Functional Assessment Scale; CAPS: Clinical-Administered PTSD Scale; CATS: Cultural Adjustment and Trauma Services; CBT: Cognitive Behaviour Therapy; CCPT: Child-Centered Play Therapy; CCT: Controlled Clinical Trial; CDI: Children's Depression Inventory; CEW: Creative Expression Workshops; CGAS: Child Global Assessment Scale; CIDI: Composite International Diagnostic Interview; CISM: Critical Incident Stress Management; CP: Creative Play as developed by War Child Holland; CPTSD-RI: Child Post Traumatic Stress Reaction Index; CSCS: Piers-Harris Children's Self-Concept Scale; DRSR: Depression Self-Rating Scale; DYISPS: Diagnostic Symptom for Psychological Disorders; ESL: English as a Second Language; FACES: Family, Adult and Child Enhancement Services; HSCL: Hopkins Symptom Checklist-25-HTQ; Harvard Trauma Questionnaire; IDP: Internally displaced person; IES: Impact of Events Scale; IPT: Interpersonal therapy; Exposure Therapy; PDS: Posttraumatic Diagnostic Scale; KIDNET: Narrative Exposure Therapy adapted for children; K-SADS: Kids Schedule for Affective Disorders and Schizophrenia; MINI: Mini International Neuropsychiatric Interview; NET: Narrative Scale-Somali Version; RCMAS: Revised Children's Manifest Anxiety Scale; RCT: Randomised Clinical Trial; R-IES: Revised Impact of Events Scale; RSET: Rosenberg Self-Esteem Scale; SEI: Self-Esteem Inventory; SDQ: Strengths and Difficulties Questionnaire; TF-CBT: Trauma-Focused Cognitive Behaviour Therapy; TGIC: Trauma Grief Inventory for Children; TRF: Achenbach's Teacher's Report Form; TSCC: Trauma Symptom Checklist for Children; TSCL: Trauma Symptom Checklist for Children; TST: Trauma Systems Therapy; UPID: UCLA PTSD Index for DSM-IV; WTAES: Violence, War and Abduction Exposure Scale; War Trauma Questionnaire; WTSS: War Trauma Screening Scale. doi:10.1371/journal.pone.0089359.t001

Table 2. Summary of significant findings in studies.

First author	Intervention	Significance	Effect size Cohen's <i>d</i> (data permitting)
Depression			
Barrett, 2003[56]	CBT	Decrease in hopelessness symptoms in high school students as measured by the BHS ($p < .01$)	0.93
Bolton, 2007[49]	<i>IPT</i>	Group <i>IPT</i> reduced depressive symptoms ($p = .02$)	0.57
Ellis, 2013[35]	TST	Decrease in depression symptoms ($p = .011$) as measured by the DSRS	
Fox, 2005[54]	CBT	CBT reduced depressive symptoms ($p < .001$)	
Möhlen, 2005[55]	Creative arts	Range of creative art techniques reduced depressive symptoms ($p = .014$)	
Anxiety			
Barrett, 2003[56]	CBT	Anxiety symptoms decreased following group based CBT for elementary school ($p < .001$) and high school students ($p < .05$) as measured by the RCMAS	0.93 (elementary) 0.67 (high)
Ehnholt, 2005[12]	CBT	Decrease in anxiety symptoms ($p = .018$) as measured by the RCMAS	0.64
Möhlen, 2005[55]	Creative arts	Range of creative art techniques reduced anxiety symptoms ($p = .006$)	
PTSD			
Barrett, 2003[56]	CBT	Decrease in PTSD symptoms for high school students with group based CBT ($p < .001$) on the TSCC PTSD subscale	0.92
Beehler, 2012[17]	CBT, TF-CBT, comprehensive	Decrease in PTSD symptoms with TF-CBT ($p < .05$), supportive therapy ($p < .04$) and a decreasing trend was found with CBT ($p < .07$).	
Catani, 2009[50]	<i>KIDNET</i> & meditation-relaxation	<i>NET</i> and meditation-relaxation reduced PTSD symptoms, sustained at follow-up ($p < .001$)	
Ehnholt, 2005[12]	CBT	Decrease in PTSD symptoms ($p = .011$) as measured by the IES	0.88
Ellis, 2013[35]	TST	Decrease in PTSD symptoms ($p = .016$) as measured by the PTSD-RI	
Ertl, 2011[51]	<i>NET</i>	Decrease in PTSD symptoms with <i>NET</i> , as measured by the CAPS, compared to supportive counselling ($p = .02$) and waiting list controls ($p = .02$)	0.31
Gupta, 2008[43]	<i>Creative arts: Rapid-Ed</i>	Decrease in PTSD symptoms in 96% of participants following intervention.	
Möhlen, 2005[55]	Creative arts	Decrease in PTSD symptoms with a range of creative art techniques ($p = .018$)	
Onyut, 2005[42]	<i>KIDNET</i>	Decrease in PTSD symptoms with <i>KIDNET</i> ($p = 0.039$)	
Schottelkorb 2012 [47]	TF-CBT & CCPT	Both interventions significantly decreased PTSD symptoms in those with symptom scores in the clinical range (child and parent-reported measures)	
Functional impairment			
Beehler, 2012[17]	CBT, TF-CBT, & supportive therapy	Decrease in functional impairment with TF-CBT ($p < .01$), supportive therapy ($p < .001$) and CBT ($p < .03$).	
Birman, 2008[40]	Comprehensive service, counselling, therapy, creative arts	Decrease in functional impairment following a mixed intervention of cognitive therapy and creative arts ($p < .001$).	
Catani, 2009[50]	<i>KIDNET</i> & meditation-relaxation	Decrease in functional impairment sustained at follow-up with both <i>KIDNET</i> and meditation-relaxation ($p < .001$).	
Ertl, 2011[51]	<i>NET</i>	Decrease in functional impairment with <i>NET</i> compared to supportive counselling ($p = .008$) and waiting list controls ($p < .001$)	0.64
Other			
Barrett, 2003[56]	CBT	Anger: Decrease in levels of anger ($p < .001$) in high school students as measured by the TSCC Anger scale	0.79
Ehnholt, 2005[12]	CBT	Behavioural problems: Decrease in behavioural problems ($p = .027$) as measured by the SDQ	
Ehnholt, 2005[12]	CBT	Emotional problems: Decrease in emotional problems ($p = .010$) as measured by the SDQ	0.32
Rousseau, 2009[46]	Sandplay	Emotional problems: Decrease in parent-rated SDQ emotional problems ($p = .002$) Relational problems: Decrease in parent-rated relational problems ($p = .001$)	0.43 0.48
Ellis, 2013[35]	TST	Resource hardship: Decrease in resource hardship ($p = .027$)	
Durà-Vilà, 2013[36]	Individual, family & supportive therapy	Conduct problems: Decrease in parent-rated conduct problems ($p = 0.043$) Hyperactivity: Decrease in teacher-rated ($p = 0.015$) and parent-rated ($p = 0.001$) hyperactivity Peer Problems: Decrease in teacher-rated peer problems ($p = 0.017$) as measured by the SDQ	

Table 2. Cont.

First author	Intervention	Significance	Effect size Cohen's <i>d</i> (data permitting)
Fazel, 2009[41]	Supportive therapy & creative arts	Peer Problems: Decrease in teacher-rated peer problems for both CBT and creative arts therapy ($p = .005$)	
Kalantari, 2012[44]	Exposure through writing	Traumatic grief: Decrease in children's traumatic grief symptoms ($p < .001$) as measured by the TGIC	0.67
Rousseau, 2005 [45]	Creative expression	Mental health symptoms: Decrease in self-reported mental health symptoms	
Ager, 2011[48]	Creative arts	Well-being: Improved well-being at 12 months according to self-rated ($p < .001$), and parent-rated ($p = .01$) measures but not teacher ratings ($p > .1$)	0.75 (self-rated); 0.5 (parent-rated)

Italicized studies indicate those conducted in refugee and IDP camps.

CAPS: Clinical-Administered PTSD Scale; CBT: Cognitive Behaviour Therapy; CCPT: Child-Centered Play Therapy; IPT: Interpersonal therapy; KIDNET: Narrative Exposure Therapy adapted for children; NET: Narrative Exposure Therapy; PSSA: Psychosocial Structured Activities program; PTSD-RI: PTSD Reaction Index; RCMAS: Revised Children's Manifest Anxiety Scale; SDQ: Strengths and Difficulties Questionnaire; TF-CBT: Trauma-Focused Cognitive Behaviour Therapy; TGIC: Trauma Grief Inventory for Recovery; TSCC: Trauma Symptom Checklist for Children; TST: Trauma Systems Therapy.
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means, therefore calculations could only be conducted for studies with a control group. Cohen proposed $d = 0.2$ as a small effect size, $d = 0.5$ as a moderate effect size, and $d = 0.8$ as a large effect size [34]. As limited follow-up data were available, the effect sizes were calculated from end of treatment scores.

Results

The database search identified 2,237 potentially relevant papers, of which over 500 were duplicates and the majority were not describing an intervention. 36 full papers were reviewed of which 23 met inclusion criteria reporting on 21 studies (refer to Figure 1 for the process of study selection). Two online publications were subsequently published in print [35,36]. The majority of papers were excluded on initial screening because they did not report on an intervention or the intervention reported was conducted on adults, non-refugee populations, or in hospital settings. Two papers reported on subsamples of larger included studies [37,38]. The studies were undertaken in ten different countries on either specific refugee populations or mixed groups of migrant children, including refugees. Four authors provided further information on their studies (A. Ager, personal communication, November, 24, 2013; D. Birman, personal communication, December, 24, 2012; M. Hodes, personal communication, May, 20, 2013 & E. Newnham, personal communication, May, 20, 2013). Through searching article reference lists one unpublished study was identified which could not be obtained [39].

Intervention features

All twenty one studies meeting inclusion criteria were published since 2000 and included data from approximately 1,800 children (some studies included other migrant children). These reported school and community-based interventions aimed at the mental health, psychosocial development and functioning of asylum-seeking and refugee children. Table 1 presents a summary of the studies included with information on the intervention used, the population targeted and the assessment of study quality. Given the marked difference of refugee camp settings, the interventions that were provided in these camps are presented separately.

Due to the considerable variation in the types of intervention being delivered and the populations targeted by each intervention, a meta-analysis could not be conducted due to the significant clinical heterogeneity of the samples. Two broad classes of intervention were identified, firstly interventions based primarily on the verbal processing of past experiences ($n = 9$), and secondly,

creative art techniques ($n = 7$) with five further studies using a combination of both. The verbal processing approaches included CBT and TF-CBT; NET, Eye-Movement Desensitization and Reprocessing (EMDR) and Trauma Systems Therapy (TST). The creative art techniques drew on an array of different therapies including music therapy, creative play, drama and drawing. The range of different mental health interventions utilised in the included studies is shown in Figure 2. Services were delivered either in the school ($n = 11$), community ($n = 3$) or refugee camps ($n = 7$ of which 2 were in camp schools). Of these, four studies included consultation meetings with professionals working in other agencies [35,36,40,41].

Study Quality

Quality of design and methods. In assessing overall quality of design and methods in the studies, four studies scored 'fulfilled'; ten 'partially fulfilled' and seven 'not fulfilled'. For example, information on attrition rates (participants lost at follow-up) was only reported in six studies and minimising biases reported in 18 studies (four 'fulfilling' criteria and 14 partially fulfilling criteria). All 21 studies fulfilled the criteria for statistical reporting.

The sample sizes of included studies ranged from 6 participants [42] to 315 participants [43]. Eight studies used random allocation to determine groups [44–51]. Four studies were controlled clinical trials [12,35,52,53], eight were cohort designs [17,36,40–43,54,55] and one was a case control study [56]. Recruitment strategies differed across studies; in six studies children were selected to receive an intervention based on meeting specific criteria [42,44,49–51,53]. In five studies a whole class received the intervention [35,45,46,54,56]. Seven studies used referrals from school staff [12,17,36,40,41,47,48]. In three studies children were either selected on the basis of their refugee status [52], their residence in refugee accommodation [55], or randomly selected from a school register [43].

Treatment quality. In assessing treatment quality, seven studies scored 'fulfilled', eight 'partially fulfilled' and six 'not fulfilled'. Interventions typically lasted 10–12 weeks although there was a range from a fortnight [50] to 16 weeks [49]. The number of sessions varied between 6 and 17, most commonly lasting one hour. In three studies, interventions were conducted over the course of a school year [35,36,41]. A further two studies enlisted a range of individual and group therapies and longitudinal data were collected and analysed [17,40]. Beehler *et al.*, collected data over a 3 year period (the number of sessions cannot be inferred)

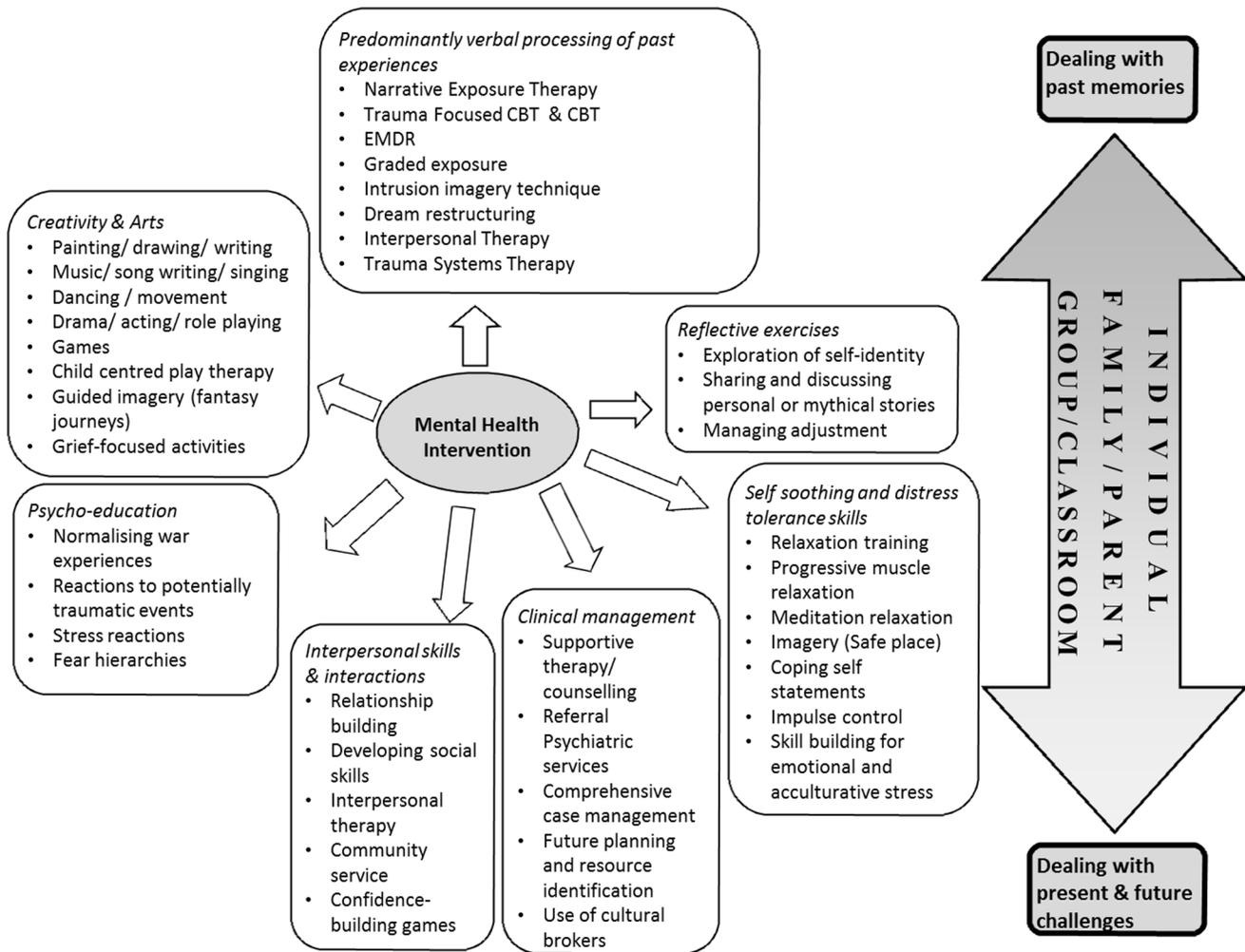


Figure 2. Diagram to show the range of mental health interventions included in the selected studies.
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[17], and Birman *et al.*, engaged participants in services for 1 month to 7 years [40]. Parents were involved in six interventions [17,36,40,41,48,55]. Three studies involved family therapy sessions [17,36,40], one involved individual parental support [48] and two studies incorporated both family sessions and individual parental sessions [41,55]. In one study, school staff also received weekly consultation with mental health professionals at the schools [41].

Two studies, both fulfilling most of the quality criteria, are described in the text boxes. Text Box 1 describes a CBT-based intervention in schools [56] and Text Box 2 describes a NET trial conducted in a refugee camp [51].

Effectiveness of the interventions

The intervention programmes reviewed addressed a range of difficulties experienced by asylum-seeking and refugee children. The studies reporting significant changes in psychological symptoms are summarised in Table 2. Cohen’s *d* effect sizes are reported for the seven studies that provided sufficient data for these to be calculated, five of which were for therapies based on verbal processing of previous traumatic events [12,44,49,51,56]. The effect sizes ranged from 0.31 to 0.93 and six of the studies had effect sizes in the medium to large range.

Both the verbal processing-based and creative art-based interventions led to significant reductions in symptoms of depression, anxiety, PTSD, functional impairment and peer problems. Verbal processing therapies were also effective in treating anger [56], traumatic grief [44], resource hardship [35], behavioural and emotional problems [12], and hyperactivity, peer and conduct problems [36]. Creative arts were also effective in treating well-being [48], and emotional and relational problems [46].

All but one study conducted in refugee and IDP camps found significant findings [53]. Two of these studies reported a significant decrease in functional impairment following NET [50,51]. Two studies found a decrease in PTSD symptoms following a creative arts intervention [43] and KIDNET (an adapted version of NET for children and adolescents) [42]. Bolton found interpersonal therapy (IPT) reduced symptoms of depression [49] and Ager found improvements in well-being following a psychosocial activities programme [48].

Five studies reported significant reductions in symptoms of depression [35,49,54–56]. Two of these studies used CBT. Bolton found IPT superior to an activity-based intervention in treating symptoms of depression ($p = .02$). Furthermore, the activity-based intervention was no more effective than waiting list controls in

treating depression [49]. Although these results point towards the importance of the cognitive behavioural approach in treating depression in refugee children it should be noted that Möhlen found a range of creative art techniques significantly reduced symptoms of depression ($p = .014$) [55].

Three studies reported a significant improvement in symptoms of anxiety. Group-based CBT and a creative art-based intervention incorporating psycho-education, creative techniques and relaxation activities in individual, family and group sessions were found to decrease levels of anxiety [12,55,56].

Nine studies reported a decrease in symptoms of PTSD among asylum-seeking and refugee children [12,17,35,42,43,50,51,55,56]. All but one of these treatments was grounded in the verbal processing of past experiences. Four of the studies were undertaken in low-income countries [42,43,50,51].

Only four studies reported improvements in functional impairment [17,40,50,51] incorporating a range of interventions. Catani found no significant difference in functional impairment following KIDNET or meditation-relaxation although at six month follow up recovery rates for KIDNET were higher at 81% as opposed to 71% [50]. Ertl, however, found functional impairment improved significantly with NET compared to supportive counselling ($p = .008$) and waiting list controls ($P < .001$) [51]. In the Birman study, participants received tailored services to meet their individual needs; it is therefore difficult to evaluate which elements of the intervention had the greatest impact on improvements in functioning [40]. Similarly, Beehler utilised a variety of interventions including TF-CBT, supportive counselling and other CBT approaches [17].

Discussion

Despite millions of children affected by forced migration only limited evidence is available as to possible school and community interventions to support the mental health of this group. Overall, 21 studies were identified, most conducted in schools with a variety of therapeutic tools and modalities utilised. Of the eight studies from LMICs, seven were conducted in refugee camps. Many of the interventions focused on past traumatic events, either using verbal processing, for which there is the strongest evidence-base, or by using an array of creative arts techniques. Significant improvements were seen for depression, anxiety, PTSD, functional disturbances and peer problems in both types of interventions. Individual as well as group interventions were effective; as were both short and long-term treatments. CBT or TF-CBT and NET both have evidence to support their use. Some services developed comprehensive interventions. Effect sizes calculated to compute symptom change in disorders were, however, primarily available for interventions based on the verbal processing of past experiences.

Six out of the seven studies conducted in refugee camp settings showed a significant reduction in psychological symptoms. The success of these interventions are noteworthy given that one third of all refugees will spend some time in a refugee camp, either in their own country or a neighbouring low and middle-income country (LMIC) [13]. NET was used in three of these studies and is an example of how complex interventions can be delivered in resource-poor settings.

Recent studies have highlighted the importance of offering comprehensive or multi-modal services to refugees and their families. Multimodal interventions aim to concurrently address issues of psychological functioning, social and cultural adaptation, physical health and ongoing psychosocial difficulties [3]. These multimodal interventions are thus integrated into other systems of

care, such as women's health or primary care and might play a particularly important role in contexts where mental health resources are scarce. Although the evidence supporting their use is limited, these services try to address the complex array of difficulties refugee and asylum seeking families might encounter. At the societal level, they might try to influence the wider environment through advocating for more services and stable housing, promoting language proficiency, improving immigration applications and employment opportunities. The restoration of a supportive environment for the young person and their family is likely to be key to stabilising their psychological health [28,57]. This ensures that all the needs identified by the individual or family are addressed and the focus is not entirely on their mental health [4,58]. Restoration of social support networks for children and their families is another important aspect of multimodal interventions and have been demonstrated in post-conflict settings [59]. The importance of harnessing cultural resources and extended kin networks are likely to also be important [60] and some of the studies included in this review included 'cultural brokers' in the mental health teams. In this systematic review, only three of the included studies were comprehensive and multimodal in design [17,35,40].

These studies therefore highlight the importance of addressing previous traumatic experiences utilising approaches that focus on exposure to the event in question through verbal processing. The studies that used CBT had the largest effect sizes. The evidence supporting the many different creative arts techniques is, at present, not as robust, however, interesting evidence is emerging in both post-conflict and post-migration environments on the importance of multimodal treatments. Many questions regarding treatments, therefore, remain unanswered and warrant further exploration. Collecting variables on educational attendance and attainment, future aspirations of individuals and the overall school climate from the perspective of students and staff would be important to determine the impact of services located within schools. Only five of the 21 included studies had more than 100 participants and so larger controlled studies with longitudinal collection of data will provide much needed evidence of effectiveness. Studies could elucidate the differential impact of effective treatments, such as a comparison of TF-CBT and NET; or determine whom to include in treatment by exploring interventions incorporating families, peers and school staff; as well as exploring the influence of different community locations for treatment such as working within the school compared to a local health clinic or within the family home. Answering some of these questions could enable a better appreciation of factors influencing therapeutic effectiveness, acceptability of treatment and engagement for these populations who are difficult to access in traditional services.

Limitations

Several limitations of this review should be highlighted. Of the 21 studies included, only eight monitored treatment fidelity and eight conducted a follow-up assessment. In combination with small sample sizes, lack of blind assessment, and inactive or no control groups the overall quality of studies reviewed was a limitation and highlights the areas needed to be addressed by further work. Participant eligibility varied across studies; in the majority of cases refugees and asylum-seekers were enrolled in treatment irrespective of whether they met clinically significant rates of psychological problems prior to the commencement of the intervention.

