DEVELOPING AND EVALUATING INTERVENTIONS FOR CHILDREN AND YOUTH IN SETTINGS AFFECTED BY ARMED CONFLICT

Guidebook

Intervention Research by War Child

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WAR CHILD HOLLAND'S CARE SYSTEM AND RESEARCH AGENDA

War Child Holland (hereafter War Child) contributes to the resilience and psychosocial wellbeing of children and communities affected by armed conflict. The Care System outlines our approach to working with children, their families and the community – covering good practices, our research agenda and practice-driven innovations.

The Care System takes **a socio-ecological approach**, with services targeting children, families, educational environments and communities. We provide **multi-sectoral** and mutually strengthening interventions at multiple levels. **A multi-levelled approach** responds to differing scales of need from generalised prevention to focused, non-specialised targeted support for individuals and families experiencing distress. Our programmes are partially delivered by non-specialists, under task-shifting model.

War Child is child and youth-centred, embraces strengths and rights-based approaches. We strive to work in a gender-responsive, demand-driven and equitable manner.

War Child invests in **a research agenda** to rigorously develop, test and evaluate multiple interventions. We aim to develop an evidence-based system of care that can be implemented at scale to increase access and strengthen quality in humanitarian interventions and create a positive impact for children and their communities.

A guidebook for developing and expanding effective interventions

Within this guidebook, you can expect to learn about War Child's approach to creating evidence-based interventions. Each chapter of the guidebook centres on one phase of the process - starting from formative research. Sequentially, the phases of intervention development, feasibility evaluation, effectiveness evaluation and preparation for scale will be covered. A few strategies that we employ for implementation at scale are also described: co-branding, design thinking and cultural and contextual adaptation.

Within every chapter, we briefly describe the high-level steps we take within this phase of the process. Resources will be attached for a deeper dive into how to achieve these steps. Each chapter also includes a case study that demonstrates how we have applied these steps in practice – each focusing on a different intervention.

This guidebook is intended to serve as inspiration - as more evidence-based interventions for children, youth and their families affected by conflict are needed at scale.

References and recommended resources

References for the citations in the text can be found in the bibliography at the back of the booklet. You will also find recommended resources for further reading.
At the end of each case-study you will find a key resource for easy access. The rest of the resources and references are in the bibliography.

Key resource

Website Access	War Child Holland's Care System Overview www.warchildholland.org/care-system-overview/

Access Introduction bibliography → page 52

DEVELOPMENT AND EVALUATION OF INTERVENTIONS

War Child follows the Medical Research Council Framework for the development and evaluation process of complex interventions. The Medical Research Council's framework provides a strong foundation for developing and evaluating quality interventions. Key areas of the framework include development based on **existing knowledge and evidence** and that the research design appropriately supports **effectiveness evaluation**.

We aim to follow a rigorous and iterative process. General milestones applicable to all phases of on-site research include that:

- **A research protocol** is drafted, which thoroughly describes the intervention, the research design and ethical procedures: informed consent processes and protocols to mitigate and respond to potential adverse events.
- **An analysis plan** is required before data collection starts, to guide the analysis.
- The research protocol is submitted to a national institutional review board or ethical review committee for each on-site study in order to obtain **ethical approval**.
- **A research team** and implementation team are recruited and trained.
- Study results are **published** in peer-reviewed journals, ideally open-access.
- Study findings are **disseminated** online and on social media, such as on Twitter @WarChild_RD
- Adherence to the General Data Protection Regulation (GDPR) of the European Union and our internal **data management policy** to ensure all data is collected, stored and transferred confidentially and ethically.
- War Child integrates the perspective of **scalability** of interventions into the process of intervention research. Scalability refers to the intervention's capacity to grow in reach.[1]

[1] Scale-up strategies are covered in phase five of the guidebook, pages 40-41

Access Development and Evaluation of Interventions bibliography
→ page 52-53

PHASE 1
FORMATIVE RESEARCH

The purpose of the formative phase is to evaluate existing scientific evidence and learn about lived experiences and contextual realities to guide the intervention development.

The following deliverables can be components of the formative phase:

- **A desk study** or **literature review** can be conducted to learn of existing knowledge on the topic. A literature review often starts with developing specific research questions that then guide the identification of key search terms. The researcher may decide to search in peer-reviewed journals only or expand the search to include non-scientific literature, otherwise known as grey literature. **Data extraction and analysis plans** are written to guide the subsequent review process. When conducting a systematic literature review or meta-analysis, War Child recommends to follow the PRISMA guidelines.
- Systematic reviews, rapid reviews and umbrella reviews can be **registered at PROSPERO**, an international prospective register, or database of reviews in human and animal studies. Before conducting a review it is important to check whether a review on the same topic is already ongoing or has been published.
- **Qualitative studies** can be conducted to gain insight into specific humanitarian contexts through methods such as focus group discussions (FGDs), stakeholder assessments, delphi studies and key informant interviews.
- **Rapid needs assessments** can be conducted to provide specific contextual information.

- Alignment of the intervention to **minimum standards** used in the sector ensuring quality of programming.

Access Phase 1 bibliography → page 54-55

PHASE 1
FORMATIVE RESEARCH

CASE STUDY
Stigma reduction interventions;
what do we know already?

Several questions should be asked before developing a new intervention: What is the exact problem? What existing knowledge is already out there, and what is still unknown? What are the current directions, conclusions and solutions? While developing STRETCH, an adaptable stigma reduction approach, these exact questions were posed.

Learning about stigma and stigma reduction
Stigmatisation is a universal dynamic societal process, localised in every context, and a major contributor to inequity and injustice. Within War Child, stigmatisation was identified as a barrier to participation and inclusion in services and communities.

A systematic review (Hartog et. al, 2020a) was conducted to identify strategies to reduce stigmatisation in low- and middle-income countries. This systematic review revealed very few stigma reduction interventions that aim to reach children and adolescents.
Furthermore, most interventions focused on stigma relating to HIV/AIDS or mental health stigma. Interventions targeting children were often delivered in schools and were often short, lasting between less than half a day and a week.

The review also highlighted several promising strategies used to alleviate stigmatisation across different types of stigmas.

Alongside **the systematic review**, a formative study was undertaken in **DR Congo** (Hartog et al., 2020b) to gather insight into the stigmatisation of three substantially distinct groups: mothers who have children outside of marriage, children formerly associated with armed forces and groups, and an indigenous population group. This study revealed many similarities between these groups, confirming studies indicating the comparability between stigmas and advocating for a less siloed approach. It further highlighted the importance to understand the context to be able to tweak the response. Guided by these learnings, adjustments were made to improve STRETCH.

A third step undertaken in the formative phase contributing to development was the execution of **a stakeholder assessment** with practitioner and academic stigma reduction experts. The exercise provided insights into the potential of developing an adaptable stigma reduction approach to be applicable across stigmas and settings.

Formative phase learnings for STRETCH development

- **Come out of the siloes**: as most stigma reduction interventions focus on one stigma, there is potential for a generic stigma reduction approach due to the comparability between stigmas (van Brakel et al., 2019, Stangl et al., 2019).
- **Contextualise and adapt**: while it is important to have a standard approach that can be replicated in various settings, specific attention needs to be made to ensure that the intervention is contextualised for each setting.
- Intervene at **multiple levels**: often, stigma reduction interventions target one group within the community (e.g. at school). However, stigmatisation is a process that runs throughout society and needs to be addressed at different levels simultaneously.
- Think about **intersectionality**: social identities and local norms impact experiences of stigma. While addressing stigma, other factors which could contribute to further marginalisation should be taken into account.
- **Nothing about us without us**: It is crucial that people who face stigmatisation are heavily involved in addressing the problem.
- Make use of **promising strategies**: while there is still a lot of uncertainty about which methods effectively address stigmatisation, some strategies show indications of effectiveness, like social contact strategies and information-based strategies.

Conclusion

The formative process was essential to considering current research insights while developing STRETCH. Formative research ensures cross-contextual relevance and an understanding of what works and contributes to a better end-product. The next step is finalisation of the intervention manual to conduct a practice run and feasibility study.

Key resource

Title	Stigma reduction interventions for children and adolescents in low- and middle-income countries: Systematic review of intervention strategies.
Authors	Kim Hartog, Angelica Krouwer, Graham Thornicroft, Brandon Kohrt, Mark Jordans
Year	2020
Journal	Social Science and Medicine, 246, 112749.
Access	www.doi.org/10.1016/j.socscimed.2019.112749

Access Phase 1 - STRETCH bibliography → page 55

PHASE 1: FORMATIVE RESEARCH

PHASE 2: INTERVENTION DEVELOPMENT

PHASE 3: FEASIBILITY EVALUATION

PHASE 4: EFFECTIVENESS EVALUATION

PHASE 5: QUALITY AT SCALE

PHASE 2 INTERVENTION DEVELOPMENT

The intervention development phase aims to translate the insight gained in the formative stage to an intervention manual, ready to be tested.

The following deliverables can be expected:

- **The intervention manual** instructs facilitators on how to implement. The intervention manual should align with the Theory of Change and can be designed in collaboration with partners. Consulting community members, practitioners and researchers in the sector to review the manual can increase the manual's quality and relevance.
- **Practice runs** can be conducted. Practice runs are short studies that test the implementation of (elements of) the intervention manual to learn whether the intervention can be implemented as described in the intervention manual.
- The manual should be **adapted based on the feedback** and insights obtained through the practice runs.
- **A Theory of Change** is a crucial element in developing interventions. Theories of Change map out pathways of change, including planned activities, preconditions, long-term outcomes and the desired impact. Developing a Theory of Change also helps to unpack measurement of the intervention outcomes. War Child follows the Aspen Institutes Community Builder's Approach to Theory of Change.

Access Phase 2 bibliography → page 56

PHASE 2 INTERVENTION DEVELOPMENT

CASE STUDY
Development of a community-driven child protection intervention

Steps undertaken to develop the community-led child protection intervention: Seeds.

What is Seeds?
Existing structures that protect children can weaken or break down in times of humanitarian crisis - exposing children to significant risks. The intervention Seeds builds on the intrinsic motivation of communities to keep children safe. In community-led approaches to child protection, communities are recognised as power-holders and decision-makers. Agencies on the other hand, can play a role in facilitating bringing people and resources together. Communities identify child protection concerns to address, decide how to take effective action using their own capacities and resources and monitor and evaluate them. Because the initiatives are locally-owned and managed by the community, using their own ideas, creativity and motivation to keep their children safe, they have the potential to be sustainable.

How did we develop Seeds?
A zero-draft version of the Seeds intervention manual was developed based on:

- **A systematic review** was conducted to synthesise existing literature on community-led approaches to child protection. The review highlighted three main findings:
  - A practice-research gap exists for community-level approaches generally and more specifically in humanitarian settings.
  - The importance of targeting different socio-ecological levels when implementing community-level interventions.
  - The identification of recommended strategies implementing agencies can adopt in their work.

  These strategies include linking with existing processes and structures, considering inclusivity and carefully negotiating possible tension between traditional mechanisms and rights-based frameworks. These findings, and findings of a literature review conducted in 2009 (Wessells, 2009), were used as basis for the development of the intervention manual.
- **A qualitative study was conducted in Lebanon** to pilot the topics, questions and participants of the first Seeds intervention phase. Adjustments were made to the intervention manual accordingly.
- **The intervention manual was field tested in Sri Lanka** with the aim to carry out an overall preliminary assessment of the feasibility of the intervention. A run-through of intervention and training elements was completed, and feedback was collected. Detailed adjustments to the various training components and intervention phases were made accordingly.
- **A team of child protection** practitioners from different contexts and organisations joined the development of the Seeds intervention manual. The development team came together during multiple workshops and provided input for and feedback to the manual.

Conclusion
The various steps taken in the development process resulted in an evidence-informed Seeds intervention manual. The next step in the process is a feasibility study in Colombia (2021), where the research methodology will be piloted and the relevance and sustainability of Seeds assessed.