The studies were varied in their scope, environment and target population and so limited conclusions can be drawn on what is most effective for these settings. The interventions adopting the

most multimodal approaches attempting to address both systemic and individual needs were those with the lower quality ratings. This could reflect the difficulty of evaluating more complex interventions trying to address potential difficulties in community, school and refugee camp settings [17,36,40].

Studies of interventions for children living within current conflict conditions were excluded but could have provided some important examples of interventions. There have, however, been two recent comprehensive systematic reviews on mental health interventions for children living in conflict and post-conflict environments [28,57].

Conclusion

Refugee children arriving in a new country, either with or without their families, are likely to benefit from schools and services that can enable them to settle in their new environment. For those arriving in high-income countries, for example, accessing services can be fraught with difficulties due to linguistic, social, and historical reasons [61]. Cultural and family beliefs about psychological difficulties can also prevent parents or carers seeking professional help [37]. Furthermore, caregivers might not recognise some difficulties in children as being a manifestation of psychological problems. Past experiences faced by refugees can also make it difficult to establish a sense of trust necessary for a therapeutic relationship [62]. As a result, mental health services can experience difficulties in reaching these children and it is therefore important to determine the value of offering services in other settings [60,63–66]. These problems are overshadowed by the many larger difficulties faced in providing services in LMICs [1], however, some studies included in the review have been able to demonstrate impressive results in low-resource settings.

Adolescents derive psychological benefit from feeling they belong to a school yet this task can be particularly difficult if one arrives with limited knowledge of the local language and culture. This can be further complicated if they are more conspicuous at school and bullied as a result [67]. Schools are often recommended as a location for interventions because they can be familiar, non-stigmatising environments that offer broad access to children and families [20,59,68]. Developing sustainable and accessible interventions are essential and training local non-mental health professionals to deliver interventions could address this need [69]. Some studies utilised lay therapists successfully, a model that needs replication in other settings and with other therapeutic modalities. To this end, within schools, teachers or other members of school staff could be trained to promote mental health by creating a supportive and caring environment and through implementation of preventative and efficacious psychological interventions [12].

Parents and other primary caregivers can be compromised in the context of societal violence and subsequent migration and therefore families need to be supported in the community [60,63–65]. Interventions to try and address the overall environment of refugee children are therefore important, not only for unaccom-

panied minors [8] but all refugee children attending schools and living in new places. Longitudinal studies underline the importance of addressing these issues, as a study of refugees two decades after settlement in America showed how persistent later psychological problems are, especially if the refugees are unemployed and living in poverty [66].

The different contextual factors, environments and socio-cultural political contexts that refugees come from and find themselves in cannot be ignored [70] and services need to try and address the heterogeneity of difficulties, both past and present, that refugees experience [3]. This is the rationale for offering a broad range of services to refugee children [36] yet the evidence-base remains weak to support this approach over individualised trauma-focused work. For adult refugee populations and other traumatised children, CBT is the most studied and effective intervention [3,71]. There is, however, probably a need to also address current daily stressors [4] although interventions should not undermine natural recovery processes [69].

Achieving in school, with regards to both education and peer relationships, is a key determinant of success and future mental health [72]. War and conflict disrupt social, educational and economic systems and these exert effects on psychological well-being in complex ways [4]. These disruptions disproportionately affect the young and their transitions into adult life [72]. In particular, for younger populations the importance of family, peer and educational domains are crucial to help them fulfil their potential [72] and examples of effective mental health interventions are highlighted in this review.

Supporting Information

Diagram S1

(DOC)

Checklist S1

(DOC)

Text Box S1 FRIENDS programme delivered in a school setting.

(TIF)

Text Box S2 Narrative Exposure Therapy delivered in refugee camp setting.

(TIF)

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Author Contributions

Conceived and designed the experiments: MF. Performed the experiments: RT. Analyzed the data: RT MF. Contributed reagents/materials/analysis tools: RT MF. Wrote the paper: RT MF.

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The National Child
Traumatic Stress Network



Mental Health Interventions for Refugee Children in Resettlement

White Paper II

**From the National Child Traumatic Stress Network
Refugee Trauma Task Force**

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Heartland Health Outreach,
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Introduction and Background

The mission of the National Child Traumatic Stress Network (NCTSN) is to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States. The Refugee Trauma Task Force of the NCTSN specifically focuses on refugee children and their families. This White paper is a product of collaborative activities of this Task Force.

Previously, the Refugee Trauma Task Force published a White Paper titled *Review of Child and Adolescent Refugee Mental Health* ([White Paper I], Lustig et al., 2003) that reviewed the available literature. The paper described varied experiences in the lives of refugee children, including phases of migration, stressors associated with those phases, consequences of such stressors for psychological well-being, and coping strategies for dealing with the stressors. The paper also reported that high prevalence of psychopathology as defined by Western models of illness have been found in refugee children across numerous studies. Traumatic events experienced by refugee children prior to migration and during flight, as well as stresses during resettlement put them at risk for psychopathology. The paper concluded that many refugee children can greatly benefit from mental health services.

At the same time, the White Paper also noted that little information exists with respect to which mental health interventions are effective for traumatized refugee children, with no clinical controlled trials conducted with refugee children in resettlement reported in the literature. As a result, no evidence-based interventions for refugee children have been identified, making it difficult to determine appropriate standards of care for this high need population.

Despite little evidence about effectiveness of such interventions, many programs across the country, including several of the sites that participate in the NCTSN, are currently providing services to refugee children. In the absence of specific standards of care for traumatized refugee children, these programs face many challenges in creatively addressing the multiple needs of this vulnerable population. However, little is known about what service providers are doing, and which approaches they are taking to address the complex mental health needs of refugee children.

To learn about the services being provided within the network, the Refugee Trauma Task Force conducted a Survey of National Refugee Working Group Sites (Benson, 2004). The 13 sites surveyed are primarily located in urban areas, and serve a wide range of refugee populations from a variety of different countries. Most striking was the finding that mental health is not the only type of service provided across these sites, and that services are frequently provided outside traditional mental health clinic settings. In addition to mental health, a wide range of services is being provided, including medical, legal, case management and other social services. Alternatively, mental health programs have developed collaborations with other service providers where they refer their refugee clients. Further, most sites report conducting extensive outreach in the refugee communities and with other service agencies. In addition, most sites do not provide services only in a clinic setting, but also in schools, and in other community sites. These findings suggest that programs that provide services to refugees are using models of service that extend beyond the traditional clinic based mental health service model. The needs of refugee clients seem to require such a community based and comprehensive approach.



The purpose of this White Paper II–Interventions is to begin to fill the gap between a relative lack of research on effectiveness of mental health interventions for refugees, and the emerging efforts of agencies that provide services to this population. First, this paper revisits and summarizes the research reported on in White Paper I on the mental health needs of refugee children. Next, we propose that because of the complexity of needs of refugee children described in the literature, a comprehensive mental health services approach is needed. This notion is also supported by the preliminary data gathered from the NCTSN sites providing such services to refugee children (Benson, 2004). The remainder of the paper then focuses on exploring what a comprehensive mental health service model for refugees might look like. We identify necessary components or “key ingredients” of such a comprehensive model, and review the literature for any findings that may support the value of specific approaches or techniques. Finally, we make recommendations for next steps toward improving standards of mental health care for traumatized refugee children.

Who Are Refugee Children?

The focus of this paper is on mental health services to traumatized refugee children resettled in the U.S. The United Nations Convention Related to the Status of Refugee (1951) defines a refugee as a person who

owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country (UNHCR, 2002).

Refugees are specifically distinguished from economic migrants, who may leave a country voluntarily to seek a better life. Such immigrants would continue to receive the protection of their government if they were to return home. However, refugees flee because of the threat of persecution and cannot return safely to their homes.

According to the United Nations High Commissioner for Refugees (UNHCR), there are almost 22 million refugees located throughout the world (UNHCR, 2002). Approximately half of the world’s 20 million refugees are children (UNHCR, 2002; Joseph Westermeyer, 1991). Between 1988 and 2001, over 1.3 million refugees were admitted to the United States of America (U.S. Committee for Refugees, 2001).

We use the term “refugee” in this paper to refer to children who have experienced war related trauma or political violence regardless of whether they have legal refugee status in the U.S. Further, our focus is on refugee children in resettlement, who are undergoing the process of acculturation and adaptation to a new country and culture. Although they may share aspects of their experience with refugees who are internally displaced, such as during civil war, or in refugee camps, the experiences of permanently resettled refugees are distinct from these other situations, and involve different considerations in service delivery and intervention design.



Mental Health Issues for Refugee Children in Resettlement: Refugee Experiences and Mental Health Needs

Exposure to Trauma

As discussed extensively in the White Paper I, refugee children experience a great number of stressors throughout their pre-migration, flight, and resettlement experiences that impact on their psychological well being. Refugee children experience trauma resulting from war and political violence in their countries of origin prior to migration, as well as during flight or in refugee camps. These multiple stressors include direct exposure to war time violence and combat experience, displacement and loss of home, malnutrition, separation from caregivers, detention and torture and a multitude of other traumatic circumstances affecting the children's health, mental health and general well being. A large number of studies have documented a wide range of symptoms experienced by refugee children, including anxiety, recurring nightmares, insomnia, secondary enuresis, introversion, anxiety and depressive symptoms, relationship problems, behavioral problems, academic difficulties, anorexia, and somatic problems (Allodi, 1980; Almqvist & Brandell-Forsberg, 1997; Angel, Hjern, & Ingleby, 2001; Arroyo & Eth, 1985; Boothby, 1994; Cohn, Holzer, Koch, & Severin, 1980; Felsman, Leong, Johnson, & Felsman, 1990; Gibson, 1989; Goldstein, Wampler, & Wise, 1997; Hjern, Angel, & Hoejer, 1991; Hodes, 2000; Kinzie, Sack, Angell, Manson, & Roth, 1986; Krener & Sabin, 1985; Macksoud & Aber, 1996; Masser, 1992; McCloskey & Southwick, 1996; McCloskey, Southwick, Fernandez-Esquer, & Locke, 1995; Mollica, Poole, Son, Murray, & Tor, 1997; Muecke & Sassi, 1992; Paaredekooper, de Jong, & Hermanns, 1999; Papageorgiou et al., 2000; Weine, Becker, Levy, & McGlashan, 1997; C. Williams & Westermeyer, 1983), and linked the presence of these symptoms to exposure to trauma prior to migration. With high prevalence of posttraumatic stress symptoms among refugee children reported to be between 50-90% (Lustig et al., 2004), many refugee children are in need of *trauma-informed treatment and services*.

Access to Mental Health Services

Despite evidence for the need for such treatment, refugee children in resettlement are unlikely to benefit from mental health services because they rarely use them. This problem is not unique to *refugee* children, as many recent reviews have observed that few U.S. children in need of mental health services receive care (Collins & Collins, 1994; Kataoka, Zhang, & Wells, 2002; Stephenson, 2000; Surgeon General's Report, 1999). Epidemiological studies report that fewer than 20% of children who need mental health care actually receive services (Lahey, Flagg, Bird, & Schwab-Stone, 1996). In addition, of those children who do receive services, fewer than 50% receive the appropriate service relative to their need (Kazdin, 1996).

Because refugee children face additional barriers to receiving care, experts suspect that most refugee children in need of mental health services do not find their way into the existing mental health care system (Geltman, Augustyn, Barnett, Klass, & Groves, 2000; Westermeyer & Wahmanholm, 1996). One survey of refugee *health* programs in nine metropolitan areas in the U.S. found that while 78% of the sites offered mental health care, only 33% of the sites carried out mental health status examinations (Vergara, Miller, Martin, & Cookson, 2003). This suggests that refugees with mental health problems are unlikely to be identified, and thus



unlikely to receive treatment. Overall, these findings suggest that *interventions that facilitate access and engagement in mental health services* for refugee children are needed.

Culturally Competent Services

One of the main barriers to services for refugee children and families involves lack of such services available in their native language. Though no specific information on refugee children is available, several studies that examined utilization of mental health services by ethnic and linguistic minorities (Snowden & Cheung, 1990; S. Sue, Fujino, Hu, Takeuchi, & et al., 1991; Takeuchi, Sue, & Yeh, 1995; Ying & Hu, 1994) found that Hispanic and Asian groups are underserved relative to Whites. Even when refugee children and families do seek mental health care, it is not clear to what extent existing services are well suited to the values and customs of their native culture. Thus, to increase the extent to which refugee children and families make use of mental health services and can benefit from services, *culturally informed and linguistically matched mental health services* are needed.

Stresses in Resettlement

Refugee children experience a number of stressors during resettlement resulting from difficulties integrating into a new country and culture that may negatively affect their mental health, and prevent them from getting treatment. Acculturative stress is a term used to describe the multiple stressors faced by refugee families in resettlement (Berry, Kim, Minde, & Mok, 1987; Gil & Vega, 1996; Mena, Padilla, & Maldonado, 1987; C. Williams & Berry, 1991). Refugee families confront a number of everyday struggles including meeting their basic needs of housing, employment, and health care. They confront these challenges in a new language and within the norms and laws of a new culture. In addition, refugees are often separated from extended social networks of family and friends. Yet social support has been found an important factor in facilitating refugee adjustment (Emmelkamp, Komproe, Van Ommeren, & Schagen, 2002; Hays, 1991; Kovacev & Shute, 2004; Pecora & Fraser, 1985; Shisana & Celentano, 1987; Simich, Beiser, & Mawani, 2003).

For children, the family and school are the most important arenas where acculturation and coping take place. With respect to family relationships, it has been noted that acculturation unfolds at different rates for parents and children, creating an “acculturation gap” (Buki, Ma, Strom, & Strom, 2003; Gonzales, Dumka, Deardorff, Carter, & McCray, 2004; Kwak, 2003; Muir, Schwartz, & Szapocznik, 2004; Szapocznik, Kurtines, & Fernandez, 1980). Refugee children adapt to the new culture more quickly than their parents, particularly in terms of language acquisition. Over time, this gap is seen as leading to parent-child conflict around areas such as autonomy, dating, and cultural identity (Buki et al., 2003; Kwak, 2003). While parents may feel that their children should adhere to the norms of their native culture with respect to these issues, many children feel pressure from their peers and surrounding culture to abandon their cultural traditions. As a result, children are faced with negotiating dual cultural identities. In addition, lack of parental familiarity with the customs of the new country can result in lack of guidance and supervision (Aronowitz, 1984; Gonzales, Knight, Birman, & Sirolli, 2004; Szapocznik, Scopetta, Kurtines, & Aranalde, 1978). A related issue involves the use of children as interpreters or culture brokers in refugee and immigrant families (Buriel, Perez, De Ment, Chavez, & Moran, 1998). This role is a source of acculturative stress (Carlin, 1990; Portes & Rumbaut, 2001; C. Suarez-Orozco & M. Suarez-Orozco, 2001), and has been linked to adverse family dynamics at home (Weisskirch & Alva, 2002) because it places children in



difficult positions, including translating for parent conferences in school and communicating medical diagnoses to relatives in hospitals.

In addition to family, schools are also a source of potential acculturative stress for refugee children and adolescents. While parents struggle with meeting the basic family needs, children are confronted with negotiating a new school environment and integrating into new peer networks. Children and adolescents struggling with identity formation may experience psychological difficulties in the context of dual cultural membership (Phinney, 1990), particularly if they are discriminated against and receive negative messages about their race and culture (Portes & Zhou, 1994). Studies of acculturative stress with refugee adolescents (e.g. Vinokurov, Trickett, & Birman, 2002) have found that the school experience of refugees often includes discrimination from other students and teachers, daily hassles related to language inadequacies dealt with in a non-empathic manner, peer-related hassles related to intergroup issues such as friendship and, for adolescents, dating.

Further, parental pressure to succeed academically can inadvertently heighten anxiety about school success. For children whose education has been interrupted because of war or extended stays in refugee camps, the transition to school may be particularly problematic. These children and their parents may not have even the basic knowledge of how schools function, the role of parents in schooling, or of how to operate a locker or hold a pencil (Lee, 2001).

There is no question that refugee families and children can benefit from a wide net of social services, including English language training, assistance with employment, housing, transportation, acculturation classes, and general case management services. In addition, special educational programs for newly arrived children can help them become integrated into mainstream classrooms and curriculum. This is particularly important for children with no prior education and no literacy skills in their native language, who experience many difficulties in their transition to U.S. schools. Many experts also advocate for preventive programs that can help refugees cope with the stresses of acculturation and resettlement (C. Williams & Berry, 1991) However, generally such services are not considered to be *mental health services*, and the acculturative stress and other challenges in resettlement have not been seen as appropriate targets of *mental health* interventions.

Yet it has also been suggested that the stresses of resettlement create an important context that surrounds and impacts on the mental health needs of refugee children and families, as well as on any mental health interventions. For example, while struggling for economic survival, families may not consider mental health an important enough priority to address, and may not seek mental health care for their children for that reason (Westermeyer, 1996). Because refugees experience challenges in adaptation broadly across varied life domains, traditional clinic based treatment may be insufficient to meet their needs (Chung, Bemak, & Okazaki, 1997; Miller, 1999) or to maintain the gains attained in psychotherapy. Engaging a child in clinical services that result in reduction of PTSD symptoms may not sufficiently improve the quality of life for the child when he or she has to continue to function in a stressful, economically disadvantaged and socially isolated family environment. For example, a trauma-informed intervention for traumatized immigrant children (Kataoka et al., 2003; B. Stein, Jaycox et al., 2003) was successful at reducing symptoms, but not school functioning as assessed by the children's teachers. This suggests that a broader intervention may be required to improve the child's overall level of functioning.



For these reasons, experts writing about mental health services for refugee children suggest that to be successful at engaging and benefiting refugee clients mental health services must in some way address the context of acculturation and resettlement within families, schools, and other settings of relevance to refugee children (e.g., Chung et al., 1997; Collignon, Men, & Tan, 2001; Jaranson, 1990; C. Suarez-Orozco & M. Suarez-Orozco, 2001; C. Williams & Westermeyer, 1986). For example, Chung et al. suggest that providing traditional psychotherapy for Southeast Asian refugees is important, but not sufficient in a culturally informed mental health model. Rather, they stress the importance of case management as a key component of mental health services for Southeast Asian refugees (Chung et al., 1997). In addition, psychoeducation, and integration of traditional healing are also recommended. Similarly, Ramaliu & Thurston (2003) describe the development of a Survivors of Torture Program in Calgary where program staff coordinate mental health, health, social, and other services for refugees across multiple community agencies.

Thus, experts on refugee mental health consistently emphasize the importance of attending to economic, social, educational and other needs as a component of or an adjunct to mental health services. This implies that traditional models of clinic based psychiatric services and psychotherapy are not sufficient to meet the mental health needs of refugee children. Rather, a *comprehensive services model* may be required that helps refugee children and families cope with the stresses of resettlement.

The Need for Comprehensive Services

Davies and Webb (Davies & Webb, 2000) stress that the needs of refugee children and families are best addressed through “a coordinated programme working closely with those who can help shape a culturally sensitive position” (p. 551) The authors stress the limitations of the existing service structures that make referrals to conventional outpatient mental health clinics with no particular expertise in addressing cultural or migration issues with agencies working in relative isolation in ways dictated by their own narrow professional perspectives. As they point out, by the time the children were referred to the child mental health service:

The “problem” had often already been defined to some extent by the referrer, was invariably pathologized, uni-dimensional, and not seen in broader psychosocial terms. Their understanding of the child’s needs took virtually no account of the child’s new context, disrupted psychological development, experience of transcultural stress and previous experience of loss and trauma (page 549).

Instead, they suggested that

child mental health services are best able to assist refugee families (on this scale) as part of a coordinated programme, working closely with those who can help shape a culturally sensitive position. However, in small multidisciplinary services with limited resources, and where the conventional medical model is still relatively strong, there is likely to be an inherent lack of flexibility. The lack of additional resources meant that key agencies were always stretched and unable to provide effective services (page 551).



Thus, a coordinated comprehensive treatment model is more likely to meet the diverse needs of refugee children and families and to be more acceptable to them, particularly since refugees often view general survival and economic issues as more pressing than their psychological concerns.

Comprehensive mental health services are receiving increasing attention in the mental health literature, and there is evidence to suggest that they are effective with some populations. In general, comprehensive service models are programs that focus on client populations with complex, persistent and varied needs across several life domains, such as adults with persistent mental illness, drug addiction issues, and troubled youth. Some examples of such treatment models include assertive community treatment (ACT) for people with severe, persistent mental illness, and treatments for children including multi-systemic therapy (MST), wraparound services and system of care treatment models for at-risk youth. Comprehensive services broadly attempt to provide multi-modal treatment approaches that address the large spectrum of needs faced by recipients, in a seamless fashion. Such services often incorporate a component of outreach to help engage populations that face barriers to accessing care.

Comprehensive services for children strive to address the children's mental health concerns within the context of their family, school, and community (Burns, Schoenwald, Burchard, Faw, & Santos, 1995). With non-refugee children, wraparound care (Burns et al., 1995), multisystemic therapy (MST, Borduin & Henggeler, 1990), and the system of care model (Lourie, Stroul, & Friedman, 1998) have demonstrated positive outcomes in studies using experimental or quasi-experimental designs. In addition, a comprehensive services model for adults with severe mental illness, assertive community treatment (L. Stein & Test), has been validated as an effective treatment for reducing social isolation, increasing access to mental health services, and improving quality of life across multiple controlled studies (L. Stein & Santos, 1998).

Although studies to support the notion that comprehensive services for refugee children are effective have not been reported, the literature on the mental health issues of refugee children supports the notion that only such an approach can address the kinds of complex needs presented by traumatized refugee children. In fact, the findings in the NCTSN survey of refugee sites (Benson, 2004) suggest that programs that provide mental health services to refugees are doing so, through either providing or coordinating multiple services for refugee families and engaging in extensive outreach. However, the needs of refugee children are distinct from adults with severe mental illness served by ACT, troubled youth served by MST, or U.S. born children enrolled in wrap around or system of care services. Thus, existing models of comprehensive services may not be appropriate or may need to be substantially revised to fit the needs of refugee children. A comprehensive service model specifically designed to meet the needs of refugee children is needed.

In reality, not all service providers will have the funding, staff and infrastructure to provide services comprehensively within one agency. Instead, mental health programs can develop collaborations with other agencies that can provide complementary services to meet the complex needs of refugee children and families. Thus, comprehensive services is an overall framework of service delivery, rather than a prescription for a particular program. The remainder of this paper will propose components of a comprehensive mental health service for refugee children, and will summarize a review of the literature that provide an evidence base for these components.



Components of Comprehensive Services for Refugee Children: A Review of the Literature

While the literature reviewed above suggests that refugee children can benefit from comprehensive mental health services, the notion of comprehensive service is broad, and difficult to delimit. It may also be impractical for any particular mental health program to address all of the economic, social, and psychological needs of a refugee family. In our review, we identified four categories of mental health issues for refugee children. Here we will present four corresponding types of intervention necessary to address these needs. They include: (1) trauma-informed treatment; (2) strategies for providing access and engaging refugee children in mental health services; (3) approaches to providing culturally competent services; and (4) strategies for helping refugee children and families cope with stresses of resettlement. We propose that these four are the essential components or key ingredients in a comprehensive services model for refugee children.