Key resource

Title	A systematic review of the literature on community-level child protection in Low- and Middle-Income Countries Systematic review of intervention strategies.
Authors	Rinske Ellermeijer, Malia Robinson, Anthony Guevara, Georgina O'Hare, Caroline Veldhuizen, Mike Wessells, Ria Reis, Mark Jordans
In submission	

Access Phase 2 - Seeds bibliography → page 56-57

PHASE 2 INTERVENTION DEVELOPMENT

CASE STUDY
A Case for Teacher Wellbeing

Stressors pose a significant risk to both teachers' own social and emotional competence, including stress and emotional management, interpersonal skills, positive self-concept, motivation and optimism. Stress profoundly impacts teachers' ability to provide the inclusive, holistic learning outcomes in classrooms that they are increasingly being held accountable for (Vega & Bajaj, 2016; Colvin et al., 2016).

Given the interpersonal nature of teaching, further studies have found that such stress and burnout are linked to lower teacher performance levels and ultimately to low academic, social and emotional learning outcomes in students (Carver-Thomas & Darling-Hammond, 2017).

Coaching-Observing-Reflecting-Engaging (CORE) for Teachers combines scaffolded psychological care, whole school system of care, and real-time, individualised classroom support through coaches, to **improve teachers' wellbeing** and teachers' **social and emotional competencies.**

CORE was developed to improve teacher wellbeing in conflict and crises affected-settings. After initial desk research, CORE was further developed and adapted iteratively based on theory of change development in collaboration with technical specialists, learnings from a practice run in Colombia, and a cultural and contextual adaptation process in Gaza.

Two theoretical frameworks underpin CORE

- **Acceptance and Commitment Therapy** (ACT) is a cognitive behaviour therapy for treating a range of psychological disorders, and promoting wellbeing (Hayes et al. 2013; Levin et al. 2012). ACT can support increased psychological flexibility in teachers allowing them to identify and manage emotions and bring personal values into decision making on behaviour and behaviour change.

- **Collaborative for Academic, Social, and Emotional Learning** (CASEL) framework of five intrapersonal, interpersonal, and cognitive competencies (Schonert-Reichl, Kitil, & Hanson-Peterson, 2017).

CORE development learnings

- **Include teachers' voices** in decision making around their professional development but also in the adaptations of CORE.
- **Ensure relevance** by taking different perspectives into account: from the teacher to the school to the country setting. That means allowing time for a rigorous cultural and contextual adaptation process for each distinct cultural setting.

- **Give intensive and real-time support** to teachers by investing in training and supervising coaches and having enough time to give teachers regular and meaningful support within the school day.

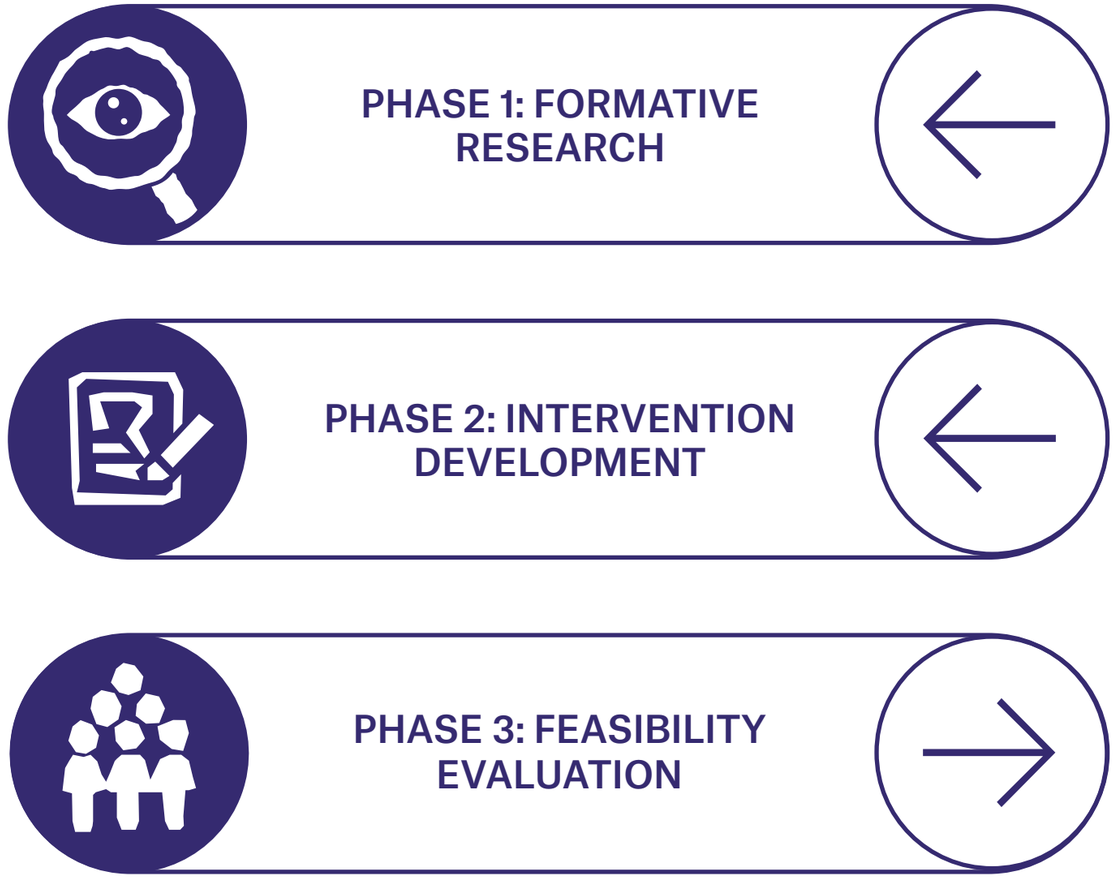
The future of CORE

Given the lack of research into teacher-wellbeing interventions in fragile and conflict-affected situations, the development of CORE could address a critical gap in evidence-based approaches to support teachers in conflict and crises affected contexts. In the future, we aim to test the effectiveness of CORE and, if it is shown to be effective, scale the intervention.

Key resource

Website Access	War Child Holland – CORE for Teachers www.warchildholland.org/intervention-core

Access Phase 2 - CORE bibliography → page 57-58



PHASE 3
FEASIBILITY EVALUATION

The purpose of the feasibility evaluation is to learn about the feasibility of the intervention. The intervention is piloted with a small sample of participants and run through in its entirety. In this step, the evaluation design and methods of measurement are tested and validated.