By designating these four components as “key ingredients,” we mean that the comprehensive services model must in some way have a strategy for addressing each of these four needs relevant to the mental health of refugee children. A program’s specific strategies and approaches may vary widely depending on its structure and focus. While some programs may administer specific interventions to address each of these four components, others may collaborate with other agencies and refer their patients for adjunct services. However we emphasize the importance of attending to each of these components in every overall intervention design.

We then turned to the literature to review what is known about effectiveness of each of these four intervention components with refugee as well as non-refugee children. As the literature on effectiveness of interventions of refugee children is only beginning to emerge, we broadened our review to include interventions with refugee adults, and immigrants, as well as other traumatized children. The intent was to identify any empirical evidence for particular strategies that can be used as components of a comprehensive services model for refugee children.

Trauma-Informed Treatments for Refugee Children

Several evidence-based interventions have been developed to address trauma in children. Cognitive-behavioral therapy (CBT) is generally accepted as an efficacious trauma-informed treatment for children. To date, published randomized controlled trials of these trauma-focused treatment programs mainly focus on children who have been sexually abused (for a review, see Cohen, Deblinger, Mannarino, & Steer, 2004; Saywitz, Mannarino, Berliner, & Cohen, 2001). Thus while these interventions can be used to inform treatments for refugee children, as currently developed they are not designed to address many of the unique circumstances of traumatized refugee children. Since the nature of the traumatic event (such as duration, chronicity, perceived controllability, and predictability) has been found to be related to the types of symptoms manifested (Terr, 1995), the intervention design may need to be altered to address war-related trauma.

School-Based CBT Interventions

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a 10 session group CBT intervention designed to address PTSD, anxiety, and depression related to community violence exposure. It has been used with traumatized immigrants, and therefore is potentially suitable for traumatized refugee children because it addresses issues of trauma as well as culture. The



intervention uses a self-report questionnaire to identify children at school (ages 11-15) who have been exposed to trauma and are experiencing symptoms of PTSD. Group CBT sessions are then provided within the school setting. Results from a fully randomized controlled trial with English-speaking 6th graders in a predominantly Latino area of LA (B. Stein, Jaycox et al., 2003) showed that students who received the intervention had significantly fewer self-reported symptoms of PTSD and depression, and fewer parental reports of psychosocial dysfunction at the three-month follow-up assessment. These effects were not observed with regards to teacher report of classroom behavior, however.

Another study utilized an eight-session version of the intervention provided in Spanish to Latino immigrant students by bilingual/bicultural social workers (Kataoka et al., 2003). In addition, supportive and psychoeducational sessions were provided to teachers and parents. The research design and findings were similar to those reported by B. Stein et al. (2003), with intervention group children showing improvement in symptoms but not in classroom behavior at three months.

Although data on outcomes have not been reported, this intervention has also been conducted with immigrant children from multiple language groups, and materials for the interventions in a number of refugee languages have been developed (B. Stein, Kataoka et al., 2003). This makes this intervention potentially relevant to multiple refugee populations. However, a limitation of this particular intervention approach is that children are screened for appropriateness for the intervention based on a self-report questionnaire of trauma symptoms and exposure. Thus, only children old enough and willing to disclose their trauma and symptoms in a questionnaire format are selected to participate.

A similar school-based CBT group intervention was conducted by Layne, Pynoos, Salzman et al. (2001) with war-exposed, internally displaced adolescents in Bosnia. The treatment program consisted of 23 group sessions that covered psychoeducation, therapeutic exposure, cognitive restructuring, stress management-relaxation skills, and practical problem solving of current life events. The adolescents' traumatic stress symptoms were found to decrease over time, though the study did not include a control group. Since these refugees were living within their own country, the intervention did not address issues of cultural competence.

Psychoeducational and Parenting Intervention for Mothers

A psychoeducational program for mothers of internally displaced traumatized children has been studied in Bosnia and Herzegovina (Dybdahl, 2001) and found to be effective. The goal of the intervention was to improve the children's psychosocial functioning, as well as the mental health of their mothers. Mother-child pairs were randomly assigned to a control group, whose members received medical care and participated in scheduled evaluations, or to an intervention group, whose members participated in a five-month psychosocial intervention in addition to receiving medical care and participating in scheduled evaluations.

Dybdahl's (2001) intervention was manualized, and consisted of semistructured weekly group meetings of approximately five mothers with trained group leaders over the five months. The groups included therapeutic discussions, psychoeducation about trauma, and guidance on facilitating parent-child interactions and communication.

Findings suggest that the intervention was effective at improving the mental health of mothers as well as children. Mothers in the intervention groups had substantially greater reduction in



symptoms as measured by the Impact of Events Scale, and rated themselves as happier on a well-being scale than mothers in the control condition. Children in the intervention group were rated as having fewer problems at post test than at pretest by mothers and by psychologists, whereas the control group had little change. The intervention group children also improved their scores on a measure of cognitive abilities relative to the control group. Finally, children in the intervention group showed greater changes on physical measures, including gain in height and weight, and hemoglobin counts at post test relative to controls. As the intervention was exclusively focused on mothers, the study highlights the importance of focusing on caregivers' mental health and training as effective strategies in treating traumatized refugee children. However, the intervention did not need to address issues of cultural competence since these refugees were internally displaced within their native country.

Art and Expressive Therapy

A treatment approach that seems to be widely practiced, though rarely studied or evaluated, is the use of art and other expressive techniques as a tool with traumatized refugee children. Creative arts therapies are commonly used and have been proposed as potentially useful tools for the diagnosis and treatment of psychological trauma, at least with Vietnam Veterans (Johnson, 1987). For traumatized refugee children who are too embarrassed, highly resistant, or do not have the language skills to talk about their traumatic memories, creative arts therapies have been regarded as especially helpful as a way to allow clients to disclose and process their traumatic experiences in ways that are less threatening than talking (Rousseau, Lacroix, Bagilishya, & Heusch, 2003). Other clinicians have found that art therapy and art creation may provide refugee clients with a needed feeling of structure, a sense of control, a way to re-assert their identities through emotional expression, and a counterbalance to their losses (Fitzpatrick, 2002). Some clinicians have also noted that creative therapy techniques such as storytelling may be especially appropriate for refugee children from cultures that have a strong tradition of storytelling (Rydberg, 2002).

However, it is important to note that for traumatized children the process of art creation may be too ambiguous and unstructured, and may cause further anxiety (Hocoy, 2002; Neugebauer, 2003). For example, conversations about traumatic experiences in interviews were found to exacerbate negative affect among traumatized Bosnian children living in Sweden (Angel et al., 2001). At the same time, many evidence-based interventions for children, including CBT, use art as a tool within a structured session that helps the child process cognitions and affect. Thus, careful studies of uses of art and expressive therapy with refugee children are warranted to inform providers of this widely accepted, but untested, practice.

Summary of Trauma-Informed Treatments

Taken together, studies of interventions with traumatized refugees suggest that CBT may be a helpful tool to use with traumatized refugee children either in individual or group treatment. However, existing studies have demonstrated benefits of CBT with respect to symptoms but not overall functioning of the children. On the other hand, a psychoeducational and parenting program with mothers was found to be effective across a range of outcome measures including health, mental health, cognitive and psychological functioning. The intervention targeted mothers rather than children directly, and the findings suggest that this may be a promising direction for future intervention development with refugee children. However, the intervention was not carried out with children in resettlement, and thus did not address cultural issues. Finally, while art and expressive therapy remains a popular practice with refugee children, it has



not been adequately articulated as an intervention model, and evidence is not available to support its effectiveness.

Strategies to Improve Access to Care and Engagement in Services

The centrality of engagement in mental health services, particularly with immigrant populations, is stressed by Szapocznik et al. (1988), who argue that engagement cannot be seen as separate from the intervention itself. Indeed, interventions cannot be effective if they are not utilized by the intended clients. Varied strategies have been studied to improve engagement and retention in mental health services.

Several investigators have studied intervention strategies for engaging clients in mental health services, usually focused on the initial contact between agency and clients. For example, Russell, Lang, and Brett (1987), Shivack and Sullivan (1989), Szapocznik et al. (1988), and McKay et al. (1998) all have reported success with telephone engagement interventions in which providers offer detailed information about the agency and the services, and problem-solve with clients around practical concerns such as work schedules, childcare responsibilities, or transportation. While promising with respect to *engaging* families in treatment initially, these approaches have not been consistently effective at *retaining* families in services beyond the initial sessions. Rather, more profound changes in the structure of the services may be required in order to ensure ongoing access for children who need services (Horwitz & Hoagwood, 2002). Further, these interventions remain untested with refugee children and their families.

In the refugee context, Weine and colleagues (Weine et al., 2004; Weine et al., 2003) investigated the effects of a multi-family intervention focused on engagement into services for Bosnian and Kosovar refugee families in Chicago. The goal of CAFES (Coffee and Family Enhancement Services) was to facilitate access to mental health services for adult Bosnian refugees with symptoms of PTSD. Bilingual/bicultural project staff contacted refugee families and arranged a home visit in which families were invited to participate in the intervention, and randomly assigned to intervention or control. The intervention itself consisted of facilitated multi-family groups held weekly at a community agency. The groups were led by a trained bilingual/bicultural worker who conducted the nine weekly sessions following a manualized curriculum.

The intervention goals were to increase social support of the participants, provide them with education about trauma and mental health issues, and facilitate access to mental health services. Thus, the intervention did not aim to provide mental health treatment per se. Longitudinal assessments occurred every six months for eighteen months. Results suggested that the CAFES group was effective in engaging families in the intervention itself, facilitating access to mental health services, reducing symptoms of depression, and improving family communication relative to controls. The intervention also increased social support for the males participating in the study (Weine et al., under review).

Another approach to access and engagement that is frequently mentioned in the literature involves use of alternative service settings to provide mental health care. Settings such as schools and medical offices can be more comfortable places for refugees to turn to for services than traditional mental health facilities (Kinzie, Tran, Breckenridge, & Bloom, 1980; Surgeon General's Report, 2001). As noted above, schools have been identified as an important setting for delivering mental health services to children in general (Hoagwood & Erwin, 1997), and



refugee children in particular (Bemak & Cornely, 2002; Hodes, 2000, 2002). In addition to the school-based CBT group treatments described above, a number of other school-based interventions for refugee children have been reported (Hones, 2002; O'Shea, Hodes, Down, & Bramley, 2000; Rousseau et al., 2003; Rousseau, Singh, Lacroix, Bagilishya, & Measham, 2004).

One intervention specifically focused on providing mental health treatment to traumatized refugees in a primary school in London (O'Shea et al., 2000). Teachers identified 14 refugee pupils with psychological difficulties related to exposure to high levels of past violence and losses and referred them to an outreach mental health worker. A range of psychological and family interventions were offered by the mental health worker on the school site, including interventions with teachers, the children alone, and with relatives. A pre-post design with no control group showed an overall reduction in symptoms, with some children showing dramatic benefit. However, the study was not designed to test the effectiveness of the school setting as an engagement strategy, per se. Thus, while locating services in alternative locations may be a promising strategy of improving access for refugee children, studies have not been conducted to support the effectiveness of this approach.

Summary of Access and Engagement Strategies

Taken together, these studies suggest that specialized efforts at engagement can be extremely useful at providing access to refugees. Weine's intervention with refugees is particularly promising, and may be structured as a first phase of a mental health intervention for families of children identified as needing services. The advantages of locating services in schools and medical settings seem evident but have not been studied.

Approaches to Cultural Competence

The term "cultural competence" refers to the capacity of programs to provide services in ways that are acceptable, engaging, and effective with multicultural populations. A number of theoretical models and frameworks for considering cultural competence in mental health interventions have been proposed in the literature to aid professionals (see for example Cole & Bird, 2000; Cross, Bazron, Isaacs, & Dennis, 1989; Mason, Benjamin, & Lewis, 1996; Misra-Hebert, 2003; Roberts et al., 1998; Stroul & Friedman, 1986; Vargas & Koss-Chioino, 1992). Although most of these models have not been developed to target refugee child and adolescent needs specifically, they do offer guidelines for incorporating attention to culture and language in mental health interventions.

Broadly, there are three ways that programs and service providers can attain cultural competence. First, an agency can enhance the extent to which existing "mainstream" service providers recognize cultural issues and are knowledgeable about the cultures of their clients. Agencies can do this through training of their providers, and may redesign existing services to incorporate more "culturally sensitive" strategies to meet the needs of culturally diverse clients. Second, a program can employ service providers from the cultures of the groups being served; in the absence of mental health professionals from these cultures, employing ethnic paraprofessionals to work collaboratively with the mental health professionals is a possible alternative. Finally, an agency can organize ethnic/culture-specific programs or centers, gather expertise in one setting, and specialize in serving a particular cultural group.



Enhancing Cultural Awareness and Sensitivity of Mainstream Providers

Training mainstream providers to be knowledgeable and sensitive to the cultures of the people they serve has been widely advocated as a strategy to achieve cultural competence. However, Gong Guy et al. (1991), in a survey of services available to Southeast Asian Refugees in California, found that cross-cultural training for those serving refugees was virtually non-existent. In addition, while a measure of cultural competence of service providers has been developed (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; D. W. Sue et al., 1998), studies have not examined the extent to which cultural training or cultural competence of providers is linked to better outcomes for culturally diverse clients.

One exception is a recent report by Miranda, Schoenbaum, Sherbourne, Duan and Wells et al. (2004) that described a Quality Improvement (QI) program for treatment of depression in managed care organizations that included cultural orientation to Mexican American and African American clients. Existing mental health service providers received training in issues to consider in working with these ethnic minority patients, such as the importance of *respeto* and *familismo* for Mexican Americans, and the importance of clinicians having a direct and open style, and respecting religion and spirituality for African Americans. Results suggest that both minorities and non-minorities were more likely to benefit from treatment when QI procedures were introduced; however, the additional value of the cultural orientation provided was not examined to determine whether it had an impact over and above the training on standards of care.

Other published articles provide only general guidelines for training service providers to achieve cultural competence or suggestions for how to modify therapeutic techniques (Chung et al., 1997). For example, though not focused on refugees, Roberts et al. (1998) and Vargas & Koss-Chioino (1992) suggest that cultural competence training needs to include exposure to aspects of the new culture, initially supervised experience of new skills, and expertise acquired through extended practice and research. Additionally, both models of training highlight the potentially fine line between cultural stereotyping and cultural sensitivity. Vargas and Koss-Chioino (1992) recommend that professionals who are receiving training research culture-specific differences with knowledgeable professionals, as well as members of the community of interest, rather than relying on stereotyped beliefs, cross-cultural generalizations, or experience gleaned from case studies.

Ethnically Matched Professionals and Paraprofessionals

The use of *ethnically matched professionals and paraprofessionals* has been suggested as an important means of overcoming cultural and language barriers (Gong-Guy et al., 1991; Musser-Granski & Carrillo, 1997). A number of authors have suggested that engagement, retention, and outcomes in treatment can be improved if mental health service providers are matched to clients with respect to culture, ethnic or racial group, language, prior experience, or other factors. Clients matched with a clinician with respect to their ethnicity and language have been found to stay in treatment longer (S. Sue et al., 1991) and to be less likely to use hospital emergency rooms for mental health services (Snowden, Hu, & Jerrell, 1995) and to benefit more from treatment than those not matched.

However, lack of trained *bilingual, bicultural professionals* has been noted with respect to multiple ethnic groups, including Hispanics and Southeast Asians in the U.S. (Gong-Guy et al., 1991; Kataoka et al., 2002; Musser-Granski & Carrillo, 1997; Surgeon General's Report, 2001). Most clearly documented is the gap between Spanish-speaking service provider availability and



the increasing Latino population (Kataoka et al., 2002), with about 40 percent of Hispanic Americans in the 1990 census reporting that they did not speak English very well.

With respect to Southeast Asians, Gong Guy et al. (1991), in a survey of services accessible to Southeast Asian Refugees in California, found a severe shortage of adequately trained bilingual and bicultural mental health personnel. In addition, existing outpatient services were characterized by long delays and by availability of services only through interpreters. Clearly, one way to improve services would be to increase the number of trained bilingual/bicultural mental health providers.

In situations where bicultural/bilingual professionals cannot be located, researchers have begun to examine the use of ethnic paraprofessionals, who often have bachelors degrees or lower levels of training in clinical issues (D. Williams, 2001). In cross-cultural situations, paraprofessionals may be more effective at conducting community outreach, ensuring access to services for potential clients, facilitating their engagement and retention in services, and providing interpretation when needed. On the other hand, by definition, paraprofessionals do not have any formal training with respect to case management or interpreting services. Thus, in situations where they are called on to serve as interpreters for severely disturbed refugees, this lack of training may lead to problems of misdiagnosis and other distortions which can seriously undermine the clinician's attempts to treat refugee clients (Gong-Guy et al., 1991; Musser-Granski & Carrillo, 1997). Further, paraprofessionals who are themselves refugees may themselves have lived through traumatic events and may become re-traumatized when working with refugee clients. Extensive training and supervision are then needed to address these concerns.

Studies of effectiveness of paraprofessionals have yielded somewhat conflicting findings. On the one hand, Durlak, (1979) and Nietzel and Fisher (1981) found that when dealing with non-psychiatric populations, paraprofessionals can perform effective counseling. However, these studies did not involve *ethnic* paraprofessionals matched on culture and language with their clients. On the other hand, Ying & Hu (1994) compared mental health service use and outcomes of four Southeast Asian groups (Vietnamese, Cambodians, Laotians and Hmong) with four other Asian American groups (Japanese, Chinese, Filipino and Korean). The Southeast Asians were more likely to be seen by paraprofessionals than members of other Asian groups. They were also more likely to use more sessions, and to continue with treatment when the service provider was a paraprofessional. However, outcomes for Southeast Asians were poorer than for other groups even when the diagnosis and initial level of functioning were controlled for. This study may suggest that while the use of paraprofessionals may lead to better retention, paraprofessionals may lack the training and skills needed to provide effective mental health services for these clients.

Taken together, these studies suggest that in the absence of ethnic professionals, an effective approach may involve pairing clinical professionals with ethnic paraprofessionals so that clients have the benefit of both access and effectiveness of services. However, including paraprofessionals in clinical teams requires attention to training and supervision. Refugee paraprofessionals may require assistance in analyzing coping patterns in their own immigration experience and how their current level of acculturation is reflected in their work (Ryan & Epstein, 1987). They may also need help managing their changing roles in their ethnic community, and in setting priorities, limits and boundaries with clients.



Culture-Specific Clinics or Centers

There is evidence that mental health clients in community programs designed with a particular culture in mind stay in treatment longer and are less likely to drop out of treatment than those using mainstream services (Snowden & Hu, 1997; Takeuchi et al., 1995). Additionally, Snowden, Hu, & Jerrel (1995) found that receiving treatment at an ethnic-specific program that met cultural competence criteria was more important to treatment outcome than ethnic match of provider in non-ethnic specific programs.

Snowden (1998) reviewed several ethnically matched organizations that demonstrated significant outcomes for increasing access and engagement for minority populations and identified key distinguishing features that the agencies shared. The most successful agencies tended to be affiliated with grassroots efforts, located within the community of interest, and to have members of the community represented on agency boards. Successful ethnic-specific agencies also maintained relationships with indigenous healers and had many cooperative relationships with faith-based and service organizations within the community.

Agencies with better retention rates included family-oriented planning and treatment in their assessment and treatment plans, and made conscious efforts to create a welcoming and accepting atmosphere. These organizations overwhelmingly included non-English speaking professionals or paraprofessionals on their staffs, and strove to achieve an understanding of local norms relating to beliefs about mental illness through didactic efforts with community members, and ongoing training efforts. However, studies of relative effectiveness of ethnic-specific *refugee* programs have not been reported.

In the refugee context, specialized clinics for particular refugee groups have emerged as one treatment model. The Oregon Refugee Indochinese Psychiatry Clinic (Kinzie et al., 1980), and the Harvard Program in Refugee Trauma (Boehnlein, 1987) were both dedicated to serving Southeast Asian (Indochinese) refugees. Although neither of these clinics specialized in provision of services to children, they provide important examples of models of service for refugees.

The Oregon Indochinese Psychiatry clinic was established in 1977 at the Oregon Health Sciences Center (Kinzie, 1986; Kinzie & Manson, 1983; Kinzie et al., 1980). Services were provided by psychiatrists and Indochinese counselors. Additionally, Indochinese counselors addressed adjustment problems of the refugees specifically. Kinzie et al. (1980) reported on 50 adult, predominantly Vietnamese, patients evaluated or treated in the clinic. Most patients received psychotropic medicine for psychotic disorders or depressive symptoms. These patients often had frequent, brief follow-up visits, and were reported to show good to marked symptomatic improvement.

The Oregon center continues to provide refugee mental health services, but has shifted in focus to include an increasingly diverse range of refugee populations. Currently it is a multicultural center, with the model of services extended to other ethnic groups. Ethnic counselors and professionals continue to work at the center, but are now multicultural. In addition, the center now has a specialized children's program, which is part of the NCTSN.

The Boston Indochinese Psychiatry clinic was founded in 1982 (Boehnlein, 1987) to provide services to traumatized Indochinese refugees in ways that were easily accessible, informed by the cultures and circumstances of the refugee populations, but not stigmatizing. The treatment model was framed as a medical intervention as most patients initially presented with medical



problems, were comfortable with medical settings, and expected to receive injections, pills, or other forms of medical treatment from a physician. After the initial evaluation of the patient's presenting symptoms, weekly clinic contact by a co-therapy team was begun, leading eventually to monthly or bimonthly treatment that continued, on average, for two or more years. Psychological problems surfaced later, sometimes after some treatment, as most clients regarded emotional symptoms as secondary to their somatic complaints.

Bicultural workers were given ongoing clinical training and consistent, supportive clinical supervision. These workers were already knowledgeable and empathic with their clients having experienced similar traumatic events themselves. Integration of folk healers and folk treatment systems was also attempted, although few such healers were available in the Boston area. Patients were also encouraged to engage in self-evaluation, and to use the culturally valid versions of the Hopkins Symptom Checklist, developed by the program in Vietnamese, Laotian, and Cambodian languages.

These specialized ethnic specific refugee clinics have had a long history of providing services to traumatized refugees. These programs are well known and much respected in the service provider community. They have accumulated a great deal of clinical wisdom, though no research on effectiveness of these services is reported in the literature.

Summary of Cultural Competence

Cultural competence of mental health providers is a key ingredient for effective services to refugees. However, providing culturally informed treatment is extremely difficult. With respect to training mainstream professionals, while it is likely that such training would be beneficial, there is no empirical evidence to suggest that training is sufficient to ensure provision of culturally informed services, nor have specific training models been articulated and tested. Evidence does seem to suggest that culture-specific centers have advantages over other approaches. However, such centers are only possible in communities with high refugee concentrations, and are dependent on availability of potential ethnic service providers. The use of paraprofessionals seems to have much promise, but may also require provision of extensive supervision and training. An approach not mentioned in the literature is the practice of using interpreters in psychotherapy and other kinds of treatment. Overall, creating culturally competent programs for refugees, particularly for smaller refugee groups, remains a particularly challenging task, and requires multiple strategies to accommodate unique situations in diverse communities.