The following milestones are essential to the feasibility evaluation:

- **Development of the pilot research protocol** which outlines the methodological procedures including: the research background, rationale, objectives, participants, setting, recruitment, study design, methodology, statistical considerations, data management, dissemination, and timeline. Research questions and methods are pre-specified to increase scientific rigour.
- **Feasibility standards**, like cost coverage, acceptability and implementation coverage, demand and practicality can be measured at the pilot stage. This is beneficial for future efforts to scale the intervention. Within the feasibility evaluation and roll out of our interventions, we measure **quality of implementation**. Three indicators are utilised to demonstrate quality of implementation: adherence to the manual, competence of facilitators[2] and attendance of participants.
- **A translated and culturally adapted intervention manual**, to ensure it fits the local context. It is necessary for local experts and the target groups to be involved as part of this process to understand the context and to adapt the intervention to ensure cultural fit.
- **Adapting and validating measurement instruments** for the context and the population. Cross-cultural adaptation of instruments to language, setting and context reduces risk of introducing bias into a study. To validate instruments a check is done whether it measures what it intends to measure. **Qualitative methods** can further support in-depth understanding.
- Based on **the analysis** of the results, **adaptation and updating of the intervention manual**, integrating the lessons learned.

Access Phase 3 bibliography → page 59

[2] Measured using WeAct for non-specialists working with children and EnAct for non-specialists working with Adults. These tools are freely available on the EQUIP platform hosted by the World Health Organization

PHASE 3
FEASIBILITY EVALUATION

CASE STUDY
Overcoming barriers in mental health care with the Community Case Detection Tool

In this case study we describe the steps taken to test the feasibility and accuracy of a proactive case detection tool for emotional and behavioural problems among children and adolescents.

What is the Community Case Detection Tool?
A crucial element of a multi-level care system approach is **identifying children** and adolescents in need of care and **promoting help-seeking**.

The Community Case Detection Tool (CCDT) supports community gatekeepers - trusted community members with strong community engagement **without prior mental health training** - to proactively detect patterns of behaviour as indicators of significant mental health needs and subsequently to encourage help-seeking.

The tool comprises illustrated vignettes depicting culturally relevant indicators of childhood psychological distress and family-related problems. Each vignette uses specific cultural idioms of distress, adapted to each particular context, and avoids stigmatising or psychiatric terminology. Community gatekeepers are trained to watch out for signals of distress, as portrayed in these vignettes.

A simple question diagram supports community gatekeepers in determining the severity and functional impact of the detected problems and advises the gatekeeper about follow-up actions. When a child matches the patterns of behaviour presented on the tool, which are thought to impact daily functioning, the gatekeeper is advised to approach the family to **encourage help-seeking**.

How was the feasibility of the tool tested?
The CCDT is developed based on an evidence-based tool for the detection of adult mental health problems (Jordans et al., 2015). Building on this tool and positive findings among adults, a child-focused CCDT was developed and piloted.

The tool's accuracy was evaluated on a small scale in nine schools in the West Bank, in the occupied Palestinian territory. The tool was culturally and contextual adapted, to prepare it for feasibility testing in the occupied Palestinian territory. The adaptation included (back) translation of language and concepts for increased relevance and appropriateness, focus group discussions and expert consultation. A two-week practice run was conducted to assess the safety and feasibility of the tool and process in the Palestinian context, identify the most relevant groups of gatekeepers, and select the implementation setting.

Drawing on the promising findings in school settings in occupied Palestinian territory (van den Broek et al., 2021a),

we hypothesised that the CCDT could also be applied to community settings and adapted the tool to the Sri Lankan context. Focus group discussions were conducted with community members and mental health and child protection service providers, and input was collected on the most common problems and idioms of distress. Additionally, the tool was translated using a back-translation method.

The accuracy of this version was evaluated in the Eastern Province of Sri Lanka, to learn how many children were detected by trained community gatekeepers using the CCDT required mental healthcare services. Trained community gatekeepers used the tool for six months in their daily routine. Children and families detected as potentially in need of mental healthcare were invited for a clinical interview by a mental health counsellor using a structured clinical interview.

The CCDT results were compared with a professional opinion on the need for mental healthcare and the results of a widely used screening tool, the Strengths and Difficulty questionnaire (SDQ). The results were promising, as 7 out of 10 children and families detected by community members using the CCDT were confirmed to require treatment (van den Broek et al., 2021b).