Interventions Designed to Address Stresses of Resettlement

As discussed earlier, all of the literature on mental health interventions with traumatized refugees suggests that interventions must in some way address the general adaptation and stressors encountered by refugees in the process of resettlement through case management, support services, or other means of helping families problem solve practical issues in adaptation (Chung et al., 1997; Kataoka et al., 2003; Kim, Snyder, & Lai-Bitker, 1996). Although such interventions are not traditionally thought of as mental health services, they may not only support the mental health care being provided, but may also be linked to mental health outcomes. Therefore they are important to a comprehensive mental health services model for refugees.



Broadly, a mental health program can accomplish this in two ways: (1) by providing case management and (2) by providing preventive interventions, or referring clients to preventive interventions at other agencies and institutions.

Case Management

Case management has been suggested as an important component of mental health services for refugees (Chung et al., 1997) and most of the interventions for refugees described above have incorporated it as one of the services provided. Both the Boston and the Oregon Indochinese Psychiatry Clinics supplemented psychiatric services with extensive case

management and counseling provided by ethnic workers (Boehnlein, 1987; Kinzie et al., 1980). The CAFES bilingual/bicultural group leaders were available to group participants to problem solve a variety of situations and provided referral to a range of services, including mental health (Weine et al., 2004; Weine et al., 2003). However, the value added by case management to the overall effectiveness of the mental health program with respect to mental health outcomes has not been studied.

Case management may be more effective when the mental health program has formed collaborative relationships with multiple community agencies. In this way, case managers can ensure that these varied services work in concert with one another. For example, the description of the Calgary Survivors of Torture Program (Ramaliu & Thurston, 2003) notes the extensive inter-agency coordination among various community agencies and groups. Agencies that provide a range of services under one roof may have an advantage by being able to coordinate programming for refugees.

Preventive Interventions as Components or Adjunct to Treatment

A number of experts suggest that prevention is an important component of mental health services for refugees (De Vries & Van Heck, 1994; Westermeyer, 1987; C. Williams, 1989; C. Williams & Berry, 1991; Yule, 2000). Preventive programs offer many advantages, as they can often be carried out by paraprofessionals with consultation from mental health professionals, and can be structured in ways that reach a large number of children in need. In particular, schools have been noted as an excellent setting for prevention programs for refugee children that also provide opportunities to identify children that require more intensive services. For example, Yule (2000) proposes an hierarchical model of support and intervention for internally displaced refugee children whereby psychosocial help is delivered primarily through schools with only a small proportion of more complex needs being met by specially trained mental health professionals. However, no evidence-based preventive interventions designed with refugee children in mind are reported on in the literature.

For children more generally, a large number of school-based preventive programs have been developed and validated, including programs to reduce risks of disruptive behaviors, substance abuse, and psychopathology (Felner & Adan, 1988; Greenberg, Domitrovich, & Bumbarger, 2001; Weissberg, Kumpfer, & Seligman, 2003). Although none of these evidence-based programs has been developed for traumatized refugee children specifically, they may be quite relevant and useful. For example, programs that are aimed at easing a child's transition to school (Felner & Adan, 1988; Felner et al., 2001; Felner, Ginter, & Primavera, 2002), mentoring (Langhout, Rhodes, & Osborne, 2004; Rhodes, Grossman, & Resch, 2003), buddy programs (Cowen et al., 1996), parenting (Hughes & Gottlieb, 2004; Patterson, DeGarmo, & Forgatch, 2004; Webster-Stratton, Reid, & Hammond, 2004), and other interventions may be adapted and used for refugee children who also confront these risks and challenges.



Some of these programs have been developed for immigrants, and are designed to address cultural issues that may also be relevant for refugee children. For example, the Family Effectiveness Training (FET, Szapocznik, Rio, Perez-Vidal, Kurtines, & Santisteban, 1986; Szapocznik, Santisteban, Rio, Perez-Vidal, & et al., 1989) is an intervention designed to reduce the acculturation gap in immigrant families with the goal of improving family adjustment and preventing adolescent behavior problems. FET is a 13-session program that includes specific attention to these cultural issues and their implications for intergenerational communication and child problem behavior. It has been found to be effective relative to a no treatment control with respect to improvement in family functioning, problem behaviors as reported by parents, and on a self-administered measure of child self-concept.

Interventions designed to ease refugee children's transition to school have been described in the literature, but not evaluated empirically. Narrative inquiry and creative expression interventions have been used to ease cultural and school transition for refugee children. Hones (2002) describes taking a participatory action research perspective in which students were recruited to keep dialogue journals of their experiences over the course of the school year. In these journals, the adolescents catalogued their acculturative stresses and difficult lives. In so doing, they created a resource for school intervention possibilities to aid their acculturation and adaptation to American life. The journals also served the function of affirming the cultures and lives of the adolescents. As Hones (2002) writes: "*Preliminary findings of this research suggest that dialogic pedagogy has the potential to transform the lives of bilingual secondary students and those who work with them*" (p. 1182). In like manner, Rousseau et al. (Rousseau et al., 2004) describe the development of creative expression workshops to provide refugee and immigrant children with an opportunity "*to construct meaning, to structure identity, and to work through their losses and reestablish social ties.*" (p. 235). Similarly, the Playing to Grow intervention developed for Guatemalan children residing in refugee camps, has emphasized working with their teachers to build a safe environment for the children, allowing the children to heal through play, and a way to share their thoughts and feelings (Miller & Billings, 1994). In this program, activities such as collage, collective storytelling, and sociodrama are used in addition to individual and collective drawing.

Summary of Interventions Addressing Resettlement Stress

Case management and preventive interventions programs are ways that mental health services can address the resettlement stresses of refugee children and families. While case management may be a useful component of a comprehensive services model, and an excellent strategy to engage and retain clients in mental health services, its effectiveness and relevance for mental health outcomes has not been studied. With respect to preventive interventions, while many evidence-based programs for children have been developed, none has been adapted to the needs of refugee children specifically. Rather, the literature contains reports of school based preventive interventions designed specifically with refugee children in mind, but not studies of their effectiveness. Thus, the challenges of how to provide preventive interventions to refugee children that are effective and relevant to their specific needs remains. Further, the challenge remains of how to integrate preventive activities into a comprehensive mental health services model.



Conclusions, Recommendations, and Next Steps

We began this paper with the suggestions that traumatized refugee children can most benefit from comprehensive mental health services that address the trauma, but also ensure access and engagement and provide culturally relevant and trauma-informed treatment. In addition, the services must in some way address the resettlement difficulties experienced by refugee children and families. Having reviewed the literature, we conclude that although a comprehensive model for refugee children has not been empirically studied, research on existing interventions provides some evidence for the effectiveness of specific strategies that can be used to build such a model.

Each of the interventions reviewed in this paper focus on different “key ingredients” of the proposed comprehensive services model. For example, the focus of the CBITS program (Kataoka et al., 2003) was on symptoms resulting from traumatic exposure, and CBT, an evidence-based technique, was used. With respect to access and engagement, locating the intervention at school helped identify and engage a larger number of children than would have been possible at a clinic, and perhaps made the treatment less stigmatizing. Cultural competence was addressed by selecting specific language/cultural groups as targets of intervention, developing materials in the children’s languages, and using ethnic professionals to provide the interventions. However, issues of resettlement stress were not addressed in this intervention model.

The CAFES/TAFES intervention, on the other hand, did not provide trauma-informed treatment. Instead, the intervention focused on engaging refugee families in the intervention, educating them about effects of trauma and mental health treatment, and referring them to mental health services provided elsewhere. Engagement in the multi-family groups was accomplished through extensive outreach in the community, by holding the groups at times convenient to participants, and by focusing group discussions on topics of interest to the participants. Resettlement stresses were a focus of this intervention, which was designed in part to be preventive in nature; thus extensive orientation and education on various aspects of resettlement was provided, and the groups were designed to increase social support. Cultural competence of the intervention was addressed through employing ethnic paraprofessionals who conducted outreach and led the groups.

Since both of these interventions provide empirical support for effectiveness at treating symptoms (Kataoka et al., 2003) and engaging refugee families in treatment (Weine et al., 2003) they provide potential building blocks for a comprehensive services model for refugees, although Weine’s model did not focus on children. However, important challenges remain with respect to how to provide culturally competent treatment to diverse refugee populations, as research does not provide sufficient guidance with respect to what works. In addition, creating mental health programs that can integrate clinical services with case management and preventive services is challenging. Thus, while the literature provides us with some potential building blocks of an intervention model, there is not sufficient evidence to guide the development of a comprehensive mental health program that can combine multiple components. We propose the next steps toward better understanding and development of evidence-based interventions for refugee children in the next section.



Toward Practice-Based Evidence

In light of the absence of evidence-based interventions for refugee children, and the difficulties involved in developing interventions for refugee children that satisfy scientific evidence-based criteria, we emphasize the relative importance of “practice-based evidence.” Practice-based evidence refers to the process of identifying and studying clinical treatment models and conceptualizations that currently exist in the “real” world (Barkham et al., 2001; Krakau, 2000; Margison et al., 2000; Stiles et al., 2003).

Many refugee children are currently receiving treatment in agencies and clinics throughout the U.S., as multiple programs in local communities have struggled with how to create effective and accessible services for these populations. Within the NCTSN network, many sites are currently providing services to refugees. Most of these interventions have not been subjected to systematic evaluation, much less randomized controlled trials. Nonetheless, we suggest that the field has much to gain from beginning to identify and describe these interventions. Clinicians and other interventionists working in local communities have accumulated great local wisdom with respect to their work (see for example clinical reports by Hodes, 2002; Rousseau et al., 2004).

A focus on studying existing practices with refugee children can serve the long term goal of developing evidence-based interventions for traumatized refugees in several ways. The transfer of interventions found to be efficacious under tightly controlled laboratory conditions to the local community clinic can be fraught with numerous difficulties (Weisz, Chu, & Polo, 2004). Rather an “emic” or “inductive” (S. Sue & Chu, 2003) approach of studying existing local efforts may be more parsimonious for developing evidence-based practices for refugee children. Thus resources may be better expended on learning how practices that are currently occurring within local community settings have successfully solved a number of problems of implementation, financing, access, cultural competence, and other challenges that a newly imported intervention developed elsewhere would need to address “from scratch.” Further, existing programs are by definition sustainable, since they have naturally evolved from efforts of the local agencies and organizations. A “practice-based evidence” approach would focus on ways of documenting these practices and studying outcomes for children that they serve.

Our next steps are to begin to collect data in order to describe these programs and begin to document outcomes. We are interested in documenting various components of the services being provided, learning about particular background characteristics of the children that are relevant to understanding the treatment that they receive, and ultimately learning whether these children are improving as a result of the care they receive. Through its Data Core, the NCTSN has initiated a data collection protocol across all of the sites. However, many of the measures included in the Data Core may not be well suited to describing refugee mental health programs. Thus, the next steps of the Refugee Trauma Task Force are to develop a Refugee Data Core that can be implemented across all the sites that serve refugees. Our hope is that this approach will ultimately help us learn from existing practices, compare varied approaches, and build evidence for models for effective comprehensive services for refugee children.



Network Sites that Provide Services to Refugee Children

In California

- The Chadwick Center for Children and Families Trauma Counseling Program at Children's Hospital and Health Center in San Diego
Web: www.chadwickcenter.org
- Children's Institute International at Central LA Child Trauma Treatment Center in Los Angeles
Web: www.childrensinstitute.org
- LAUSD Community Practice Center at the Los Angeles Unified School District in Van Nuys
Email: marleen.wong@lausd.net
- The Miller Children's Abuse and Violence Intervention Center in Long Beach
Web: www.memorialcare.org

In Florida

- Healing the Hurt at Directions for Mental Health, Inc. in Clearwater
Web: www.directionsmh.org

In Illinois

- International Family, Adolescent, & Child Enhancement Services (I-FACES) at Heartland Health Outreach, Inc. in Chicago
Web: www.heartland-alliance.org

In Massachusetts

- The Trauma Center, Massachusetts Mental Health Institute in Allston
Web: www.traumacenter.org
- The Center for Medical and Refugee Trauma at Boston Medical Center in Boston
Web: www.bmc.org/childpsychiatry

In New York

- The Jewish Board of Family and Children's Services (JBFCS) Center for Trauma Program Innovation (CTPI) in New York City
Web: www.jbfcs.org
- Mount Sinai Adolescent Health Center in New York City
Web: www.mountsinai.org/msh/msh_program.jsp?url=clinical_services/cfe_pp.htm
- North Shore University Hospital at the Adolescent Trauma Treatment Development Center in Manhasset
Web: www.northshorelij.com/
- Safe Horizon-Saint Vincent's Child Trauma Care Continuum in New York City
Web: www.svcmc.org
Web: www.safehorizon.org

In Oregon

- Intercultural Child Traumatic Stress Center of Oregon at the Department of Psychiatry in Portland

In Pennsylvania

- Children's Crisis Treatment Center West African Refugee Project in Philadelphia
Web: www.cctckids.com

In South Carolina

- National Crime Victims Research and Treatment Center (NCVC) at the Medical University of South Carolina, Charleston
Web: www.musc.edu/cvc/

In Texas

- DePelchin Children's Center Child Traumatic Stress in Houston
Web: www.depelchin.org



In Virginia

- **International C.H.I.L.D. at the Center for Multicultural Human Services (CMHS) in Falls Church**
Web: www.cmhs.org

In Washington

- **Harborview Child Traumatic Stress Program, Seattle**
Web: <http://depts.washington.edu/hcsats/>

In Washington, D.C.

- **Identification and Treatment of Traumatic Stress in Children and Adolescents in Latino and Other Immigrant Populations at La Clinica del Pueblo, Inc.**
Web: www.lcdp.org

In Wisconsin

- **Mental Health Center of Dane County Adolescent Trauma Treatment Program**
Web: www.mhcdc.org/



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We undertook a systematic search and review of individual, family, community, and societal risk and protective factors for mental health in children and adolescents who are forcibly displaced to high-income countries. Exposure to violence has been shown to be a key risk factor, whereas stable settlement and social support in the host country have a positive effect on the child's psychological functioning. Further research is needed to identify the relevant processes, contexts, and interplay between the many predictor variables hitherto identified as affecting mental health vulnerability and resilience. Research designs are needed that enable longitudinal investigation of individual, community, and societal contexts, rather than designs restricted to investigation of the associations between adverse exposures and psychological symptoms. We emphasise the need to develop comprehensive policies to ensure a rapid resolution of asylum claims and the effective integration of internally displaced and refugee children.

Search strategy and selection criteria

The Medline, Scopus, PsycINFO, Embase, Web of Science citation, and Cochrane databases were systematically searched for studies about risk and protective factors that were reported from January, 1980, to July, 2010. Searches of similar terms were combined such as "asylum seeker", "refugee", "displaced person", "migrant" with "child", "adolescent", "young", "minor", "youth" or "teenage", and terms including "psychiatr*", "psycholog*", "psychosocial", "mental", "resilience", "outcome", "development", "protective factor", "adaptation", "modifying factor", "vulnerability factor", "risk factor", "recovery", "wellbeing", "emotion", "behaviour", "behavior", "trauma", "traumatic", and "adjustment". We also searched for specific countries of origin. Adaptations to the terms and MeSH searching were implemented, depending on the search style of each database. Additionally, reference and citation lists in published works, grey literature, and the authors' databases were reviewed. Inclusion criteria included study population, publication date, data about risk or protective factors, and sample size. There were no language restrictions.

We included studies of risk and protective factors for psychological, emotional, or behavioural disorders with a minimum sample size of 50 participants, and studies with 25 participants or more if a predictor variable was assessed for which there was minimal evidence from larger studies. Studies with participants aged up to and including the age of 18 years were eligible for inclusion; those with wider age categories were only included if all participants were younger than 25 years and mean age was 18 years or younger. We contacted investigators who had undertaken more than one study to clarify whether samples overlapped. Countries were defined by income in accordance with the World Bank classification.

5296 potentially relevant reports were identified through database searches, of which 1581 were duplicates. 737 summaries were reviewed and 257 full-text papers were obtained. Our final sample consisted of 44 studies from high-income countries, with 5776 displaced children and adolescents (nine studies had overlapping samples). They included forcibly displaced children from Bosnia, Cambodia, Central America, Chile, Croatia, Cuba, Iraq, Middle East, Somalia, Sudan, Vietnam, and the former Yugoslavia, who were either internally displaced or resettled in Australia, Belgium, Canada, Croatia, Denmark, Finland, the Netherlands, Sweden, the UK, and the USA. Mental health outcomes measured in these studies were generally grouped as internalising or emotional problems, including depression, anxiety, and post-traumatic stress disorder; and externalising or behavioural problems. We adhered to the terms used in each study describing the mental health outcomes and groups of displaced or refugee children. A meta-analysis was not done because of clinical and methodological heterogeneity.

Introduction

Children and adolescents who flee persecution and resettle in high-income countries often endure great physical and mental challenges during displacement, and suffer continuing hardships after arrival. Most of these refugees come from geographically distant, low-income settings.¹ The adverse events that necessitated their flight are often only the beginning of a long period of turbulence and uncertainty. Young people might travel for weeks or months in dangerous circumstances to seek asylum in a high-income country, and are sometimes temporarily or permanently separated from family and need to use professional traffickers to reach their destination.² The challenges typically encountered after arrival include, first, the complex legal immigration processes that asylum seekers must negotiate to gain refugee status or be repatriated,³ and second, the huge social, cultural, and linguistic differences between the place of origin and the new setting.

The process of sociocultural adaptation can be quite gradual, and refugees integrate to different extents with the host community.⁴ Children with disrupted or minimal school education are suddenly immersed in a new education system. Racial discrimination and bullying, exacerbated by policies to accommodate asylum seekers in already impoverished and disadvantaged areas, are widespread.⁵ Immigration policies for dispersal and detention can negatively affect refugees' attempts to settle in their host community.⁶ However, rapid resolution of asylum decisions eases access to social, health, education, and employment opportunities and infrastructures. Refugee children in high-income countries do not usually lack basic material necessities, yet certain factors nonetheless place their healthy development at risk. In this Review, we draw attention to the specific risk and protective factors that affect the psychological wellbeing of refugee children. Table 1 summarises all the studies included in this Review. Table 2 summarises the main findings according to individual factors, and table 3 according to family, community, and societal factors.

Effects of displacement

Although there are a reasonable number of reports about children exposed to conflict,⁵¹ the importance of displacement, as an additional variable to exposure to organised violence, has only been assessed in four Croatian studies.^{23,29,31,50} In a study³¹ with a 30-month follow-up, post-traumatic stress disorder, depression,

and somatic complaints decreased with time in internally displaced and non-displaced children, but psychosocial adaptation remained worse in displaced children and did not improve with time. In another study,²⁹ comparison of Bosnian refugee children and displaced and non-displaced Croatian children showed that the refugee children had higher anxiety and had

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	Study site	Study population	Number	Age* (years)	Domain assessed	Measurements
Ajdukovic et al, ⁷ 1993	Croatia	Internally displaced children and their mothers	319	Up to 18	Family	Semistructured interviews, authors' own exposure and stress (checklist of emotional, behavioural, and psychosomatic symptoms) scales
Almqvist et al, ⁸ 1997	Sweden	Iranian refugee children	50	4–8	Individual and family	Semistructured interview and observation of child's play
Almqvist et al, ⁹ 1999	Sweden	Iranian refugee children	39	6–10 (at follow-up)	Individual, family, and community	Semistructured interview, Social Adjustment Index, Global Self-Worth
Angel et al, ¹⁰ 2001	Sweden	Bosnian refugee children	99	6–16	Individual and family	Clinical interviews, observation of child, short Cederblad questionnaire
Bean et al, ¹¹ 2007	Netherlands and Belgium	Unaccompanied refugee children in the Netherlands; Dutch normative sample; immigrant and refugee group in Belgium	920 UASC (and 1059 Dutch children, and 1294 migrants and refugees in Belgium)	12–18	Individual and family	HSCL-37A, SLE, RATS
Bean et al, ¹² 2007	Netherlands	Unaccompanied refugee children from 48 countries	582	12–18	Individual, family, community, and society	HSCL-37A, SLE, RATS, CBCL for age 4–18 years (guardian report), TRF for 4–18 years
Berthold et al, ¹³ 1999	USA	Khmer refugee adolescents (born in Cambodia or in refugee camps or in Vietnam)	76	11–19 (mean 16)	Individual	SCECV, LA PTSD Index, CIS
Berthold et al, ¹⁴ 2000	USA	Khmer refugee adolescents	144	14–20 (mean 16)	Individual, family, and community	HTQ part 1, modified SCECV, LA PTSD index, CES-DC, Personal Risk Behaviour scale, Perceived Social Support from Family and Friends, Orthogonal Cultural Identification Scale
Cohn et al, ¹⁵ 1985	Denmark	Chilean children whose parents had been tortured	85 (58 born in Chile)	Not stated	Family	Clinical interview
Daud et al, ¹⁶ 2008	Sweden	Second-generation Iraqi children whose parents had been tortured versus North African children whose parents had not been tortured	80	7–16	Family	WISC-III, DICA-R, PTSS, I Think I Am scale, SDQ
Derluyn et al, ¹⁷ 2007	Belgium	Unaccompanied refugee children	166	9–18	Individual	HSCL-37A, SDQ-self, RATS, SLE, social workers completed CBCL for age 6–18 years and SDQ-parent
Derluyn et al, ¹⁸ 2009	Belgium	Newly arrived adolescents; 10% were UASC	124 UASC	11–18	Family	HSCL-37A, SLE, RATS
Ekblad et al, ¹⁹ 1993	Sweden	Refugee children and their mothers from former Yugoslavia residing in a refugee camp	66	5–15	Individual, family, community, and society	Structured interview
Ellis et al, ²⁰ 2008	USA	Somali adolescent refugees	135	11–20 (mean 15)	Individual, family, community, and society	UCLA-PTSD RI, WTSS, DSRS, Everyday Discrimination Scale, Adolescent Post War Adversities Scale, Acculturative Hassles Inventory
Fox et al, ²¹ 1999	USA	Vietnamese and Cambodian adolescents	47	9–15 (mean 11)	Individual and society	Structured interview, authors' own assessment of emotional effect of violence; CDI