Conclusion

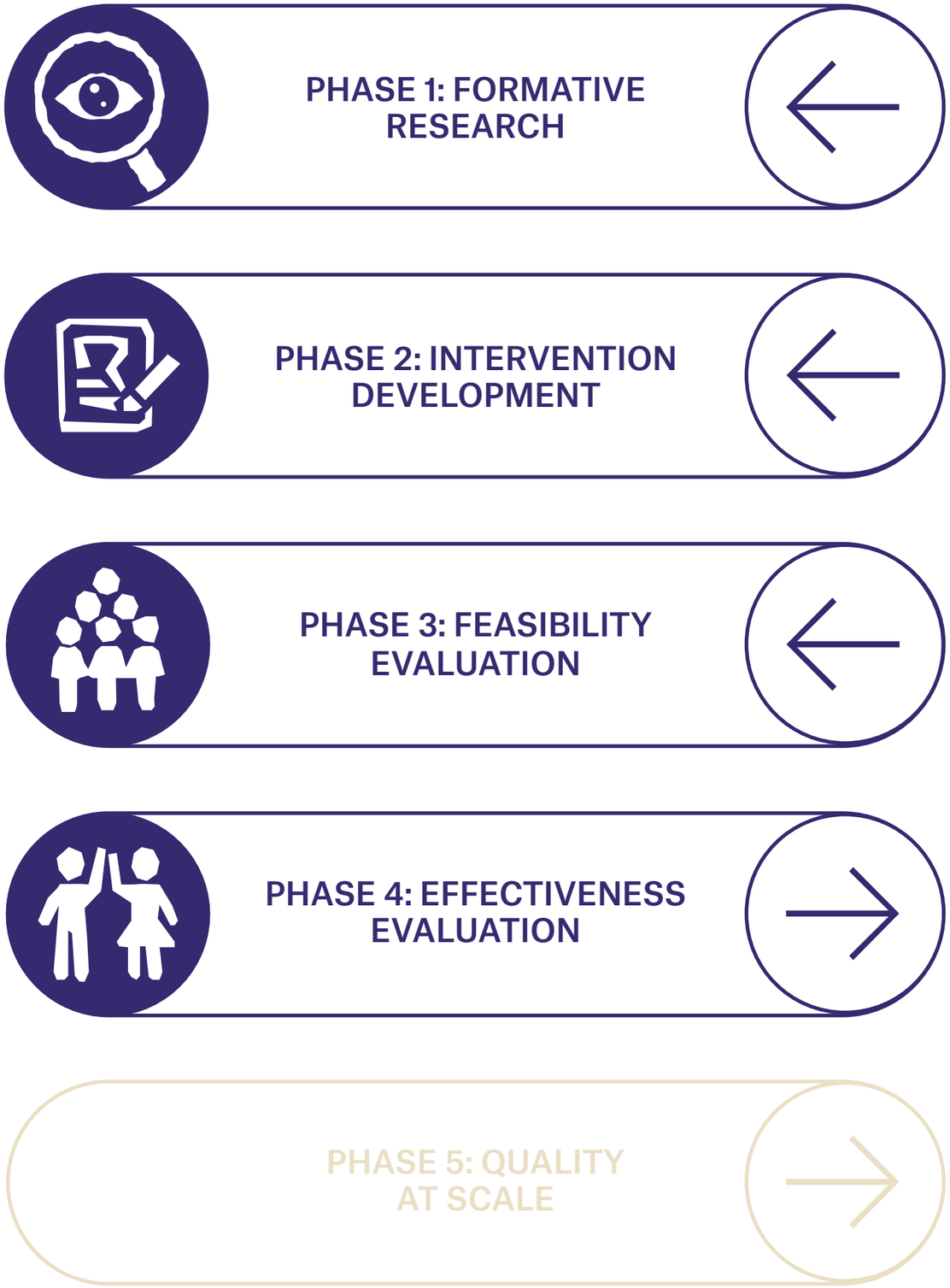
The two studies demonstrated that community members using the CCDT can accurately detect two out of three children and families in need of mental healthcare.
The performance of the CCDT was comparable with the SDQ, which provides further evidence of the potential of the CCDT as an alternative scalable method to universal screening to promote help-seeking for mental healthcare.

Overcoming under-detection is only the first step in the process of seeking help. Additional strategies are needed to tackle intersecting demand-side barriers to encourage help-seeking behaviour effectively. Future research will therefore focus on developing and evaluating a help-seeking encouragement strategy to complement the tool.

Key resource

Title	Accuracy of a Proactive Case Detection Tool for Internalising and Externalising Problems Among Children and Adolescents
Authors	Myrthe van den Broek, M., Lina Hegazi, Nisreen Ghazal, Laylaly Hamayel, Anna Barrett, Brandon Kohrt, Mark Jordans
Year	2021
Journal	Journal of Adolescent Health
Access	www.doi.org/10.1016/j.jadohealth.2021.03.011

Access Phase 3 - CCDT bibliography → page 60



PHASE 4 EFFECTIVENESS EVALUATION

To evaluate the effectiveness of an intervention, we aim to conduct a full-scale trial with an adequate sample size. From there you can observe whether the intervention is effective in reaching its desired outcomes. Where feasible, War Child conducts (cluster) randomised controlled trials (RCT) to evaluate effectiveness. However, other research designs are employed when RCT's are not appropriate for the intervention or context.

The following steps are major segments of effectiveness evaluation:

- An approved **evaluation protocol**, which is developed based on the pilot study. This protocol details the intervention, appropriate research design, the measurement instruments - both quantitative and qualitative, ethical procedures, the analysis plan and the sampling strategy.
- **A calculation of statistical power** should be made, specifying how many participants need to partake in the study to detect the "true effect" in the population, with your sample.
- In the case that the research setting is different than the context in which the pilot study took place, **a cultural and contextual adaptation process** should be followed. This process guides the research team to adapt the intervention to the cultural context.
- **Validated measurement tools should** be used or developed per study setting, where feasible.
- **Management and analysis** of the data should follow the steps outlined in the research protocol.

- **Publish** the results in peer-reviewed journals and disseminate plain-copy summaries.
- **Disseminate** at community-level using culturally appropriate means.

Access Phase 4 bibliography → page 61

PHASE 4 EFFECTIVENESS EVALUATION

CASE STUDY
A Caregiver Support Intervention for Families in Adversity

Want to strengthen the resilience and psychosocial wellbeing of children affected by armed conflict? We have learnt that you also need to support the wellbeing of their parents. Be There is a nine-session group intervention aimed at strengthening the psychosocial wellbeing and parenting of parents and other caregivers of children, ages 3-12, affected by war and forced displacement.

Be There
Armed conflict and displacement generate highly stressful conditions that can negatively impact parenting. Be There provides caregivers with training in evidence-based methods of stress management in a supportive group setting. The intervention includes training in positive parenting—warm and responsive parenting that uses proven, non-violent forms of behaviour management. Be There assumes that **caregivers already possess a great deal of parenting knowledge and skills**, but that **chronic stress and distress makes it difficult to parent effectively**.
By first helping participants lower their stress level, then

layering on training in positive parenting, Be There can help caregivers use the competencies they already possess, as well as the new parenting knowledge and methods taught in the intervention.

Evaluating the effectiveness

Be There was developed with content drawn from diverse cultural contexts, using concepts and methods from mindfulness, stress and coping, early childhood development, and positive parenting (Miller et al, 2020a). We conducted two Randomised Controlled Trials (RCT): a pilot RCT and a fully powered RCT. The pilot RCT in North Lebanon included 79 families (72 with both caregivers) (Miller et al, 2020b) and demonstrated feasibility of all methods.