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	Study site	Study population	Number	Age* (years)	Domain assessed	Measurements
(Continued from previous page)						
Geltman et al, ²² 2005	USA	Sudanese unaccompanied adolescents	304	Mean 18 (range not stated)	Individual, family, community, and society	HTQ-CHQ
Grgic et al, ²³ 2005	Croatia	Croatian camps for internally displaced people	112	12–15 (mean 14)	Individual and family	CDI, WTQ, Index of Family Relations
Grgic et al, ²⁴ 2005	Croatia	Returned previously displaced adolescents versus never displaced	57	16–18 (mean 17)	Displacement	CDI, HSC, C-PTSDI
Hjern et al, ²⁵ 1991	Sweden	Chilean refugees	50	2–15 (mean 6)	Individual	Adapted Cederblad questionnaire
Hjern et al, ²⁶ 1998	Sweden	Chilean and Middle Eastern refugee children 18 months after arrival	63	2–15 (mean 6)	Individual, family, community, and society	Authors' own questionnaires for organised violence, family stress, social situation in exile, school and nursery teacher questionnaire, and Cederblad questionnaire
Hodes et al, ²⁷ 2008	UK	78 unaccompanied and 35 accompanied refugee adolescents from various countries	113	13–18	Individual, family, and society	HTQ, IES, BDRS
Kia-Keating et al, ²⁸ 2007	USA	Somali adolescent refugees	76	12–19 (mean 16)	Individual and community	WTSS, PSSM, UCLA-PTSD RI, DSRS, Multidimensional Scales of Perceived Self-Efficacy
Kocijan-Hercigonja et al, ²⁹ 1998	Croatia	Non-displaced and displaced Croatian children, and refugee children from Bosnia	35 displaced and 35 refugees (and 35 non-displaced)	6–14	Displacement	SCSI, questionnaires on psychosomatic symptoms, psychosocial adjustment, anxiety and depression
Kovacev et al, ³⁰ 2004	Australia	Adolescents from former Yugoslavia	83	12–19 (mean 15)	Family and community	Social Support Scale for Children, Global Self Worth and Peer Social Acceptance scales, Acculturation Attitudes Scale
Kuterovac Jagodić et al, ³¹ 2000	Croatia	Displaced and non-displaced children resident in the same area	93 displaced (and 161 non-displaced)	Mean 13 at follow-up	Displacement	Locally developed questionnaires for war experiences, psychosocial adaptation, PTSD, depression and somatic symptoms
Liebkind et al, ³² 1993	Finland	Vietnamese refugee adolescents and their parents or carers	159	14–24 (mean 18)	Individual, community, and society	HSCL-25, Vietnamese Depression Scale
Liebkind et al, ³³ 1996	Finland	Vietnamese refugee adolescents	159	14–24 (mean 18)	Individual and community	Vietnamese Depression Scale, HSCL-25, RCRG
Montgomery et al, ³⁴ 2006	Denmark	Middle Eastern refugee children	311	3–15 (mean 8)	Individual and family	Structured parental interview for exposures to violence and current mental state
Montgomery et al, ³⁵ 2008	Denmark	Middle Eastern refugee adolescents	131	11–23 (mean 15 at follow-up)	Individual, family, community, and society	Structured parental interview, semistructured interview, YSR, YASR
Montgomery et al, ³⁶ 2010	Denmark	Middle Eastern refugee adolescents	131	11–23	Individual and family	Structured interviews with young person and parents: YSR or YASR depending on age at follow-up
Nielsen et al, ³⁷ 2008	Denmark	Accompanied refugee children in Danish Red Cross asylum centres—mixed country of origin	246	4–16	Community and society	Teacher SDQ, and self-report SDQ for children aged 11–16 years
Porte et al, ³⁸ 1987	USA	Indochinese refugee adolescents; 58 unaccompanied, in various types of alternative care; 24 accompanied	82	12–19 (mean 16)	Family	CES-DC, authors' own method of assessment of acculturation and support systems
Reijneveld et al, ³⁹ 2005	Netherlands	69 UASC in a restrictive reception centre; 53 UASC in a routine reception centre	122	14–18	Individual and society	HSCL-25, RATS
Rothe et al, ⁴⁰ 2002	USA	Cuban refugee children in a refugee camp	87	6–17 (mean 15)	Individual	PTSD RI, TRF

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	Study site	Study population	Number	Age* (years)	Domain assessed	Measurements
(Continued from previous page)						
Rousseau et al, ⁴¹ 1998	Canada	100 southeast Asian, and 56 Central American refugee children	156	Mean 10 (range not stated)	Family, community, and society	CBCL, a trauma scale, a separation index, FES, SRDS for parental depression, a social network score
Rousseau et al, ⁴² 1999	Canada	Cambodian adolescent refugees	67	Mean 14 (range not stated)	Family	YSR, AFI, measurements of school performance, authors' index of trauma exposure
Rousseau et al, ⁴³ 2000	Canada	76 Cambodian and 82 Central American refugee adolescents	158	14–15	Individual and family	CBCL, YSR
Rousseau et al, ⁴⁴ 2003	Canada	Cambodian refugee adolescents	57	Mean 14 (range not stated)	Family	YSR, a measurement of risk behaviour, AFI, SES, CSES, Racism Experience Scale
Rousseau et al, ⁴⁵ 2004	Canada	Cambodian refugee adolescents	67	Mean 14, 16 at follow-up	Individual, family, and community	YSR, CBCL, FES, BAS
Slodnjak et al, ⁴⁶ 2002	Slovenia	Bosnian refugee adolescents and local Slovenian adolescents	265 refugees (and 195 local adolescents)	14–15	Individual	CDI, IES, adapted WTQ, local Teacher's Report
Sourander et al, ⁴⁷ 1998	Finland	UASC in an asylum reception centre awaiting placement	46	6–17	Individual	CBCL
Sujoldzic et al, ⁴⁸ 2006	Bosnia, Croatia, and Austria	Adolescents from Bosnia resettled in three contexts: internally displaced in Bosnia or living as refugees in Austria or Croatia	499 refugee Bosnians (and comparator groups of 359 internally displaced and 424 non-displaced Bosnians)	15–18 (mean 17)	Individual, family, community, and society	Perceived health problems, objective health problems, index of psychological distress, SES, FAS, scale of risk and protective environmental factors, religious commitment scale
Tousignant et al, ⁴⁹ 1999	Quebec	Refugees from various countries	203	13–19	Individual, family, community, and society	Diagnostic Interview Scale for Children (version 2.25) and Children's Global Assessment Scale
Zivcic et al, ⁵⁰ 1993	Croatia	Displaced and non-displaced Croatian children in Rijeka during wartime	160 refugees (and 320 non-displaced)	8–15 (mean 11)	Displacement	CDI, authors' own emotion scale

Nine studies were either follow-up or used the same children in more than one study, and so were not recounted.^{9,32,25,33,35,36,42,44,45} UASC=unaccompanied asylum-seeking children. HSCL-37A=Hopkins Symptom Checklist-37 for Adolescents. SLE=Stressful Life Events checklist. RATS=Reactions of Adolescents to Traumatic Stress. CBCL=Child Behaviour Checklist. TRF=Teacher's Report Form (CBCL). FAS=Family Affluence Scale. SCECV=Survey of Children's Exposure to Community Violence. LA PTSD=Los Angeles post-traumatic stress disorder. CIS=Columbia Impairment Scale. Cederblad questionnaire=Cederblad questionnaire for children's mental health. HTQ=Harvard Trauma Questionnaire. IES=Impact of Event Scale. CES-DC=Center for Epidemiologic Studies Depression Scale for Children. WISC=Wechsler Intelligence Scale for Children. DICA-R=Diagnostic Interview for Children and Adolescents. PTSS=Post-Traumatic Symptom Scale. SDQ=Strengths and Difficulties Questionnaire. UCLA-PTSD RI=University of California at Los Angeles Post-traumatic Stress Disorder Reaction Index. WTSS=War Trauma Screening Scale. DSRs=Depression Self-Rating Scale. CDI=Children's Depression Inventory. HTQ=Harvard Trauma Questionnaire. CHQ=Child Health Questionnaire. WTQ=War Trauma Questionnaire. HSC=Hopelessness Scale for Children. C-PTSDI=Children's Post-Traumatic Stress Disorder Inventory. BDSR=Beck Depression Self-Rating Scale. PSM=Psychological Sense of School Membership. PTSD=post-traumatic stress disorder. SCSL=Schoolagers' Coping Strategy Inventory. HSCL-25=Hopkins Symptom Checklist-25. RCRG=Role Construct Repertory Grid (interview and questionnaire on acculturation). YSR=Youth Self Report (CBCL). YASR=Young Adult Self Report. PTSD RI=Post-Traumatic Stress Disorder Reaction Index. FES=Family Environment Scale. SRDS=Self-Report of Depressive Symptoms. AFI=Adolescent Friendship Inventory. SES=Rosenberg's Self-Esteem Scale. CSES=Collective Self-Esteem Scale. BAS=Behavioural Acculturation Scale. *Mean ages have been rounded to the nearest whole number.

Table 1: Summary of studies

fewer effective coping strategies to manage stressful situations than did the displaced and non-displaced children. In a further study,⁵⁰ the prevalence of depression in internally displaced Croatian children was not different from that in non-displaced children. Prevalence of hopelessness, post-traumatic stress disorder, or depression was not different in a comparison of internally displaced Croatian teenagers (aged 16–18 years) who had returned after 7 years in exile with those who were displaced for 6 months or less.²³ Because the results of these studies have not been conclusive, further larger studies are needed to provide useful insights into whether displacement places children at additional risk of poor mental health, and whether they

have different needs from local children exposed to conflict.

Individual factors Exposure to violence

Direct experience of adverse events is associated with an increased likelihood of psychological disturbance in refugee children. The degree of post-traumatic stress disorder was associated with personal experiences of traumatic events, especially those occurring when away from home.²² Internalising difficulties in the initial phase after displacement were associated with adverse events before migration,³⁵ whereas the rates of sleep disturbances and anxiety were increased in children with direct

exposure to adverse events before migration.²⁵ The degree of perceived personal threat during traumatic exposures was a determinant of generalised anxiety¹⁰ and post-traumatic stress disorder.⁴⁰

Additionally, migration journeys and postmigration experiences might be highly distressing. Thus, Cuban children who witnessed violence while they were detained in a refugee camp en route to the USA showed more withdrawn behaviour than did children without exposure to violence in the camp.⁴⁰ Direct and indirect exposure to violence or other potentially traumatic events, after entry into the host country, was associated with a range of negative psychological outcomes in most^{13,35,36,48} but not all²¹ studies.

Cumulative exposure to traumatic events is associated with a broad range of psychological problems in refugee groups exposed to violence during war.^{8,17,20,24,46} However, in some studies, the number of traumatic events before migration was not a predictor of post-traumatic stress disorder.^{13,14} The results of two studies have indicated that the number of lifetime traumatic events could be more consequential than are predisplacement events,^{13,36} emphasising the importance of considering the refugee's whole experience so far rather than just the premigration events. However, in one longitudinal study, a high number of adverse events before displacement continued to affect the mental health of refugees even 9 years after arrival, but those who subsequently recovered from initial symptoms were likely to have suffered fewer additional adverse events after displacement than had those who remained symptomatic.³⁶

Physical, psychological, or developmental disorders

In a longitudinal study in Sweden,⁹ pre-existing vulnerability (consisting of delayed development, long-term physical illness, or psychological problems) was a predictor of mental ill-health, poor social adjustment, and low self-worth 3.5 years after arrival, whereas the absence of evidence of such vulnerability before exposure to adverse events was a strong predictor of emotional wellbeing. Personal injury that was sustained during potentially traumatic premigration events was associated with an increased risk of post-traumatic stress disorder. Head injury, in particular, was associated with a doubling of risk.²² These potentially important factors were not investigated in other studies.

Age and sex

The relation between age and psychological symptoms is not clear from existing evidence because of the difficulty in differentiation of potential confounding factors, including age at the onset of adverse events, age at migration, and age-related policies for education, accommodation, and the decision-making processes for asylum in host countries. These variables intersect with the nature and duration of adverse exposure, affecting age-specific responses. For example, children

in their late teens confronted with a short period of exposure to violent conflict are likely to have benefited from a long period of stable psychosocial development, whereas children growing up in situations of long-standing conflict are likely to have had greater cumulative adversity. This greater adversity might increase the likelihood of psychological difficulties in these children, or conversely, strengthen their capacities for resilience.

In a UK cross-sectional survey of unaccompanied asylum-seeking children (UASC), increase in age was associated with an increase in symptoms of post-traumatic stress disorder, whereas accompanied children had fewer problems with increasing age.²⁷ This difference might indicate a difference in immigration status—ie, unaccompanied adolescents feared possible deportation after the age of 18 years, whereas most accompanied adolescents had been granted the right to remain in the UK as refugees. Similar findings have been reported in other studies of UASC in Belgium and the Netherlands.^{11,12,17} The living arrangements of UASC might have a negative effect particularly on children younger than 15 years, as reported in one study of asylum centres.⁴⁷ No independent relation was noted between age and psychological disorders in other studies.^{10,13,20,26,49}

Relations between sex and psychological functioning also show much variation. In about half the studies of accompanied and unaccompanied children, the prevalence of mental health disorders, notably depression and internalising difficulties, was higher in girls than in boys.^{13,17,27,32,39} These disorders sometimes occurred with other diagnoses,^{48,49} including post-traumatic stress disorder.^{12,46} No sex-related differences were noted in the remainder of the studies.^{10,13,20,26,28,34,40,43} Changes in sex-related effects with time were inconsistent.^{13,14,20,26,28,34,40,43,45} A protective effect of male sex for internalising disorders is consistent with findings from non-refugee populations⁵² and Reed and colleagues' Review⁵³ about low-income and middle-income countries, but biological and social causal pathways need to be assessed further.

Education

The period of formal education before displacement was unrelated to psychological distress or behavioural problems.¹² Bosnian adolescent refugees to Slovenia with high educational achievement were more likely to have post-traumatic stress disorder than were those with low achievement.⁴⁶ Although the reasons for this difference are not clear, evidence suggests that good overall functioning in refugee children can coexist with mental health symptoms.⁵⁴ In a longitudinal study, refugees whose mental health improved at follow-up after 8–9 years were more likely to be in education or employment than were those who remained symptomatic, but whether education or employment were contributing to recovery or whether children with

persistent symptoms tended to withdraw from such situations is not clear.³⁶

Family factors

Exposure to violence

Familial experiences of adverse events affect children's psychological functioning. Some types of parental exposures are more strongly associated with children's mental health problems than are children's own exposures,^{34,44} particularly if parents have been tortured^{9,15,16,34,55} or are missing.³⁴ Familial adverse events before the child's birth were a major determinant of children's later psychological outcomes in Central American, but not in southeast Asian³⁶ or Middle Eastern refugees.³⁴ Family communication might be relevant—awareness of a parent's detention was an independent predictor of post-traumatic stress disorder in the child³⁴ and a lack of discussion by the family about adverse events

was protective with respect to the child's mental health.¹⁰

These findings need to be replicated because of the small sample sizes, to compare consistency with other reports about family communication, and especially because of the substantial evidence from other situations that key family processes play an important part in helping family members to recover in times of crisis.^{36,57} Further research is needed to identify which kinds of communication are helpful or not in the different contexts.

Family composition and bereavement

Being unaccompanied on entry to the host country puts a child at risk of psychological disorders,^{11,27,58} although the experiences of UASC and accompanied children are heterogeneous. UASC often experienced higher numbers of adverse events than did accompanied children.^{18,27} Separation from the immediate family was associated with post-traumatic stress disorder in one study,²² though

Summary

Exposure to violence

Almqvist et al, ⁸ 1997	Post-traumatic stress disorder frequency was linked to degree of adverse event exposure (38%, if severe exposure; 11%, if some exposure)
Angel et al, ¹⁰ 2001	Degree of perceived personal threat during adverse event was predictive of anxiety symptoms subsequently
Berthold et al, ¹³ 1999	Lifetime and postmigration violence correlated with symptoms of post-traumatic stress disorder, but premigration violence did not
Berthold et al, ¹⁴ 2000	Although degree of violence exposure was not predictive of diagnoses of depression and post-traumatic stress disorder, high rates of symptoms were associated with increased exposure
Derluyn et al, ¹⁷ 2007	Number of traumatic experiences were predictive of symptoms of anxiety, depression, post-traumatic stress, and emotional problems
Ekblad et al, ¹⁹ 1993	Experience of direct violence was associated with poor mental health of child
Ellis et al, ²⁰ 2008	Exposure to traumatic events was most strongly associated with post-traumatic stress disorder, and was also associated with depression
Fox et al, ²¹ 1999	Violence before migration was associated with depression subsequently. Frequency of violence while in a refugee camp was not associated with depression subsequently
Geltman et al, ²² 2005	Direct personal trauma was associated with post-traumatic stress disorder, but witnessing assaults on other people was not Post-traumatic stress disorder was doubled in children who suffered head trauma. Children in their own village at the time of an adverse event had a lower risk of post-traumatic stress disorder than did those who experienced adverse events when away from their village
Grgic et al, ²⁴ 2005	A relation was noted between the number of war traumas and Children's Depression Inventory score
Hjern et al, ²⁵ 1991	Sleep disturbances and separation anxiety were significantly associated with direct experiences of persecution
Hjern et al, ²⁶ 1998	Witnessing violence was a significant predictor of symptom scores at follow-up after 17–19 months
Montgomery et al, ³⁴ 2006	Witnessing violent acts and direct exposure to organised violence were predictive of various psychological symptoms, but not the full symptom complex of post-traumatic stress disorder
Montgomery et al, ³⁵ 2008	High numbers of different premigration traumatic experiences were predictive of high internalising scores Witnessing attacks on other people after arrival in Denmark was associated with an increase in externalising behaviour
Montgomery et al, ³⁶ 2010	Traumatic experiences before arrival were significantly more common in those who were symptomatic at arrival and at follow-up than in those who never attained symptom thresholds. Numbers of types of stressful events after arrival in the host country were much lower in children who recovered from symptoms during follow-up than in those who remained symptomatic
Rothe et al, ⁴⁰ 2002	Degree of perceived personal threat during an event was predictive of withdrawn behaviour later Witnessing violence in a refugee camp was predictive of withdrawn behaviour, but time spent in a camp and separation from family in the camp and witnessing suicide attempts were not significant Fear of dying during migration while at sea was associated with withdrawn behaviour but not with post-traumatic stress disorder
Slodnjak et al, ⁴⁶ 2002	Small correlation between Children's Depression Inventory and trauma exposure
Sujoldzic et al, ⁴⁸ 2006	Violence from peers and adults was associated with poor psychological functioning in Bosnian children who were resettled in Croatia

Physical, psychological, or developmental disorders

Almqvist et al, ⁸ 1999	Absence of reported signs of vulnerability (poor physical, emotional wellbeing, or delayed development) before exposure to violence strongly determined emotional wellbeing at follow-up
Geltman et al, ²² 2005	Personal injury during premigration was associated with an increased risk of post-traumatic stress disorder; head injury, particularly, was associated with a doubled risk of post-traumatic stress disorder

Time since displacement

Geltman et al, ²² 2005	Residence in resettlement country for less than 6 months was not associated with post-traumatic stress disorder
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Summary

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Age

Angel et al, ¹⁰ 2001	No association was noted between age and scores on symptom scales
Bean et al, ¹¹ 2007	Psychological distress was higher with increasing age in unaccompanied asylum-seeking children
Bean et al, ¹² 2007	Older age was associated with higher internalising, externalising, and Reactions of Adolescents to Traumatic Stress scores at follow-up
Berthold et al, ¹³ 1999	No difference was noted in rates of post-traumatic stress disorder or functioning
Berthold et al, ¹⁴ 2000	No association of age with post-traumatic stress disorder or depression was noted
Derluyn et al, ¹⁷ 2007	Adolescents aged 17–18 years had higher depression scores; conduct problems peaked at age 16 years
Ellis et al, ²⁰ 2008	Age was not associated with post-traumatic stress disorder or depression
Hjern et al, ²⁶ 1998	Age was not an independent predictor of symptom scores in regression analyses
Hodes et al, ²⁷ 2008	For unaccompanied asylum-seeking children, Impact of Event Scale scores increased with age, and decreased with age for accompanied children
Montgomery et al, ³⁵ 2008	Fewer externalising behavioural problems were noted with increasing age
Rothe et al, ⁴⁰ 2002	Children had higher scores of post-traumatic stress disorder; Child Behaviour Checklist scores were not affected by age
Sourander et al, ⁴⁷ 1998	Children younger than 15 years had more psychological distress and behavioural problems than did older children
Tousignant et al, ⁴⁹ 1999	No association of age with the prevalence of psychopathology was noted

Sex

Angel et al, ¹⁰ 2001	No association between sex and scores on symptom scales was noted
Bean et al, ¹² 2007	Girls had higher Reactions of Adolescents to Traumatic Stress and internalising scores, but not externalising scores
Berthold et al, ¹³ 1999	No difference was noted in rates of post-traumatic stress disorder or functioning
Berthold et al, ¹⁴ 2000	Girls were more likely to be depressed than were boys
Derluyn et al, ¹⁷ 2007	Girls had higher scores for anxiety, depression, withdrawal, intrusion on the Reactions of Adolescents to Traumatic Stress, and total problems
Ellis et al, ²⁰ 2008	Sex was not associated with post-traumatic stress disorder or depression
Hjern et al, ²⁶ 1998	Girls had an increase in symptoms soon after arrival in the host country, but no difference was noted between boys and girls at 18 months after arrival
Hodes et al, ²⁷ 2008	Girls had higher scores on the Impact of Event Scale and Birlerson Depression Self-Rating Scale than did boys
Kia-Keating et al, ²⁸ 2007	Sex was not a predictor of depression or post-traumatic stress disorder
Liebkind et al, ³² 1993	Girls had higher scores than did boys
Liebkind et al, ³³ 1996	Premigration traumatic experiences were predictive of boys' Hopkins Symptom Checklist-25 scores
Montgomery et al, ³⁴ 2006	Sex was not a predictor of post-traumatic stress disorder
Montgomery et al, ³⁵ 2008	Male sex was predictive of fewer internalising behaviours at follow-up
Reijneveld et al, ³⁹ 2005	Girls had higher internalising symptoms than did boys Girls in a restrictive reception facility had higher anxiety, depression, and emotional problems than did girls in a less restrictive reception setting, whereas boys in a restrictive reception setting had similar rates to those in a less restrictive reception facility
Rothe et al, ⁴⁰ 2002	Sex was not associated with scores for Child Behaviour Checklist or post-traumatic stress
Rousseau et al, ⁴³ 2000	Sex was not associated with internalising or externalising symptoms
Rousseau et al, ⁴⁵ 2004	No sex difference was noted in early adolescence (mean age 14 years); but boys had more internalising symptoms at follow-up in mid-adolescence (16 years)
Slodnjak et al, ⁴⁶ 2002	Girls had higher frequencies of post-traumatic stress disorder and depression than did boys
Sujoldzic et al, ⁴⁸ 2006	Girls had worse functioning than did boys
Tousignant et al, ⁴⁹ 1999	All disorders except conduct disorder were more prevalent in girls than in boys

Education

Bean et al, ¹² 2007	Period of child's education before migration had no effect on scores for behavioural problems or psychological distress
Montgomery et al, ³⁶ 2010	Refugees whose mental health improved by 8–9-year follow-up were more likely to be in education or employment than were those who remained symptomatic
Slodnjak et al, ⁴⁶ 2002	Adolescents with better school achievement had more symptoms of post-traumatic stress disorder than did those with lower school achievement

Table 2: Summary of principal findings in relation to individual factors assessed in each study

arriving with a family member was not protective in another study.²⁰ UASC who had at least one family member already resident in the host country had lower scores for internalising difficulties and post-traumatic stress symptoms.¹²

Accompanied children subsequently separated from their relatives were also at risk of poor mental health.²⁶ Children whose relatives were in difficult circumstances (eg, imprisoned), and those who had difficulty contacting

their relatives had worse psychological functioning.⁷ Boys living with both parents had rates of psychological symptoms five times lower than those living in other family arrangements,⁴⁹ and fewer changes of family structure were protective for boys. From interviews, many single mothers had difficulty asserting their authority over adolescent boys, and their authority could be undermined by the boys' peers. Conflict with a mother's new partner was also postulated as a contributory factor. Adolescents

living with both parents had lower internalising scores in mid-adolescence, whereas those in single-parent households reported greater feelings of competence.⁴⁵

Family functioning and parental health

Family cohesion and perception of high parental support were associated with fewer psychological difficulties in children than were poor family support or cohesion.^{13,23,30,45,48} The results of one study showed that children whose parents divorced after displacement showed more psychological symptoms than did those whose parents did not divorce,²⁶ but this finding was not supported in another study.⁹ Displaced Croatian children whose mothers reported adaptation difficulties or conflicts had high levels of psychological distress.⁷ Evidence about the effect of postmigration changes in parental behaviour is insufficient and equivocal.^{7,34} In particular, the role of communication within families is potentially important, but there has been little investigation thereof; a lack of information about experiences of migration or exile was associated with an increased likelihood of psychological disorders¹⁹ or had no effect.³⁴ Situations in which children spoke often with mothers about difficulties were associated with an absence of substantial psychological difficulties at arrival in Denmark and at follow-up 8–9 years later.³⁶ Good parental mental health, particularly in mothers, is an important protective factor,^{19,21,26} in keeping with the evidence from non-refugee populations.⁵⁹ Refugee parents with poor mental health were noted in one study to direct feelings of anger towards their children.⁶⁰ Among Bosnian refugee families in Sweden, shared stressful experiences accounted for the correlation between the parent and child's mental health.¹⁰

Household socioeconomic circumstances

Socioeconomic status might provide some protection, in that access to material and social resources could allow an early flight from conflict and reduction in cumulative exposure to adversity.^{5,61} However, findings of studies are contradictory, with socioeconomic circumstances before displacement not being predictive of post-traumatic stress disorder,^{34,41} or parental employment status, particularly employment in a private enterprise rather than administrative or manual work, being associated with post-traumatic stress disorder in the child,³⁴ whereas being like others in the middle stratum of society might be protective (Montgomery E, Rehabilitation and Research Centre for Torture Victims, Denmark, personal communication).

Attention to mental health in the context of everyday stressors, including socioeconomic disadvantage, needs greater attention.⁶² Economic circumstances after displacement can affect the child's psychological functioning. Parental worries about financial problems have a particular adverse effect on the mental health of refugee children.^{7,63} Thus, low socioeconomic status of Bosnian refugee adolescents was linked to more depressive symptoms and poor self-esteem.⁴⁸ By contrast, clear

correlations were not noted between psychological disorders and markers of socioeconomic status in two reports.^{26,49} Paternal unemployment for longer than 6 months during the first year of resettlement was predictive in one study,⁴⁹ but not in another study⁴³ of psychological disorders in children. Conclusions cannot yet be drawn about the effect of socioeconomic status, and causal pathways are difficult to interpret because most of the studies have heterogeneous designs in terms of the inclusion of predictor variables.

Parental education

Education of the parents has a variable effect—having educated parents might be protective^{35,36,41} or have no effect.^{34,49} In a longitudinal study,³⁶ refugees whose symptoms resolved during follow-up had fathers with long periods of education in the home country, perhaps indicating resources within the family that fostered resilience. Educated, intellectual families might be targeted in some political conflicts,⁶⁴ which could outweigh any protective effect of parental education.

Community factors

Social support and community integration

Perceptions of acceptance or discrimination within host countries are highly relevant. In a study of displaced Bosnian adolescents,⁴⁸ those internally displaced or displaced to Croatia reported more perceived discrimination than did those who had resettled in Austria. Low peer violence and discrimination were positively linked to self-esteem. Boys were more likely to report discrimination than were girls,^{35,48} and this difference was predictive of poorer psychological functioning. Perceived discrimination was the best predictor of outcomes such as depression and post-traumatic stress disorder in Somali adolescents in the USA,²⁰ but had no effect in another study.³³ 41% of refugee children in a Swedish study⁹ reported bullying and those with few peers to play with were likely to show poor general adaptation.^{9,35} High perceived peer support was associated with improved psychological functioning.^{14,30} Subjective childhood experiences, including the strength of peer relationships, are integral to healthy psychological development; however, longitudinal data in the refugee context are lacking, and actual effect sizes are often left unspecified in reports.

A perceived sense of safety at school has been associated with low risk of post-traumatic stress disorder,²² and an increased sense of school belonging was shown to protect against depression^{28,45,48} and anxiety.⁴⁸ This sense of belonging is important because of the potential for modification of school learning and social environments. In one study, a change of school was not associated with deterioration in psychological functioning of UASC,¹¹ whereas in an 8-year follow-up in Denmark attendance at several different schools was predictive of high externalising behaviour scores in young refugees.³⁵ Strong school connectedness was positively linked to

Summary

Family exposure to violence

Almqvist et al, ⁸ 1997	Most children whose fathers had been imprisoned showed abnormal play behaviour
Almqvist et al, ⁹ 1999	Severe traumatic exposure in parents correlated with severe traumatic exposure in children
Angel et al, ¹⁰ 2001	Lack of family discussions about adverse events during conflict was associated with fewer psychological problems
Cohn et al, ¹⁵ 1985	Children whose parents had been tortured showed high rates of emotional and somatic disorders
Daud et al, ¹⁶ 2008	Values for I Think I Am and Strengths and Difficulties questionnaires were similar for children with traumatised and non-traumatised parents
Montgomery et al, ³⁴ 2006	Two violent exposures—mother tortured and father disappeared—and a child being informed about parents' detention were independently predictive of post-traumatic stress disorder (many other exposures were predictive of individual symptoms but not the post-traumatic stress disorder complex); parental torture before the child's birth did not increase risk
Rousseau et al, ⁴¹ 1998	Family trauma before the child's birth was a predictor of internalising and externalising symptoms in Central American but not southeast Asian children
Rousseau et al, ⁴² 1999	Family trauma before the child's birth was protective in terms of externalising symptoms, risk behaviour, and school failure in boys; in girls, it was associated positively with social adjustment
Rousseau et al, ⁴⁴ 2003	Family trauma after a child's birth showed no relation with any assessment measurements. No relation was noted between internalising and externalising symptoms in adolescence with prebirth familial trauma. In boys, the severity of prebirth exposure to familial trauma correlated with increased self-esteem in later adolescence, and decreased perception of racism, but no effect was noted in girls

Family composition and bereavement

Bean et al, ²¹ 2007	Unaccompanied adolescents had higher internalising problems, traumatic stress reactions, and stressful life events than did other groups
Bean et al, ²² 2007	Change of guardian did not affect measurements. Reactions of Adolescents to Traumatic Stress and internalising scores were much higher if no family member was in the host country, or if living in a large residential setting rather than foster care or a small group setting
Derluyn et al, ¹⁸ 2009	Unaccompanied children were more likely to have experienced all types of adverse events than were accompanied children
Ellis et al, ²⁰ 2008	Arriving with or without parents was not associated with post-traumatic stress disorder or depression
Geltman et al, ²³ 2005	Separation from family was associated with post-traumatic stress disorder, whereas presence of any biological family member or friend during migration or in camp was not associated with post-traumatic stress disorder. Sudanese children living in a group home or foster care without other Sudanese people were more likely to have post-traumatic stress disorder than were those in foster care with other Sudanese people (other fostered children or foster family)
Hodes et al, ²⁷ 2008	Unaccompanied asylum-seeking children had higher numbers of traumatic events and scored higher on the Impact of Event Scale than did accompanied refugee children; Birlson Depression Self-Rating Scale scores were not different Unaccompanied asylum-seeking children in low-support living arrangements showed significantly higher scores for post-traumatic stress symptoms than did those living with more support For accompanied children, there was no difference in scores between those living in two-parent or single-parent households
Porte et al, ³⁸ 1987	Refugee children in homes with people of the same ethnic origin (own families or foster care) were much less depressed than were those living in either foster or group homes with local families
Rousseau et al, ⁴¹ 1998	In children of southeast Asian origin, but not Central American children, being from a single parent household was a predictor of internalising symptoms; number of people in household was not a predictor
Rousseau et al, ⁴³ 2000	Increasing household size and living with a single parent were associated with internalising symptoms in Cambodian but not Central American refugees
Rousseau et al, ⁴⁵ 2004	Living in a one-parent or two-parent household had no effect in early adolescence (mean age 14 years); at follow-up in mid-adolescence (16 years), single-parent households were associated with higher feelings of competence, but those in two-parent households had fewer internalising symptoms; no association was noted between one-parent or two-parent household and externalising symptoms
Toussignant et al, ⁴⁹ 1999	Prevalence of psychological problems was five times lower in boys living with both parents than in boys living in other family arrangements. Number of residences since birth was higher in boys with a diagnosis than in boys without a diagnosis. Children in host families with no kin contacts had more psychological problems

Family functioning and parental health

Ajdukovic et al, ⁷ 1993	Children had high stress scores if their mothers reported difficulties in adapting to their new environment or felt burdened with conflicts, if they had difficult mother-child relationships, if their separated family members were in difficult circumstances (such as being prisoners of war), or if they had difficulty contacting separated family members Children living in host families rather than in shelters had lower stress scores, but had high stress scores if their mothers had negative views of the people they were living with
Almqvist et al, ⁹ 1999	Maternal emotional wellbeing was a determinant of the child's emotional wellbeing at follow-up Marital discord predicted poor general adaptation
Angel et al, ¹⁰ 2001	Children whose parents were in need of psychiatric treatment had high total problem and anxiety scores, but association was attributable to shared stressors in multiple regression analysis; parents' talking about the war seemed to exacerbate negative effects of stress in worst-affected children, but not in those least affected
Berthold et al, ⁴⁴ 2000	Perceived family support negatively correlated with post-traumatic stress disorder and depression
Ekblad et al, ³⁹ 1993	Having a mother who was described as apathetic or unstable was linked to poor mental health of the child; an optimistic mother was linked to good mental health Lack of information about the flight was associated with poor mental health in children
Grgic et al, ²³ 2005	Number of traumatic events was associated with Hudson's Index of Family Relations score; most children perceived family relationships as positive, but 21% reported substantial problems with family relationships
Hjern et al, ²⁶ 1998	Separation from family members and parental divorce after migration were associated with high symptom scores initially and at follow-up. Having a parent in psychiatric care was associated with high symptom scores at follow-up. Recent family stressors were a predictor of poor mental health
Kovacev et al, ³⁰ 2004	Greater parental support was associated with high Global Self Worth scores

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Summary

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Montgomery et al, ³⁴ 2006	Current family structure, a change in parental behaviour towards the child, and the child being informed about family exposures to violence and the reason for escape were not predictors of post-traumatic stress disorder
Montgomery et al, ³⁶ 2010	Refugees without many symptoms were likely to speak to their mothers frequently about problems, both at arrival and 8–9-year follow-up
Rousseau et al, ⁴³ 2000	No association of emotional and behavioural problems was noted with parental unemployment
Rousseau et al, ⁴⁵ 2004	Protective effect of family cohesion was associated with feelings of competence in early adolescence (mean age 14 years), and reduced externalising symptoms in mid-adolescence (16 years) Family conflict did not increase risk in early adolescence, but was associated with increased parental report of externalising symptoms in late adolescence
Sujoldzic et al, ⁴⁸ 2006	Poor family connectedness was associated with depression

Household socioeconomic circumstances

Ajdkovic et al, ⁷ 1993	Children whose mothers reported having poorer financial and material support had high stress scores
Angel et al, ¹⁰ 2001	No independent effect of preflight socioeconomic status was noted on the child's psychological wellbeing at follow-up
Hjern et al, ²⁶ 1998	Socioeconomic conditions in the host country did not correlate with symptom scores
Hodes et al, ²⁷ 2008	Premigration socioeconomic circumstances of unaccompanied asylum-seeking children and accompanied refugee children were not different
Montgomery et al, ³⁴ 2006	Parents who had premigration occupations and fathers who had worked in private enterprises were predictive of post-traumatic stress disorder, but the parents' economic situation and social class were not
Sujoldzic et al, ⁴⁸ 2006	Low affluence was associated with depression
Tousignant et al, ⁴⁹ 1999	Downward professional mobility or current parental employment status was not associated with psychological problems, but a period of prolonged paternal unemployment in the first year of arrival was associated with psychological problems

Parental education

Ekblad et al, ¹⁹ 1993	Father's high educational achievement was linked to poor mental health of child
Montgomery et al, ³⁴ 2006	Parents' education was not a predictor of post-traumatic stress disorder
Montgomery et al, ³⁵ 2008	Less maternal education was associated with more externalising behaviours
Montgomery et al, ³⁶ 2010	Refugees whose symptoms resolved during follow-up had fathers with long periods of education in the home country
Rousseau et al, ⁴¹ 1998	In children of southeast Asian origin, parental education was associated with externalising behaviour
Rousseau et al, ⁴³ 2000	No association with emotional or behavioural problems was noted with parental education
Tousignant et al, ⁴⁹ 1999	Parental education was not a predictor of psychological problems

Social support and community integration

Almqvist et al, ⁹ 1999	Having peers to play with was predictive of higher scores of general adaptation and social adjustment
Bean et al, ¹² 2007	Change of school during 1-year follow-up did not affect levels of psychological distress or behavioural problems
Berthold et al, ¹⁴ 2000	Perceived support from friends negatively correlated with post-traumatic stress disorder and depression
Ekblad et al, ¹⁹ 1993	Social support associated with good mental health in child
Ellis et al, ²⁰ 2008	Carer fluency in the host language (English) was not associated with post-traumatic stress disorder or depression; acculturative stressors were related to post-traumatic stress disorder, but not depression; perceived discrimination was associated with post-traumatic stress disorder and depression
Hjern et al, ²⁶ 1998	Extent of the social network did not affect symptom scores
Geltman et al, ²² 2005	In Sudanese children, living in a group home or foster care with an American family without other Sudanese people was associated with post-traumatic stress disorder, whereas living with a Sudanese family or with an American family alongside other Sudanese children was not, and feeling safe at home was associated with a reduced risk Feeling safe at school was associated with a reduction in risk of post-traumatic stress disorder This disorder was associated with children feeling less comfort with host society and culture, feeling lonely or isolated where they were living, and reduced participation and satisfaction in group activities
Kia-Keating et al, ²⁸ 2007	Sense of school belonging was negatively predictive of depressive symptoms, irrespective of past exposure to adversities
Kovacev et al, ³⁰ 2004	Increased support from classmates and close friends was associated with high Global Self Worth scores The acculturation styles of assimilation and separation were not predictive of Global Self Worth scores; integration was positively predictive of Global Self Worth and marginalisation was negatively predictive
Liebkind et al, ³² 1993	Children identified increasingly with host country with time
Liebkind et al, ³³ 1996	Presence of people of the same ethnic origin in the community was protective against anxiety for girls but not boys Discrimination experiences were not predictors of disorders Dissociation from traditional family values and a positive attitude towards acculturation was predictive of anxiety symptoms in girls but not boys For boys, adherence to traditional family values had a protective effect
Montgomery et al, ³⁵ 2008	The number of types of postmigration discrimination experiences was associated with increased internalising behaviours Not attending school or work and high number of school changes were associated with externalising behaviour Higher numbers of Danish friends was associated with lower internalising behaviours
Nielsen et al, ³⁷ 2008	Children who had at least four relocations had poor mental health
Rousseau et al, ⁴¹ 1998	In children of southeast Asian origin, having a large potential social network of the same ethnic origin was a predictor of internalising and externalising symptoms Central American children having an active social network from the host country was a predictor of internalising behaviour, possibly related to greater demands and obligations associated with an extended family network in some cultures Number of people in the household was not a predictor

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Summary	
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Rousseau et al, ⁴⁵ 2004	Acculturation alone had no effect on externalising or internalising symptoms, or on competence, but it interacted with sex such that less acculturated boys had more symptoms The degree of acculturation did not change with the duration of follow-up Parental fluency in the host language had no effect
Sujoldzic et al, ⁴⁶ 2006	Poor school connectedness was associated with depression, anxiety, and somatic stress. Poor attachment to the neighbourhood was associated with depression; perceived discrimination was associated with poor psychological functioning in Bosnians in Croatia but not Austria
Tousignant et al, ⁴⁹ 1999	Parental fluency in the host language, social integration, and frequency of conversations outside the home were not associated with psychological effects, but mothers with few visitors and few wider kin contacts were both associated with psychological problems
Ideological and religious contexts	
Montgomery et al, ³⁵ 2008	Being Christian or Muslim negatively predicted clinically significant internalising behaviour, but not overall internalising or externalising symptoms
Sujoldzic et al, ⁴⁸ 2006	Religious commitment was protective against depression and anxiety
Ethnic origin	
Bean et al, ²⁷ 2007	Unaccompanied asylum-seeking children from Eritrea, Ethiopia, and Guinea had higher externalising and internalising scores than did those from other African countries and China
Hjern et al, ²⁶ 1998	Region of origin had no effect on symptom scores
Hodes et al, ²⁷ 2008	Region of origin had no effect on trauma scores, but refugees from the Middle East had higher Birlson Depression Self-Rating Scale scores than did those from Europe or Africa
Rousseau et al, ⁴¹ 1998	Ethnic origin was the main determinant of children's emotional profile
Tousignant et al, ⁴⁹ 1999	Rates of psychological problems were similar for all regions except the Middle East, which showed lower rates
Resettlement location	
Bean et al, ²⁷ 2007	Children relocated to another regional immigration office during 1 year follow-up had higher internalising scores than did those who were not relocated
Ellis et al, ²⁰ 2008	Housing adequacy was not associated with post-traumatic stress disorder or depression
Fox et al, ²¹ 1999	No association was noted between adverse events in refugee camps and subsequent psychological problems
Geltman et al, ²² 2005	Living in an urban neighbourhood in the host country was not associated with post-traumatic stress disorder
Liebkind et al, ³² 1993	Area of residence in host country had no effect on mental health
Nielsen et al, ³⁷ 2008	In children who had four or more relocations within the host country, the odds ratio of having mental health difficulties was 3
Tousignant et al, ⁴⁹ 1999	No association was noted between residence in a refugee camp en route to the host country and psychological effects later. Boys with psychiatric diagnoses had a greater number of changes in residence
Immigration process	
Bean et al, ²⁷ 2007	Lack of a temporary residence permit was linked to high internalising scores
Ekblad et al, ³⁹ 1993	Long period in a refugee camp in the host country was linked to poor mental health
Ellis et al, ²⁰ 2008	Number of years in the USA was negatively associated with depression; no association with post-traumatic stress disorder was noted Resettlement stress was associated with post-traumatic stress disorder but not depression
Nielsen et al, ³⁷ 2008	Children who had been seeking asylum for more than 1 year had poor mental health
Reijnveld et al, ³⁹ 2005	Unaccompanied girls seeking asylum in a restrictive reception centre showed more internalising symptoms than did girls in a less restrictive setting

Table 3: Summary of principal findings in relation to family, community, and societal factors assessed in each study

self-esteem, whereas low social support at school was correlated with increased depression.⁴⁸

Little connectedness to the neighbourhood was associated with depression.⁴⁸ The presence of wide kin contacts and the mother often receiving visitors at home were protective.⁴⁹ Living and socialising alongside other people of the same ethnic origin seems to provide protection from psychological morbidity, particularly while in foster care.^{22,38} The presence of people of the same ethnic origin had a protective effect against anxiety in Vietnamese girls, but no effect in boys.³³ However, the extent of social networks per se was not associated with psychological functioning in one report,²⁶ and large social networks with people of the same ethnic origin were associated with poor functioning in another report.⁴¹

Acculturation is usually a slow, subtle, and continuous process, and is especially difficult to measure quantitatively.⁶⁵ It is usually assessed as linguistic competency and

time since migration, which are only some of its components. Notably, the usefulness of the term acculturation in health research has been extensively debated by social scientists. Some degree of alignment with the host culture is probably protective. In an Australian study³⁰ of acculturation in adolescent refugees, integration into the host society (maintaining the individual's original culture while participating in the host society, as assessed with a range of scales to measure self-worth, peer acceptance, and attitudes to acculturation) was linked to improved psychosocial adjustment. Separation (mainly maintaining the individual's own culture) or assimilation (adaptation to the values of the host society) were not predictors of psychosocial adjustment, whereas marginalisation had negative effects.³⁰

Many adolescents perceive themselves to be more acculturated than are their parents, and an increasing gap in acculturation during adolescence can generate

discord.^{66,67} Achievement of competence in the host country's language can be associated with a reduced likelihood of depressive symptoms⁶⁸ and internalising behaviour scores³⁵ in young refugees, but the parents' language proficiency seems unrelated to children's psychological outcomes.^{20,45,49} Adherence to traditional values of family hierarchy according to age and sex seemed to be protective, whereas dissociation from these values and a positive attitude towards adoption of the host country's culture were predictive of poor psychological functioning.³³ In Somali adolescents resettled in the USA, closer alignment with the Somali culture was associated with better mental health for girls, whereas closer alignment with the American culture was associated with better mental health for boys.⁶⁹ A high rate of post-traumatic stress disorder was predicted by acculturative stress in the same population,²⁰ and among Sudanese refugees who felt lonely, isolated, or less comfortable in US society than in their own.²² Bosnian refugees who felt connected to their neighbourhoods had low rates of depression,⁴⁸ and refugees with support from friendships had improved psychosocial adjustment.³⁰ In a longitudinal study of Cambodian refugee adolescents in Canada,⁴⁵ changes in acculturation were not noted over 2 years, although the refugees were assessed 10–12 years after arrival. The degree of acculturation alone (as measured by the adoption of customs, habits, and language of the host country) was not associated with psychological functioning, but when combined with sex the least acculturated boys seemed most vulnerable.⁴⁵ This evidence shows complex associations between the experiences of the adolescent, family, and society, as expected from the ecological model of concentric spheres of effect.^{53,70}

Societal factors

Ideological and religious contexts

The evidence for religious beliefs is mixed. Among Bosnian adolescents resettled in Austria and Croatia, religious commitment (assessed as a composite of frequency of participation in religious activities and degree of subjective personal belief) was associated with low anxiety and depressive symptoms.⁴⁸ Among Middle-Eastern groups in Denmark, Muslim and Christian refugee adolescents had lower scores for internalising behaviours than did those who belonged to a persecuted minority religion or had changed or abandoned their faith.³⁵ Spiritual attributions about the meaning of adverse events might also be important, but no studies met our inclusion criteria; nonetheless, in a small qualitative study of unaccompanied Sudanese boys (aged 16–18 years), attribution of adverse events to God's will contributed to fairly good functioning.⁷¹ The links between religion, faith, hope, agency, and sense of coherence and responsibility implicated in risk and resilience pathways are complex, as shown for conflict-affected populations,⁷² and reports often do not do justice to these complexities.⁷³

Ethnic origin

The effect of ethnic origin on child mental health has been assessed in several studies,^{26,27,41,49} with mixed findings indicating that refugees from different countries of origin have different types and duration of exposure to potentially traumatic events and premigration circumstances, as well as cultural differences in the response to distressing events. In Bean and colleagues' study¹² of UASC, coming from 48 different countries, adolescents from different

	Domain assessed	Number of studies*	Total number of children†	Risk or protective factor
Exposure to premigration violence	Individual	13 ^{8,10,14,17,19,20,22,24,26,35,40,46,48}	3099	Risk
Female sex	Individual	11 ^{12,14,17,25,27,32,35,39,46,48,49}	3425	Risk (mainly for internalising or emotional problems)
High parental support and family cohesion	Family	4 ^{14,30,45,48}	1576	Protective
Self-reported support from friends	Community	4 ^{8,14,30,35}	397	Protective
Unaccompanied	Family	3 ^{11,22,27}	3690	Risk
Perceived discrimination	Community	3 ^{20,35,48}	1548	Risk
Exposure to postmigration violence	Individual	3 ^{13,35,48}	1489	Risk
Self-reported positive school experience	Family	3 ^{28,30,48}	1441	Protective
Several changes of residence in host country	Community	3 ^{12,37,49}	1031	Risk
Parental exposure to violence	Family	3 ^{8,34,41}	517	Risk
Poor financial support	Family	2 ^{7,48}	1601	Risk
Same ethnic-origin foster care	Family	2 ^{22,38}	386	Protective
Single parent	Family	2 ^{41,49}	359	Risk
Parental psychiatric problems	Family	2 ^{10,26}	162	Risk

Only factors that were validated in at least two studies resulting in the same direction of effect, were included in the Review. *Reported as one study if the same sample was used in more than one reported study. †Includes forcibly displaced children and comparator groups, hence high numbers of participants.