Our fully powered RCT (Miller et al, 2020c) was conducted in North Lebanon, **to evaluate the effectiveness** of Be There, involving a total of 240 families (480 caregivers, of which 50% male) with at least one child between 3 and 12 years old. Potential participants were recruited through various means, such as announcements during breakfast meetings, door to door recruitment, flyers etc. After the participants had completed the baseline assessment, randomisation was conducted at the family level, using participatory methods to strengthen community buy-in and trust in the process. One caregiver from each family was asked to draw a lollipop out of a bag containing two colours of lollipops. The meaning of the colour - corresponding to either the intervention group (receiving Be There immediately) or the waitlist group (receiving Be There after follow-up assessments) - was thereafter decided upon by a toss of a coin. This was done in the community as well. Seven measures - already pre-validated through the pilot RCT - were used in this study including:

- Measuring parenting as our primary outcome
- Parental warmth, harsh parenting, parenting knowledge and child psychosocial wellbeing as secondary outcomes
- Caregiver distress, stress, psychosocial wellbeing and stress management as mediators.

The RCT was conducted amidst **challenging times**. To respond to the economic crisis and the budget constraints, the team decided to work in two waves of Be There implementation to be able to be more resource-efficient. However, halfway through the second implementation wave, Lebanon experienced a nation-wide lockdown due to COVID-19. Implementation of this wave had to stop after six of the nine sessions. However, the team managed to complete all assessments - baseline, end-line, and follow up - where necessary through phone (Chen et al, 2020). Despite these challenging circumstances, nonetheless it was found that Be There **improved caregivers' mental health, strengthened parenting generally and led to a decrease in harsh parenting**, and resulted in an **improvement in children's psychosocial wellbeing**. Moreover, we were able to demonstrate that lowering caregiver distress actually led to a decreased use of harsh parenting practices.

Conclusion

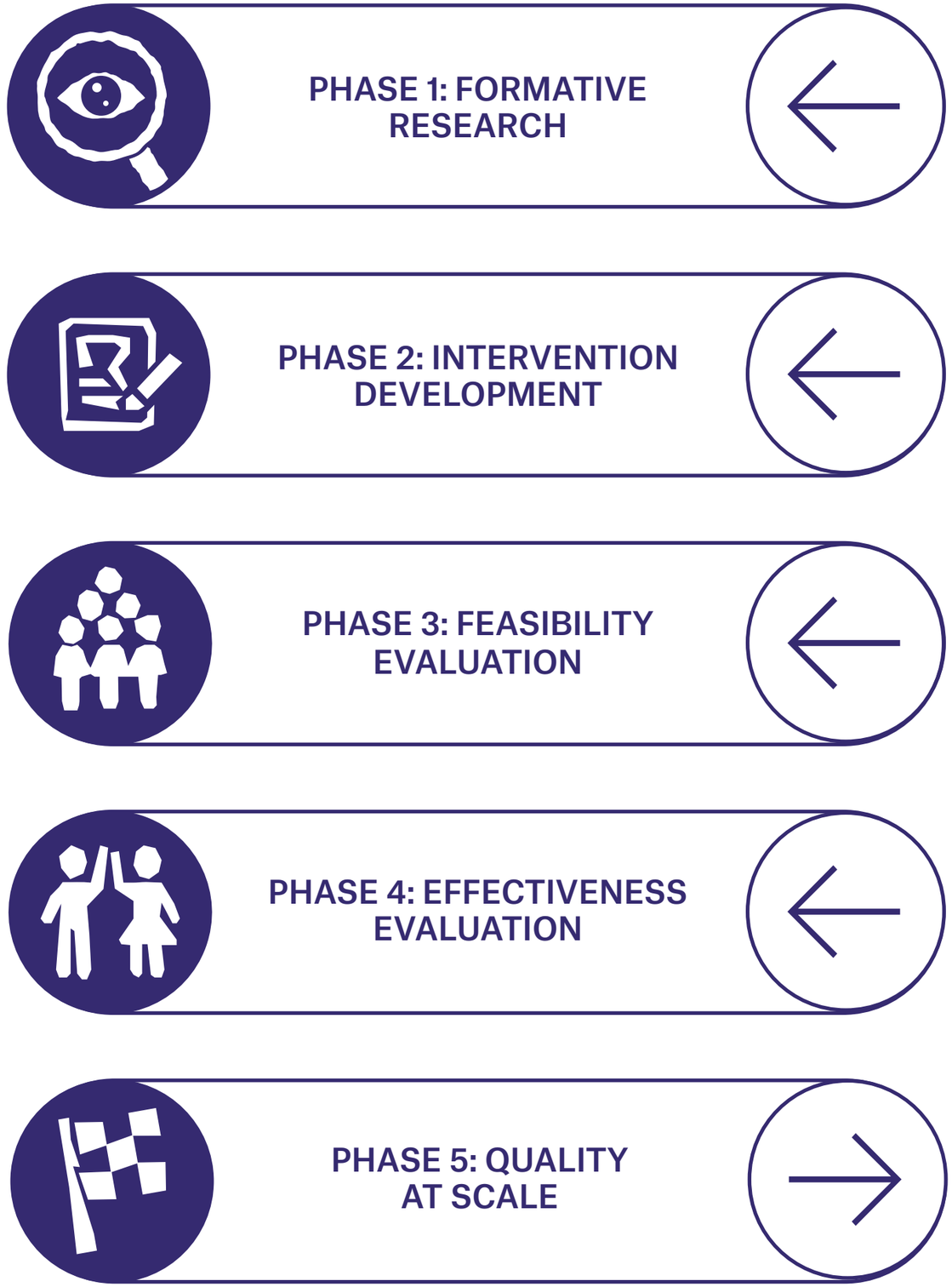
Armed conflict and forced displacement are highly stressful experiences for parents and other caregivers of children. Over time, persistently high stress may increase harsh parenting and makes it challenging to respond to and

nurture children with warmth. **Be There targets caregiver stress and psychosocial wellbeing, while providing alternatives to harsh parenting and strengthening positive caregiver-child interactions, and increasing men's participation in their children's daily lives**. Be There is now being **prepared for scaling and adaptation** for use in diverse cultural contexts.

Key resource

Title	Protocol for a randomised control trial of the caregiver support intervention with Syrian refugees in Lebanon.
Authors	Kenneth E. Miller, Maguy Arnous, Fadila Tossyeh, Alexandra Chen, Ioannis Bakolis, Gabriela V. Koppenol-Gonzalez, Nayla Nahas & Mark J. D. Jordans
Year	2020
Journal	Trials
Acces s	www.doi.org/10.1186/s13063-020-4175-9

Access Phase 4 - Be There bibliography → page 61-62



PHASE 5
QUALITY AT SCALE

Worldwide millions of children and youth live in areas affected by conflict. Interventions to address issues they phase are often not designed with low- and middle-income contexts in mind, and a lack of specialists in conflict-settings can affect coverage of services. Stigmatisation can also play a role in blocking access to essential services.

Interventions developed by War Child are designed with scale in mind, from the outset. We integrate a scaling perspective in our work by considering cost, access, resources, feasibility, effectiveness, (co-) branding, design-thinking, and cultural and contextual adaptation.

The following milestones are necessary for scaling up:

- Perform a **relevance analysis** to understand the need for a certain intervention in the local context.
- **An intervention toolkit** which is easy to understand, use and disseminate. This includes didactical considerations, editorial review, graphic design and (co-) branding.
- **A cultural and contextual adaptation** manual that outlines how to adjust the intervention to new local settings. The manual should specify the evidence-based mechanisms of the intervention, and pathways of change which are necessary for change to occur. The manuals also demarcate which elements of the intervention need to be adjusted to suit the new cultural context, like cultural idioms, constructs and language adjustments. The contextualisation processes conducted in the previous steps will form the base of this guide.
- **A capacity strengthening guide** for future facilitators and trainers of the intervention.
- Guidance on **monitoring the quality of implementation** during roll out. We recommend measuring adherence, attendance and competence of facilitators using WeAct or Enact, available on the EQUIP Platform.

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PHASE 5
QUALITY AT SCALE

CASE STUDY
Moving from research
to implementation:
Ensuring quality of care

Evidence-based interventions can be scaled widely.
But how do you ensure that they are scaled with quality?
This case study describes how to monitor and ensure quality implementation.

War Child has developed a model to monitor implementation quality at scale using three simple indicators: competence, adherence and attendance. We aim to develop a quality assurance support system using a centralised database to monitor the levels of implementation quality.

The Quality of Care model
We recommend monitoring of three indicators, as described by Jordans and Kohrt (2020):

- **Competence of facilitators** are measured to monitor the quality of facilitation. Provider competence is defined as the knowledge and skills required to deliver an intervention to the standard needed for it to achieve its expected effects (Fairburn and Cooper, 2011). Due to the lack of specialized service providers in areas affected by conflict, task-shifting models are necessary to implement at scale. Scaling of services requires non-specialists who have the right competencies to deliver the empirically supported interventions.
  The competency levels of facilitators working with children can be measured using the WeAct tool (Jordans et al., 2021).
- **Adherence** is measured to monitor the extent to which the facilitators execute the core elements of the intervention. A checklist can be used to observe the level of adherence to the intervention design, and how well the design was adhered to (Fairborn & Cooper, 2011).
- **Attendance** of participants as reaching effective outcomes is only possible if the level of attendance is sufficient. Attendance is also measured as low attendance can serve as a red flag for other implementation issues.

Conclusion
Data on these three indicators allow us to draw conclusions about the quality of implementation at scale. We aim to develop a centralised database to monitor implementation quality at scale, with a quality assurance system in place to provide support if any of these indicators fall below the threshold for sufficient quality.

Key resource

Title	Scaling up mental health care and psychosocial support in low-resource settings: A roadmap to impact
Authors	Mark Jordans and Brandon Kohrt
Year	2020
Journal	Epidemiology and Psychiatric Sciences
Access	www.doi.org/10.1017/S2045796020001018

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PHASE 5
QUALITY AT SCALE

CASE STUDY
Scaling up EdTech:
Can't Wait to Learn

Can't Wait to Learn (CWTL), War Child's tech-based education programme, has entered the scale-up research phase. We aim to generate knowledge and evidence on how CWTL, an education technology (EdTech) innovation, can be adapted and scaled to improve education access and quality for refugee and displaced children in conflict-affected countries.

Access to equitable and quality education remains a critical issue in countries affected by armed conflict, extreme poverty, and forced displacement. The COVID-19 global pandemic has massively challenged education systems worldwide with lengthy school closures, underlining the need for catch-up and accelerated education and highlighting the risk that children face out of school like child marriage, teenage pregnancy, and child labour. War Child partnered with Global Partnership for Education through its Knowledge and Innovation Exchange (KIX) global grant to deliver sustainable education through evidence-based EdTech programming. To achieve that, we explore, extend and integrate the roles of multiple stakeholders, including caregivers, local communities, educators, academic institutions, implementing organisations and policymakers.

Building evidence

CWTL's design is based on substantial empirical evidence and practice-based research. The programme was first developed in 2012 in Sudan for children living in areas where formal education infrastructure was unavailable. In 2018, a rigorous quasi-experimental study in Sudan compared the effect of CWTL reading and numeracy games on children's academic competencies with that of state-provided, non-formal education for out-of-school children. While both groups made significant improvements, the Can't Wait to Learn group's learning gains were 2.5 times as much for reading and almost twice as much for numeracy (Brown et al., 2020). Additional research in Lebanon and Jordan produced promising evidence for the appropriateness of the programme for out-of-school children aged 10-14 and in-school children aged 6-13 (Turner et al., under review). An external evaluation on the home- and community-based implementation models has been conducted as a part of the COVID-19 education response in Uganda, demonstrating positive results for the programme.

Research for scale

Our current research in Chad, Uganda and Sudan is blending participatory, experimental, implementation and policy research. The aim is to generate knowledge and evidence on how EdTech innovations can be adapted and scaled to improve education access and quality for refugee and displaced children in conflict-affected countries. Within this process, multiple studies are undertaken. The findings of our research aims to produce:

- **Rigorous evidence** on the effectiveness and cost-effectiveness of CWTL;
- **Minimum quality standards**, quality assurance mechanisms and tools, relating to educator attitudes, knowledge and competencies;
- **An add-on approach** to strengthen caregiver engagement and the home-school relationship to increase children's attendance and retention in school;
- **An understanding of the actors, power relationships** and other influences in policy development and implementation;
- **Policy recommendations** for the integration and scale-up of education technology within education systems;
- **Processes and tools** to support rapid partner adoption and implementation.