Table 4: Summary of risk and protective factors for mental health outcomes in forcibly displaced children

Panel 1: Suggestions for further research**Information about specific groups of children**

- Children with pre-existing physical or psychological disorders, or learning difficulties.
- Ex-combatants.
- Trafficked children.
- Children with alternative carers.
- Children living in refugee camps, or those forced to live and work on the streets.
- Children with uncertain immigration status.
- Refugees or asylum seekers returning (involuntarily or voluntarily) to their home country from high-income settings.

Longitudinal studies

- Prospective predictors of mental health, and pathways to risk and resilience.
- Long-term effect of forced migration on individual psychological outcomes; and on structure and functioning of families and their interactions with displaced and host communities.
- Individual, family, community, and societal contexts affecting experiences and mental health outcomes, rather than designs restricted to quantification of associations between adverse exposures and poor mental health outcomes.

Effects of various risk and protective factors on child development

- Specific types of violence exposures, and links between domestic, structural, and collective violence.
- Different parenting styles.
- Past periods of stable family life and education.
- Fostering within the child's own ethnic or language group.
- The role of social networks in promoting resilience.
- Support to integrate into local communities.
- Foreign language acquisition for parents and children.

Best interventions

- Evidence for which interventions work best is insufficient. Although there is evidence for individual-level interventions such as pharmacotherapy for depression and individual-focused trauma treatments for post-traumatic stress disorder, the effects of community or societal interventions, including group psychotherapeutic treatments or school treatments, parental and teacher interventions, family-based treatments, and housing initiatives, are still unknown.

countries of origin had different patterns of psychological distress. Therefore, the heterogeneity of a refugee population needs careful attention in terms of policy and clinical need.

Resettlement location

No associations were noted between mental health outcome and whether children had lived in a refugee camp before arriving in the host country,⁴⁹ or specific adverse events in a refugee camp.²¹

UASC who were transferred to a different regional asylum office had higher scores for internalising difficulties and traumatic stress symptoms than did those who were not transferred.¹² Four or more relocations within the asylum system were predictive of poor mental health in children and adolescents in Denmark.³⁷ The fewer the lifetime residence changes for boys the better their mental health outcomes.⁴⁹ High-support living arrangements reduced psychological symptoms for

UASC,^{12,17,27} although a change of guardian during a 1-year follow-up did not adversely affect psychological distress or behaviour in UASC.¹¹

Displaced Croatian children whose families were accommodated with host families rather than in shelters had few symptoms of stress.⁷ Accommodation in centres, rather than living alone or in foster care, was associated with poorer functioning in UASC in Belgium.¹⁷ Feeling safe in an individual's own home was associated with low occurrences of post-traumatic stress disorder,²² but housing adequacy was not a predictor of depression or post-traumatic stress disorder in Somali adolescents in the USA.²⁰ Area of residence within the host country, whether urban or rural, does not seem to be associated with psychological functioning.^{22,32,49} Thus a sense of safety and privacy rather than housing quality or location might be most important to wellbeing.

Time since displacement

Residence duration in the host country has been negatively associated with depression²⁰ but not post-traumatic stress disorder.^{20,22} Results of long-term studies indicate a trend towards reduction of symptoms with time.³⁶

Immigration process

Postmigration detention seems to be especially detrimental to children's mental health. Cuban refugee children, detained for many months in Guantanamo Bay before entry to the USA, showed high levels of psychological symptoms.⁴⁰ The high prevalence of psychiatric illness during and after children's detention have been shown in small-scale studies,^{39,74,75} and girls might be especially vulnerable to the adverse effects of restrictive reception settings.³⁹ After detention, intrusive memories are common,⁷⁴ since children might be exposed to fires, rioting, violence, and self-harm attempts by parents or others while detained.⁷⁶ Children are more likely to suffer adverse mental health consequences when detained in restrictive rather than routine reception facilities.³⁹

Rapid but careful resolution of asylum claims reduces the duration of uncertainty, insecurity, and associated distress for children. Insecure asylum status is associated with a range of psychological problems.^{12,37,77} Experiences during immigration interviews²² and detention after migration can be especially distressing for children, compounding premigration negative experiences of authority and placing them in situations that can be perceived as being worse than adversity before migration.⁷⁶

Long-term outcomes

The importance of longitudinal studies to help understand prospectively which risk and protective factors are causally associated with psychological outcomes should not be underestimated. Few such studies, however, have been reported.^{35,78–80} The results of Hjern and colleagues⁷⁸ 6–7-year follow-up of refugee children in Sweden showed

improvements in mental health outcomes with time, although past exposure to violence in the home country and recent family stressors were predictive of psychological disturbance. In Sack and colleagues' 12-year follow-up study^{79,81} of Cambodian adolescents, starting when they were aged 14–20 years (mean 17 years) in the USA, depression was more closely related to postmigration stressors than to past conflict-related events, whereas diagnoses of post-traumatic stress disorder were linked to adverse conflict-related experiences. Mental health trajectories were variable with time, and although post-traumatic stress disorder tended to persist, depression initially decreased substantially during 3–6 years of follow-up, only to rise again between 6–12 years of follow-up. The refugees in this study seemed to be fairly resilient overall, having few comorbid problems such as behavioural problems or substance misuse, and most were in education or employment. In Montgomery's follow-up study³⁵ of 131 refugees in Denmark, the long-term effects of premigration adversity were mediated by a variety of different risk and protective factors.³⁵ Aspects of social life in Denmark and stresses experienced in exile were more predictive of psychological problems 8–9 years after arrival than were adverse experiences before arrival, emphasising the importance of the postmigration environment in easing recovery from distressing experiences.

Conclusions and recommendations

Many different factors affect the mental health of forcibly displaced children in the presence of substantial life challenges. Table 4 summarises the key protective and risk factors. In accord with Reed and colleagues' Review,⁵³ premigration exposure to violence was strongly predictive of psychological disturbance. Family factors and living arrangements have received much more attention in high-income settings than in the low-income and middle-income settings. Overall, the ability to integrate into the host society while maintaining a sense of one's cultural identity is protective, but its effect has not been quantified.

The evidence lends support to the idea of spirals of loss,⁸² drawing attention to the way many challenges affect refugees at all stages of their journeys. The after-effects of migration on the wellbeing of refugee children are wide-ranging and powerful, and many are modifiable. Increased prevalence of mental health disorders among displaced children is likely to be a result of the increased exposure to risk factors. Postmigration factors provide opportunities for high-income countries to intervene directly to achieve improved outcomes for vulnerable children, yet the possibility of intervention by governments and non-governmental organisations in high-income countries to keep negative exposures to a minimum in countries of origin and countries of transit should not be neglected.

Cumulative adversities usually worsen health outcomes, exerting more powerful effects than any factor alone.⁸³ The most harmful pathways are those that involve

Panel 2: Summary of policy implications for forcibly displaced children in low-income, middle-income, and high-income settings

Individual

- Reduction in postmigration exposure to different types of violence and threat, including interventions that address intrafamilial violence, bullying, and racism
- Access to physical and psychological health services

Family

- Harness local community resources to assist with integration of children and families
- Support safe and appropriate cultural beliefs and social practices
- Prioritise reunion of children with families or other carers
- Provide support for families to remain intact and to reduce conflict

Community and societal

- Stable settlement in host country, including rapid resolution of asylum claims; minimisation of relocation; supported educational placements and employment opportunities for children older than 16 years and parents; specific support for unaccompanied children; improved provision of services, enabling cultural continuity for religion and language
- Concerted action in health, social, economic, and political sectors to reduce inequalities in access to resources

exposure to violence—whether individually experienced, witnessed, or feared—and the loss of family support by death or violence,⁸⁴ for both behavioural and emotional mental health outcomes. As emphasised by the WHO framework,⁸⁵ risks cannot be simply added up, but the inter-related pathways that lead to the outcomes need to be assessed.^{86,87} Thus, although distal or premigration factors contribute to childhood adversities, repeated exposure to violence and lack of safety soon after migration or displacement are of pivotal importance. In the model proposed by Pynoos and colleagues⁸⁸ to understand the complex processes involved in trauma-related psychological changes, one important issue is that new traumatic experiences can reawaken previous traumatic memories, erode previous adaptation, and create secondary adversities; however, the possibility of post-traumatic growth—in which individuals might be better able to achieve various goals after their experiences—might be an alternative trajectory, but remains to be investigated in depth in relation to refugee children.⁸⁹

Health professionals need to assess the multiplicity of ongoing challenges to the wellbeing of refugees, if they are to advocate on refugees' behalf when the implementation of immigration, social, or health policies is to the disadvantage of a highly vulnerable community. The ecological model⁷⁰ provides a helpful conceptual framework to shape humanitarian responses to children in crisis.⁹⁰ This model emphasises that children develop in a social milieu in which family, community, and society contribute to the quality of daily life.⁹⁰ Thus prioritisation of certain policies such as the reunification of children with their families or other carers, the reinstatement of school education, and community-building activities are key.⁹¹

Successful intervention with distressed refugee children requires not only psychotherapeutic skills, but also these in combination with structural interventions such as those targeting adequate housing and psychosocial interventions like access to skills training.⁹² Ideally such resources should be available to ease integration for refugee children and their families from the time of arrival,⁹³ with the aim of preventing adverse mental health outcomes. Additionally, the ability to advise families of ways they can optimise and integrate all the important factors identified in this Review, as they forge a new path in the host country, is essential.

The elucidation of protective factors provides the building blocks in the identification of pathways to resilience in children. There is general recognition that an understanding of resilience is important for the development of interventions: focus on the identification and mobilisation of adaptive systems within the individual, family, and cultural systems is key.⁹¹ Hodes and colleagues²⁷ have suggested further investigation of the role of past periods of stable family life and education, the young person's own appraisal of adversity, the role of fostering within the individual's own ethnic or language group, and the value of social networks in promoting resilience.²⁷ Little is understood about the nature and effects of parenting styles in refugee families⁹⁴ and whether interventions could promote resilience and modify outcomes for parents and children. Help in terms of support to integrate into local communities, and language acquisition for both parents and children are interventions that warrant formal assessment. One way forward is to provide a comprehensive and sophisticated approach to understanding the inter-relationships between individual, family, community, or societal risk and protective factors in the assessment of the causal pathways that link psychological problems to mental health outcomes.⁵³ More research is needed (panel 1). First, we need to improve our understanding of children in particular groups who have, thus far, received little attention. Second, longitudinal study designs are needed to understand the processes and pathways involved in mental health outcomes, including elucidation of mediating and moderating variables.⁹⁵ Third, we need to have an improved understanding of the family, community, and societal contexts in which refugee children live. Fourth, we need to develop interventions that are then assessed according to internationally agreed guidelines.

Consideration should also be given to the long-term outcomes. Evidence suggests that complex comorbidities of post-traumatic stress disorder and other disorders are not uncommon in adult survivors of childhood forced displacement.^{96,97} Furthermore, evidence suggests that the next generation is also affected;⁹⁸ even children born to refugee parents after migration are at increased risk of psychotic disorders compared with the native population,⁹⁹ whereas second-generation labour immigrants

are not. Such complexities of the intergenerational aspects of coping with adverse experiences and social disadvantage are poorly understood in the context of refugee families. Limitations of the work so far include the assessment of a narrow set of predictor variables, particularly those that focus on individual exposures, heterogeneous research designs in studies, and, in many cases, the lack of effect sizes, which restrict our ability to draw definitive conclusions. Panel 2 summarises some policy recommendations.

Prompt, but fair and thorough, investigation and resolution of refugee status is essential to enable individuals with a genuine claim to settle rapidly in the host country. Frequent moves, delays, and prolonged bureaucratic processes have negative effects on children's mental health. Equitable and prompt access to services for physical and psychological health, and access to good housing and schooling are central to adaptation and positive mental health. A means of livelihood for families is not only important for adequate nutrition and wellbeing, but allows families to integrate into the new society. Unaccompanied children are especially vulnerable, and need specific support to ensure they can benefit from long-term stability of residence and social environment. Prolonged uncertainty about asylum status endangers their mental health. Since mental health problems originating in childhood and adolescence are often longlasting, high-income countries must implement immigration, health-care, and social policies that support family units and keep deleterious consequences for child health and development to a minimum.

Contributors

All authors were involved in the conceptualisation and the design of the Review. RVR undertook the literature searches. RVR and MF selected the studies. RVR gathered data from the studies. RVR and MF compiled the tables. RVR, MF, CP-B, and AS wrote the Review. All authors have read and approved the final version of the Review.

Conflicts of interest

We declare that we have no conflicts of interests.

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Developmental Screening of Refugees: A Qualitative Study

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abstract

BACKGROUND AND OBJECTIVES: Refugee children are at high developmental risk due to dislocation and deprivation. Standardized developmental screening in this diverse population is challenging. We used the Health Belief Model to guide key-informant interviews and focus groups with medical interpreters, health care providers, community collaborators, and refugee parents to explore key elements needed for developmental screening. Cultural and community-specific values and practices related to child development and barriers and facilitators to screening were examined.

METHODS: We conducted 19 interviews and 2 focus groups involving 16 Bhutanese-Nepali, Burmese, Iraqi, and Somali participants, 7 community collaborators, and 6 providers from the Center for Refugee Health in Rochester, New York. Subjects were identified through purposive sampling until data saturation. Interviews were recorded, coded, and analyzed using a qualitative framework technique.

RESULTS: Twenty-one themes in 4 domains were identified: values/beliefs about development/disability, practices around development/disability, the refugee experience, and feedback specific to the Parents' Evaluation of Developmental Status screen. Most participants denied a word for "development" in their primary language and reported limited awareness of developmental milestones. Concern was unlikely unless speech or behavior problems were present. Physical disabilities were recognized but not seen as problematic. Perceived barriers to identification of delays included limited education, poor healthcare knowledge, language, and traditional healing practices. Facilitators included community navigators, trust in health care providers, in-person interpretation, visual supports, and education about child development.

CONCLUSIONS: Refugee perspectives on child development may influence a parent's recognition of and response to developmental concerns. Despite challenges, standardized screening was supported.



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Dr Kroening conceptualized and designed the study, supervised the study, collected data, analyzed and interpreted data, and drafted the initial manuscript; Drs Moore and Welch contributed to the study design and analyzed and interpreted the data; Drs Halterman and Hyman contributed to the study design and supervised the study; and all authors critically reviewed and revised the manuscript and approved the final manuscript as submitted.

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WHAT'S KNOWN ON THIS SUBJECT: Research has examined developmental and behavioral screening in immigrant children, but limited literature exists addressing effective developmental and behavioral screening approaches for refugee children. Refugee and resettlement experiences increase developmental-behavioral risk and may impact critical stages of child development.

WHAT THIS STUDY ADDS: This qualitative study provides foundational information on beliefs and practices of refugee parents related to child development and disability. The Health Belief Model serves as a framework for understanding how parents of refugee status identify and respond to developmental concerns.

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By 2014, 59.5 million people worldwide were forcibly displaced from their homes and living as refugees or stateless people. Over 50% of these individuals were children.¹ Of the nearly 70 000 refugees annually resettled to the United States, ~30% are children.² The United Nations High Commissioner for Refugees reports that refugee and resettlement experiences may impact critical stages of intellectual, social, emotional, and physical child development.³ Disruption to families and education and witnessed traumatic events impact the presentation of developmental concerns.

Globally, rates of pediatric developmental disability range from 5% to 20%.⁴⁻⁶ The prevalence of developmental delays and disability in the pediatric refugee population is unknown. Developmental screening and surveillance is recommended by the American Academy of Pediatrics for all children in the context of well-child care.⁷ However, standardized assessment instruments validated for use in non-Western cultures and languages are limited, and little is known about the cultural beliefs, perceptions, and practices around identification of developmental delays in refugee communities.⁸⁻¹³

Although developmental and behavioral screening of immigrant children has been studied, voluntary immigrants who enter the United States differ from refugees in their exposure to dislocation, deprivation, and loss (experiences common to refugees).^{3,14-17} Developmental delays in refugee children may not be appreciated by families and, once identified, cultural barriers may interfere with intervention.^{18,19} Delay or absence of services may negatively impact outcome.²⁰ Given the evidence for the positive effects of early intervention, it is important to identify the most appropriate

approach to effectively screen refugee children.²¹⁻²⁴

This qualitative study explores cultural and community-specific values and practices related to child development, as well as barriers and facilitators to developmental screening and interventions if delays are identified. We use the Health Belief Model (HBM) as a framework for understanding how parents of refugee status identify and respond to developmental concerns. The HBM explains how health-related behaviors are impacted by belief and is used to guide interventions that promote the continuum, from identification to treatment of disease.²⁵ The model assumes that the likelihood of action around a specific health behavior depends on an individual's sociocultural background (modifying factors), their beliefs (about self-efficacy, susceptibility to/seriousness of the problem, and barriers to taking action), and their exposure to cues that prompt action.

In this study, we examined themes regarding sociocultural modifiers and individual beliefs related to child development and disability that may impact a refugee parent's acceptance of developmental screening, as well as factors that might prompt recognition and response to identified developmental concerns.

METHODS

Setting and Participants

The study was conducted between March 2014 and February 2015 in Rochester, New York. Rochester is a refugee resettlement city, identified by the United Nations High Commissioner for Refugees to receive and provide services and education/employment opportunities to 700 new refugees annually, including nearly 300 (40%) children (personal communication with Jim Morris, Director of the Department of

Resettlement, Immigration, and Language Services, Catholic Family Center). Refugees are predominantly from Bhutan, Myanmar (Burma), Iraq, and Somalia.

We used a purposive sampling strategy to recruit representatives from 4 target groups: parents of refugee status ($n = 7$), medical interpreters serving refugee families who were themselves refugees ($n = 9$), clinicians caring for pediatric refugee patients ($n = 6$), and community collaborators ($n = 7$) involved in refugee resettlement (Table 1).²⁶ Parents and clinicians were recruited from the Center for Refugee Health, a primary care clinic for newly resettled families. Medical interpreters were recruited from the Office of Community Medicine within the Rochester Regional Health System. Community collaborators were recruited from the Rochester Committee on Refugee Resettlement. Participants received a \$25 gift card in compensation.

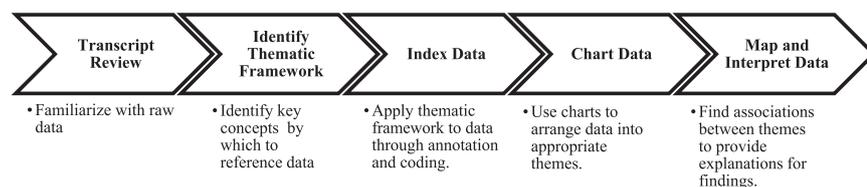
Interviews and Focus Groups

Key-informant interviews and focus groups were conducted by the physician-investigator trained in qualitative techniques (A.K.). Information was gathered in English or with in-person interpretation as needed. An open-ended interview guide was used (Supplemental Information). Member checking for understanding and clarification of participants' contributions was integrated into the interview process.²⁷ Questions explored roles, beliefs, and practices regarding child development and disability within refugee communities. The Parents' Evaluation of Developmental Status (PEDS) was provided and participants were asked to comment on how the screening tool might be received and understood by refugee parents.²⁸

TABLE 1 Study Participants by Target Group, Ethnicity, and Community Role

Target Group	Ethnic Group	Community Role
Medical interpreters	<i>n</i> = 9	Community members
	Bhutanese-Nepali (<i>n</i> = 4)	Health care liaisons/navigators
	Chin (<i>n</i> = 1)	interpreters
	Karen (<i>n</i> = 2)	
	Karenni (<i>n</i> = 1)	
Refugee parents	Somali (<i>n</i> = 1)	Community members
	<i>n</i> = 7	Mothers (<i>n</i> = 6)
	Bhutanese-Nepali (<i>n</i> = 6)	Fathers (<i>n</i> = 1)
Community collaborators	Iraqi (<i>n</i> = 1)	Community outreach program directors
	<i>n</i> = 7	English as a second language teacher
Medical providers/staff	<i>n</i> = 6	Health case manager
		Public school psychologist
		Refugee community leader
		Nurses
		Clinic social worker
		Family nurse practitioner
Total	<i>N</i> = 29	Administrative staff

Study participants included refugee parents, medical interpreters, refugee-focused healthcare providers, and community collaborators providing post-resettlement support. Selected participants represent general perspectives from Rochester, New York's predominant refugee communities. In addition, 3 parents identified their own children with developmental disabilities, including Down syndrome (Bhutanese-Nepali), attention-deficit/hyperactivity disorder and language disorder (Iraqi), and autism (Afghan).

**FIGURE 1**

Data analysis using a qualitative framework technique. A qualitative framework technique is one approach to qualitative data analysis that involves initial familiarization with transcript data, followed by development of a thematic framework used to organize data. Data are coded, indexed, and charted into annotated themes within the framework. Themes are then mapped and associated into overarching constructs.

Data Analysis

Interviews and focus groups were audio recorded and transcribed verbatim. A qualitative framework technique was used for analysis (Fig 1).^{29,30} Quotes from interviews were analyzed within a thematic framework developed by the researchers to focus on 4 HBM-related domains: (1) beliefs, values, and perceptions about child development and disability; (2) cultural and community practices related to development and disability; (3) additional observations about refugee community experiences; and (4) specific

feedback on using the PEDS in a primary care setting.

Three investigators (A.K., J.M., and T.W.) reviewed and coded each transcript independently (triangulation).²⁷ A consensus process followed, in which investigators categorized data into common themes emerging from within each of the 4 domains noted. Themes were subsequently charted and mapped into overarching constructs within and across cultural groups.²⁹

Participant enrollment continued until data saturation was achieved and additional interviews failed

to yield new themes. All study procedures were approved by the University of Rochester Research Subjects Review Board.

RESULTS

Twenty-nine individuals participated in 19 key-informant interviews and 2 focus groups, with representation from Afghan, Bhutanese-Nepali, Burmese, Chin, Iraqi, Karen, Karenni, and Somali cultural communities. Within the 4 domains of the thematic framework, investigators identified and mapped 21 themes and 11 subthemes (Fig 2, Table 2).

Domains 1 and 2: Beliefs, Values, and Perceptions and Practices Related to Child Development and Disability

Noting a consistent pattern of refugee community beliefs influencing practices, the first 2 domains were combined.

Themes of Communal Mentality, Family Structure, Parenting, and Schooling Practices

Study participants described a communal mentality, with little emphasis on privacy or autonomy (Table 3, Quotation 1). Healthcare, in particular, is traditionally not viewed as private or individual. Decisions are often made in consultation with elders in the family or community with deference to societal hierarchies (Table 3, Quotation 2).

Family structure is nonchild focused; children exist as units of the family or community. Compliance with gender-specific responsibilities is expected of children as they age (Table 3, Quotations 3 and 4).