Conclusion

Can't Wait to Learn provides an innovative solution to close the education gap for millions of children around the world affected by conflict. Multiple mixed-methods research studies conducted so far demonstrated that the programme works in different settings. Our current research aims to produce the necessary knowledge, evidence, and tools to adapt and scale an evidence-based and sustainable education programme that can be used across conflict-affected contexts by other organisations, institutions, and governmental systems.

Key resource

Title	Can't Wait to Learn: A quasi-experimental mixed-methods evaluation of a digital game-based learning programme for out-of-school children in Sudan
Authors	Felicity Brown, Alawia Farag, Faiza Hussein Abd Alla, Kate Radford, Laura Miller, Koen Neijenhuijs, Hester Stubbé, Thomas de Hoop, Ahmed Abdullatif Abbadi, Jasmine Turner, Andrea Jetten, Mark Jordanss
Year	2020
Journal	Journal of Development Effectiveness
Access	www.doi.org/10.1080/19439342.2020.1829000

Access Phase 5 - Can't Wait to Learn bibliography → page 65

CO-BRANDING

By scaling interventions through partners, more participants can be reached through evidence-based interventions. Shared ownership over an intervention can be supportive in scaling, but it can be complicated as all participating partners take with them not only their distinctive authority and expertise, but also their own corporate identities (with corresponding guidelines).

To create a brand architecture that will allow for all partners to make a project their own, we introduced a ‘co-brand zone’. Within the co-brand zone, we invite all partners for their input to create a co-brand of high quality together that will emphasise the synergy of values and competencies between all partners. By creating something new that can stand on its own. A widely supported co-brand – that does justice to all partners – provides a strong base as well as the flexibility to fully make use of each other’s added value, knowledge and reach.

DESIGN THINKING

The scale up of an evidence-based intervention is supported by simplification (Smith et al., 2015). To address an identified problem, interventions can be complex, including several interacting components (Hoddinott, 2015). War Child integrates simplification in the way an intervention is packaged and presented, for easier use and implementation. We have employed design thinking in this process: a non-linear, iterative process used to understand users, challenge assumptions, redefine problems and create innovative solutions to prototype and test. As part of design thinking, diverse groups of participants can be invited to provide input on elements of the intervention to ensure consideration of various perspectives. For the stigma reduction intervention STRETCH, through a design thinking process we developed Community Tales, a board game, which facilitates players to reflect about stigmatisation and its consequences, while learning about the key ingredients of STRETCH. Furthermore, from a user-perspective we invest in structuring the intervention in such a way that it simplifies its use. While being developed through input from end-users, these products will also be tested for feasibility, and adapted accordingly.

Access Phase 5 - Scale Up Strategies and Tool bibliography
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CULTURAL AND CONTEXTUAL ADAPTATION

Adapting interventions to the context in which they will be implemented is an important factor in a scaling process. Culturally and contextually adapting an intervention increases compatibility with local norms, meanings and values. Adaptations can be made to the constructs, idioms, language and training materials without changing the core mechanisms of action at work (Brown et al., 2020).

War Child follows an adaptation process based on internal WHO guidance on cultural adaptations of scalable psychosocial interventions (available upon request) that consists of the following elements:

- **Literature review** to gain a good understanding of the social and cultural context in which the intervention will be implemented.
- Quick **qualitative assessment** to understand problems experienced by the target population; to give insight in how these problems are expressed locally; to explore commonly used coping mechanisms; map available services; and receive input on the planned implementation of the intervention.
- Through **cognitive interviewing** we ensure that materials that are part of the intervention manual are easily understood, acceptable and relevant to the population.
- **A read through** of the materials is done to ensure consistency and appropriateness of the translation as well as compatibility of exercises with the context of the participants.
- **Mock sessions** are organised to allow identification of any further necessary adaptations.
- And lastly, **an adaptation workshop** is organised to review all collected information and determine which changes to be made.

Access Phase 5 - Scale Up Strategies and Tool bibliography
→ page 66

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PHASE 2 – INTERVENTION DEVELOPMENT

CASE STUDY: Development of a community-driven child protection intervention

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PHASE 2 – INTERVENTION DEVELOPMENT

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PHASE 5 – QUALITY AT SCALE

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PHASE 5 – QUALITY AT SCALE

CASE STUDY: Moving from research to implementation: Ensuring quality of care

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PHASE 5 – QUALITY AT SCALE

CASE STUDY: Scaling up EdTech: Can't Wait to Learn

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Recommended Resources

- Felicity L Brown, Alawia I Farag, Faiza Hussein Abd Alla, Kate Radford, Laura Miller, Koen Neijenhuijs, Hester Stubbé, Thomas de Hoop, Ahmed Abdullatif Abbadi, Jasmine S. Turner, Andrea Jetten & Mark J.D. Jordans (2020) Can't Wait to Learn: A quasi-experimental mixed-methods evaluation of a digital game-based learning programme for out-of-school children in Sudan, Journal of Development Effectiveness. → www.doi.org/10.1080/19439342.2020.1829000

- War Child Holland Care System – Can't Wait to Learn: → www.warchildholland.org/intervention-cwtl

PHASE 5 – QUALITY AT SCALE

STRATEGY: Design Thinking

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- Smith JM, de Graft-Johnson J, Zyaee P, Ricca J, Fullerton J. Scaling up high-impact interventions: how is it done? Int J Gynaecol Obstet. 2015 Jun;130 Suppl 2:S4-10. → www.doi.org/10.1016/j.ijgo.2015.03.010
- Hoddinott, P. A new era for intervention development studies. *Pilot Feasibility Stud* 1, 36 (2015). → www.doi.org/10.1186/s40814-015-0032-0

PHASE 5 – QUALITY AT SCALE

STRATEGY: Cultural and contextual adaptation

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EVER.

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