Teachers command respect (Table 3, Quotation 5) and have a role in discipline. Parents are not expected to participate in their children's education (Table 3, Quotation 6).

4 Domains

21 Themes (11 Subthemes)

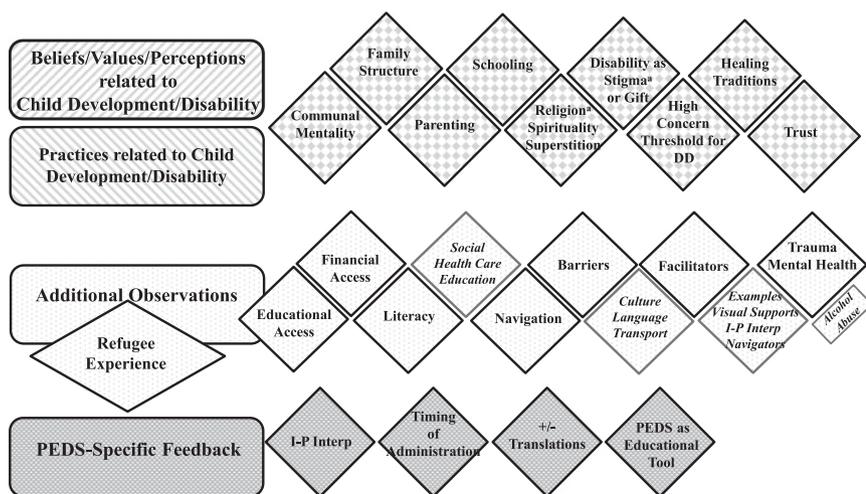


FIGURE 2

Themes from data analysis organized by thematic framework domains. Themes were grouped into 4 domains. Themes 1 and 2 were merged because of content overlap: beliefs/values/perceptions influenced practices related to development and disability. Subthemes are in italics. ^aNotes where content within themes differed across cultural groups. DD, developmental delay; I-P Interp, in-person interpretation.

Themes of Religion and Spirituality, and Stigma versus Blessing

Beliefs and practices around child development and disability are strongly influenced by religious and spiritual traditions that vary

between cultural groups. For those communities that practice a multideity religion, stigma exists for disability that is thought to be a curse, with generational/karma implications (Table 3, Quotations 7–9). This stigma isolates a family

from relatives, community members, and potential sources of support (Table 3, Quotation 10). For those communities that practice Islam or Christianity, a child with a disability is described as being given by God (Table 3, Quotation 11). Although parents still describe experiences of isolation, traditional Islamic or Christian refugee communities report more inclusive practices.

Theme of High Threshold for Developmental Concern

All refugee communities identified a high parental threshold for being concerned about developmental delays. Participants stated that parents of refugee status will not generally consider developmental delay until their child is at least 2 or 3 years old, believing that a child will follow his or her own “track” (Table 3, Quotation 12). Monitoring of developmental milestones is not a familiar concept, and most participants could not identify a specific word for development in their language of origin (Table 3, Quotation 13)

TABLE 2 Themes From Data Analysis Organized by Thematic Framework Domains

Domains 1 and 2: Beliefs, Values, Perceptions, and Practices Related to Child Development and Disability

- Theme
- Communal mentality
- Family structure
- Parenting
- Schooling
- Religion/spirituality^a
- Disability as stigma versus gift^a
- High concern threshold for developmental delays
- Trust (in the pediatric provider)

Domain 3: Additional Observations From Data Related to the Refugee Experience

Theme	Subtheme
Financial access (pre-resettlement to United States)	
Educational access (pre-resettlement to United States)	
Literacy and navigation	Social, healthcare, and education
Barriers to developmental care	Cultural differences, language, transportation
Facilitators to developmental Care	Visual supports, use of examples, in-person interpretation, cultural navigators
Mental health/trauma experiences	Alcohol abuse
Refugee experience	

Domain 4: Feedback Specific to the PEDS

- Theme
- Interpretation services (preference for in-person interpretation)
- Timing of administration
- Availability/use of translations
- PEDS as educational tool

Themes were grouped into 4 domains. Themes 1 and 2 were merged because of content overlap: beliefs/values/perceptions influenced practices related to development and disability.

^a Notes where content within themes differed across cultural groups.

TABLE 3 Qualitative Data Themes and Representative Quotations, Organized by Domains

Theme	Representative Quotations
Domains 1 and 2: Beliefs, Values, Practices Related to Child Development and Disability	
Communal mentality	(1) "...And they are now, let us say, a little bit conscious about privacy. But in our country that was not a big deal...If, for example, in our community when we were in Nepal, so if a particular person is having some peculiar type of diseases everybody used to know if a person is having like tuberculosis." (MI 1, Nepali)
Family structure	(2) "Some family have well educated – some society have well educated people in some cases...Low caste and high caste. That may affect the society's way it is, the traditional way... you know, it affects the child's health or the parents in some cases." (MI 2, Nepali)
Parenting	(3) "And after the children are like 5 or 6, 7 years old they ask them to take care of the other, the younger brother, siblings..." (MI 6, Karenni)
Schooling	(4) "Because our culture, we don't... treat the children in so much a good way or like a friend...I see some American moms talking to their child as if he's a friend or she's a friend...our way is a little more authoritative. Do this, do that. Don't do that. You know." (MI 3, Nepali)
Religion and spirituality	(5) "When I grew up, a teacher basically is your second father... You have to listen to your teacher, what he is telling you is right." (MI 9, Somali)
Disability as stigma versus gift	(6) "The expectation is that the kid comes to school to learn, the teachers know best and it's kind of like a hands-off policy...I think that many of our cultures feel that school is the responsibility of people here...they are sending their children here to learn and that's it. And that's how it would be in their home country." (CC 6, school psychologist)
High threshold for developmental concern	(7) "So most of the Nepalese are based on Hinduism and Buddhism and they believe in some kind of superstition...people think that disability children is born because of the bad scene or bad karma...So, for example, my child is disabled now and people believe we did something wrong in our previous generation and we have child with disability because of that thing." (RP 3, Nepali)
Traditional healing practices	(8) "And the demon from the forest, it, you know, it was that cursed my baby and that's why he is not sitting. It is not their fault but they believe in that way." (MI 2, Nepali)
Trust	(9) "...It is kind of like—like a curse from God or something like that. Kind of something shameful happened to the family. And yeah, they try to keep it like in the family." (MI 5, Chin)
Barriers to developmental care	(10) "Only the people who support is the family who are having child with disability." (RP 3, Nepali)
Navigation	(11) "But as in the house or outside they are respected. They believe in God and they feel that God gives and they will have to respect that." (RP 2, Iraqi)
Financial and educational access literacy	(12) "Like we don't have that culture of like tracking the development of a child. So it grows, the child grows by himself or herself, you know?" (Nepali, MI 3)
Barriers to developmental care	(13) "No [specific word in Chin for "development"]...I kind of explain like it's kind of their growth process. Something like that." (MI 5, Chin)
Barriers to developmental care	(14) "My elder brother's son who got finally diagnosed with autism, so he was like 2 years. And we expected him to speak and then behave nicely, you know. At least follow little things we say. You know, come here, go there or whatever. But he was totally disobedient. At least 2 years...everybody expects the child to speak a little bit. And smile or whatever." (MI 3, Nepali)
Barriers to developmental care	(15) "...But you know, first and foremost child development when child had any problem, medical problem or any physical and mental problem they will go to the religious first." (MI 2, Nepali)
Barriers to developmental care	(16) "They will start to tell you everything, you know, if you ask them. But...this also depend on trust. If some people don't trust you they will never tell you anything...first before you bombard them with a question you kind of create a good relationship with them. Talk to them what is the problem." (MI 6, Karenni)
Domain 3: The Refugee Experience (Additional Observations From the Data)	
Financial and educational access literacy	(17) "We were confused because we didn't know about Down syndrome...we didn't know anything about chromosome...how this gonna affect our child. And our child looked very different at the time. It was a horrible experience...So my wife was crying a lot but I tried to understand because I know how to read and how to write." (RP 3, Nepali)
Navigation	(18) "They don't speak the language, they don't speak English and they are exposed to a new system here and they don't know how to teach their children...and how to help their children." (MI 6, Karenni)
Barriers to developmental care	(19) "One family...have one kid who is mentally handicapped. And they go through the system, you know, the doctor they see. The problem is when it comes to therapy most of the people don't speak the language and they don't understand what therapy is. They don't know." (MI 9, Somali)

TABLE 3 Continued

Theme	Representative Quotations
Facilitators to developmental care	(20) "The patient, they always told me like they feel more comfortable with in-person [interpretation]...I start knowing them and they start like kind of trusting us. And then they like talking to you and seeing you...They also mention to me like the phone translators are not really efficient...they will say like we kind of ask some question but then like what we get back the answer is not exactly what we like expect." (MI 5, Chin) (21) "I've got a lot of people coming in my house. Some are having problems with the Medicare. Some are having problems with the food stamp. Even some people, if they have problem with a ticket... they will come with me. I will solve that problem...Even I don't know, I have to ask, call, make calls, do everything but I've got to help. I'll say I don't know but I'll try to help you...So I'm trying to be a middle man for the provider and the Nepali people." (MI 2, Nepali)
Mental health and trauma experiences	(22) "I just think that, you know, the culture, their background, what they saw affects them forever. They'll never forget it, what they saw." (CC 4, Teacher of English as a Second Language)
Refugee experience	(23) "We are trying to fit in America." (RP Focus Group, Nepali)
Domain 4: Feedback Specific to the PEDS	
In-person interpretation services	(24) "So sometimes the interpreter should express the facial expression, right? And the mood of a people. So in a phone they will definitely not know what mood the patient is having. So by facial expression also we can say (()) is having something more problem." (MI 1, Nepali)
Timing of administration	(25) "I will say like not the first visit. Probably like the second or third visit you will ask these kind of questions. But for the first visit if you ask too much question they probably overwhelm and they probably won't tell you the truth, they might shy..." (MI 7, Karen)
Language translations	(26) "I think it's good to have somebody to interpret because in Karen we don't...we are lack of education so not all the Karen can read Karen. There are a lot of family that I work with, they never go to school so they don't even know how to read Karen." (MI 7, Karen)
Educational tool	(27) "Some parents don't know what not to expect...Not just telling them what is normal. Because sometimes some kids look normal but they're not...maybe 'If your child did not talk by that age even though he seems to understand you, let us know.'" (MI 5, Chin)

CC, community collaborator; MI, medical interpreter; RP, refugee parent.

Like other parents, refugee parents often use instinct and comparison with siblings or community peers to identify developmental differences. Delays may or may not be of concern, depending on the age of the child and the nature of the developmental difference.

Language delays and behavioral challenges were identified as most distressing for families, with absence of speech or noncompliant behavior as the first concerns parents identify (Table 3, Quotation 14). Timing of parental disclosure of developmental concerns to a clinician is influenced by the parents' culture of origin and educational background.

Physical disabilities are common and are generally more accepted within refugee communities than cognitive, language, or behavioral concerns. Pre-resettlement, children with physical disabilities are typically integrated into family life and traditional school settings without resources or supports. If disabilities

are severe, children are isolated at home. Special schools were described in some Bhutanese-Nepali and Burmese communities for children with vision or hearing differences.

Theme of Traditional Healing Practices

Timing of parental reporting of developmental concerns may also depend on the use of traditional healing practices, which are often pursued before medical evaluation (Table 3, Quotation 15). At the advice of elders, parents are often referred to traditional healers, particularly among Bhutanese-Nepali, Karen, and Chin families.

Theme of Trust

Timing of reporting developmental concerns depends on trust, an important value in refugee communities (Table 3, Quotation 16). The greater the trust between a refugee parent and their clinician, the more likely a parent will disclose concerns. These cultural communities view medical providers as having high social status and, out

of respect, may not spontaneously ask questions or offer additional information until a relationship has been established.

Domain 3: Additional Observations Related to Refugee Community Experiences

Data from this domain revealed themes rooted in the refugee experience, including the processes of displacement, resettlement, and acculturation.

Themes of Financial and Educational Access, Literacy, and Navigation

Previous education or financial status affects a parent's literacy and navigational skills after resettlement, including their ability to understand and navigate social, healthcare, and educational systems. (Table 3, Quotations 17 and 18). Parents who are more educated were often leaders or teachers in their camps and adjust more easily to resettlement. Parents with literacy in their language of origin and some knowledge/awareness of western

culture also resettle more easily. These foundational traits facilitate learning of basic American societal practices (ie, reading and responding to mail), healthcare processes (ie, scheduling a follow-up appointment), and educational expectations (ie, practicing therapy recommendations or attending a parent–teacher conference).

Theme of Barriers to Seeking or Accepting Developmental Care

Regardless of background wealth or education, all participants identified 3 common barriers to developmental screening, diagnosis, and intervention: culture, language, and transportation. Participants reported that cultural differences in recognizing developmental expectations may limit identification of delays. Language barriers may impede communication of concerns. In addition, many refugee parents have limited access to transportation to attend evaluations or meetings.

Additionally, participants described a lack of familiarity with community-based educational interventions in the United States (Table 3, Quotation 19). Many families have no cultural context for “therapy” (physical, speech/language, or occupational therapies). Participants stated that parents often express uncertainty regarding how their child may benefit from these services.

Theme of Facilitators to Seeking or Accepting Developmental Care

Despite the barriers, participants also cited several facilitators to developmental screening, including in-person interpretation services, access to a healthcare or cultural navigator, and provider use of visual supports.

All participants preferred in-person over telephone-based interpretation services, stating that in-person interpretation facilitates communication and rapport (Table 3, Quotation 20). They felt

that providers could promote developmental care by using visual aids or specific examples to explain developmental skills.

Additionally, most participants felt that parents of refugee status benefit from a cultural or healthcare navigator; an identified leader within their respective communities capable of guiding families through the acculturation processes. Medical interpreters who were refugees themselves often assume this role, and some study participants self-identified as such a liaison (Table 3, Quotation 21).

Theme of Mental Health and Trauma Experiences

The roles of mental health and trauma experiences for both children and parents were highlighted by many (Table 3, Quotation 22). Behavioral challenges and sleep problems were connected to trauma experiences for children, whereas substance abuse (alcohol in particular) and anxiety or depression were cited as concerning for many refugee parents. Participants noted that most refugee communities do not have an understanding of “mental health,” and may be reluctant to pursue interventions.

Theme of the Refugee Experience

Participants described refugee families as desiring to share in and contribute to American society (Table 3, Quotation 23). Many described challenges to this acculturation process, noting intergenerational differences and difficulties with self-efficacy after the regulated structure and provisions of the refugee camp.

Domain 4: Feedback Specific to the PEDS

Themes of In-Person Interpretation and Timing of Administration

Participants felt that the PEDS would be well-received for developmental screening within their cultural communities. All felt that in-person

interpretation during screening is more likely to elicit parent concerns (Table 3, Quotation 24). Standardized screening tools should not be given at the initial patient visit but should be administered by the clinician in a later visit, once parent–provider trust has been established (Table 3, Quotation 25).

Theme of Translation

Most participants felt that the PEDS should be offered in a parent’s language of origin. However, low literacy rates among many refugees would require provider administration (Table 3, Quotation 26).

Theme of Educational Tool

When used with visual supports and examples of age-appropriate developmental expectations, participants felt the screening tool could teach parents more about child development (Table 3, Quotation 27).

Synthesizing the Data into the HBM

The 21 themes and 11 subthemes identified and analyzed in this study integrate within the HBM to provide a framework to approach developmental screening for refugee children (Fig 3).

DISCUSSION

This qualitative study explores diverse refugee community and collaborator perspectives of beliefs and practices around child development and disability. Integration of this rich, community-based data within the HBM offers pediatric providers a conceptual framework through which to engage with refugee parents to support standardized developmental screening and early identification of developmental delays.

Results from this study point to the value of the medical home. Our data suggest that parents of refugee

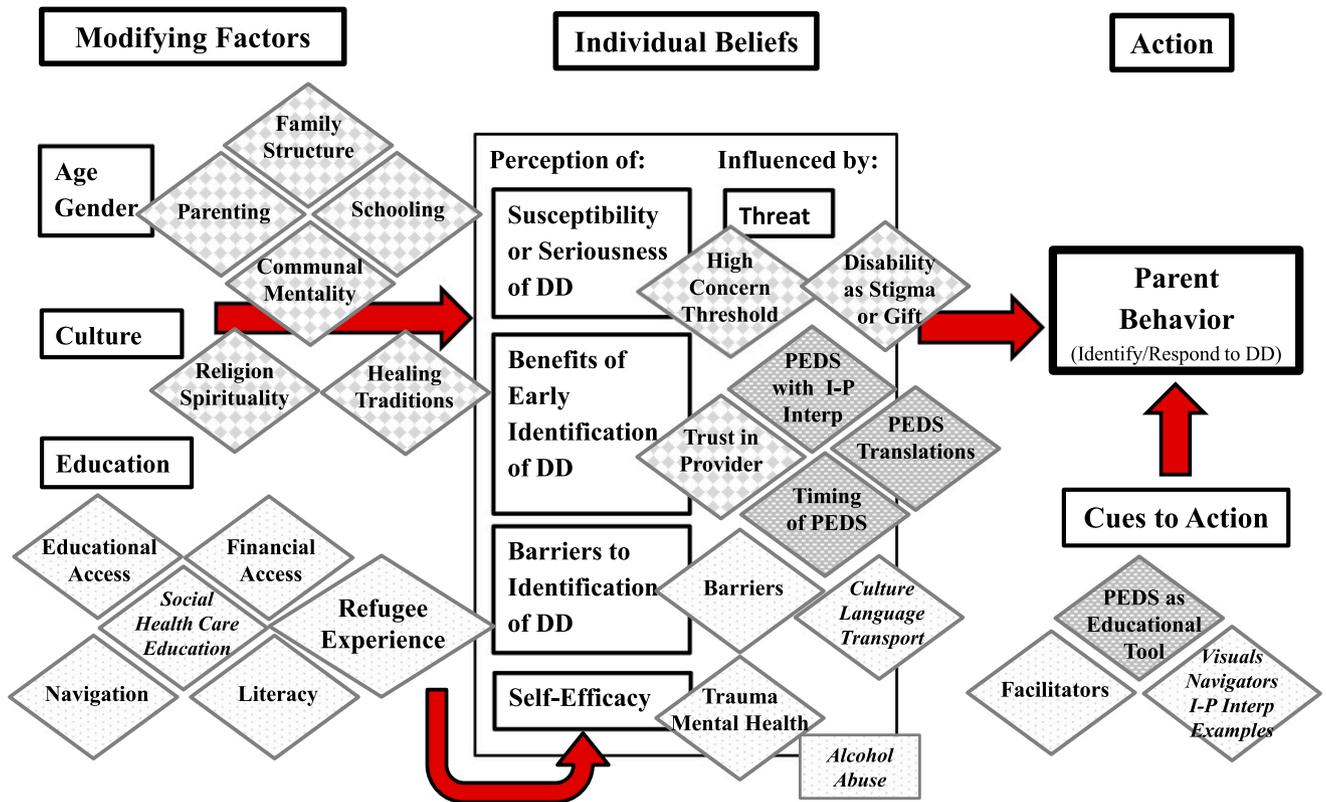


FIGURE 3

HBM as a framework to approach developmental screening for refugee children. Themes map onto HBM to explain parents' identification and response to developmental concerns. Modifying factors include sociocultural traditions, practices, and factors mediated by the refugee experience. Themes identify barriers to developmental care and facilitators enhancing parent-provider trust, PEDS screening effectiveness, and parental understanding of development. DD, developmental delay; I-P Interp, in-person interpretation.

status need a primary care setting that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.³¹ Models are emerging within refugee healthcare that provide bilingual staff, full-time social workers, and on-site mental health and interpretation services.³² Parents of refugee status respect their child's healthcare provider and are more likely to understand and participate in the process of developmental screening once there is trust in both the provider-patient/parent relationship and in the interpretation service. All participants in this study found in-person interpretation most effective for communication, particularly for discussions around child development. This highlights the importance of taking time, perhaps over several visits, to establish

rapport and cultivate relationships with families of refugee status.

This study supports the expanding role of cultural navigators who are trained to serve as leaders, mediators, and liaisons between their cultural communities and the new systems they must learn. Such cultural brokerage eases the process of resettlement and facilitates acculturation and self-efficacy.³³ ³⁴ Interpreters within refugee communities often serve as de facto cultural navigators, advocates, and care coordinators.

Our findings are consistent with a preliminary report of developmental screening of recent immigrant and refugee children, in which 6 bilingual/bicultural caseworker/cultural mediators were interviewed regarding beliefs and attitudes

about developmental screening.¹¹ Four general attitudes/beliefs were identified among study participants: parental reactions of blame, shame, confusion, or acceptance; influence of cultural and religious beliefs; inheritance of disability; and denial. As in our study, educational outreach was identified as an important means of increasing awareness of child development and barriers to screening included language, transportation, parental education level, and trust in the clinician.¹¹ Our study confirmed and extended these findings from other refugee groups in a second location.

Our study also suggests that providers may have success using the PEDS as a developmental screening tool in refugee-focused pediatric primary care, particularly when linked with appropriate

interpretation services. Translations, explanations of developmental domains, and visual supports may aid in accuracy of screening. Standardized screening with these supports is especially important when surveillance may be limited because the language of origin does not include vocabulary or context to identify the symptoms of concern. Additionally, the PEDS may serve as a mechanism to promote trust and developmental-behavioral teaching. Many participants expressed interest in learning more about child development, American child-rearing practices, and how to integrate this information within their own cultural traditions.

This study had several potential limitations. Societal hierarchical roles may have influenced focus group dynamics. Most participants spoke openly to the interviewer (A.K.), but there were a few whose responses were brief and deferential. Methods were modified early on (from focus groups to key-informant interviews) to improve communication and promote trust. Member checking was incorporated into the interview process but was not done after data analysis. As qualitative data, these results may not be generalizable to other refugee communities; however, given the shared refugee resettlement experience and the confirmation and extension of data from another refugee resettlement community, findings may be transferable to other refugee clinics considering developmental screening implementation.¹¹

This research lays a foundation for effective engagement with refugee

families around developmental screening. It will be important to evaluate the processes involved in clinic-based implementation of standardized developmental screening with pediatric refugee patients, using the PEDS or other validated tools, and develop culturally appropriate screening protocols. Community-based participatory research can promote health literacy and health care navigation for children and families with developmental disabilities, as well as provide bidirectional, culturally sensitive education on parenting practices and child behavior and development. Collectively, this research can be used to develop policies around interpretation services and intervention delivery for children of refugee status in health and education settings.

CONCLUSIONS

This study informs implementation of developmental screening of refugee children through identification of their parents' beliefs and practices and the modifying factors that influence recognition of and response to developmental concerns. The HBM illustrates initial steps for clinicians to promote developmental screening of refugee children:

1. Recognize that many parents of refugee status view child development within their own cultural context. Clinicians need to understand child-rearing expectations of the cultural groups they serve.

2. Use of in-person interpretation during developmental screening is recommended for accuracy of narrative and cultural context.
3. Developmental screening is an opportunity for educating parents of refugee status about child development. Visual supports may facilitate understanding.
4. Establishment of clinician-parent trust before developmental screening is critical.

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ABBREVIATIONS

HBM: Health Belief Model
PEDS: Parents' Evaluation of Developmental Status

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