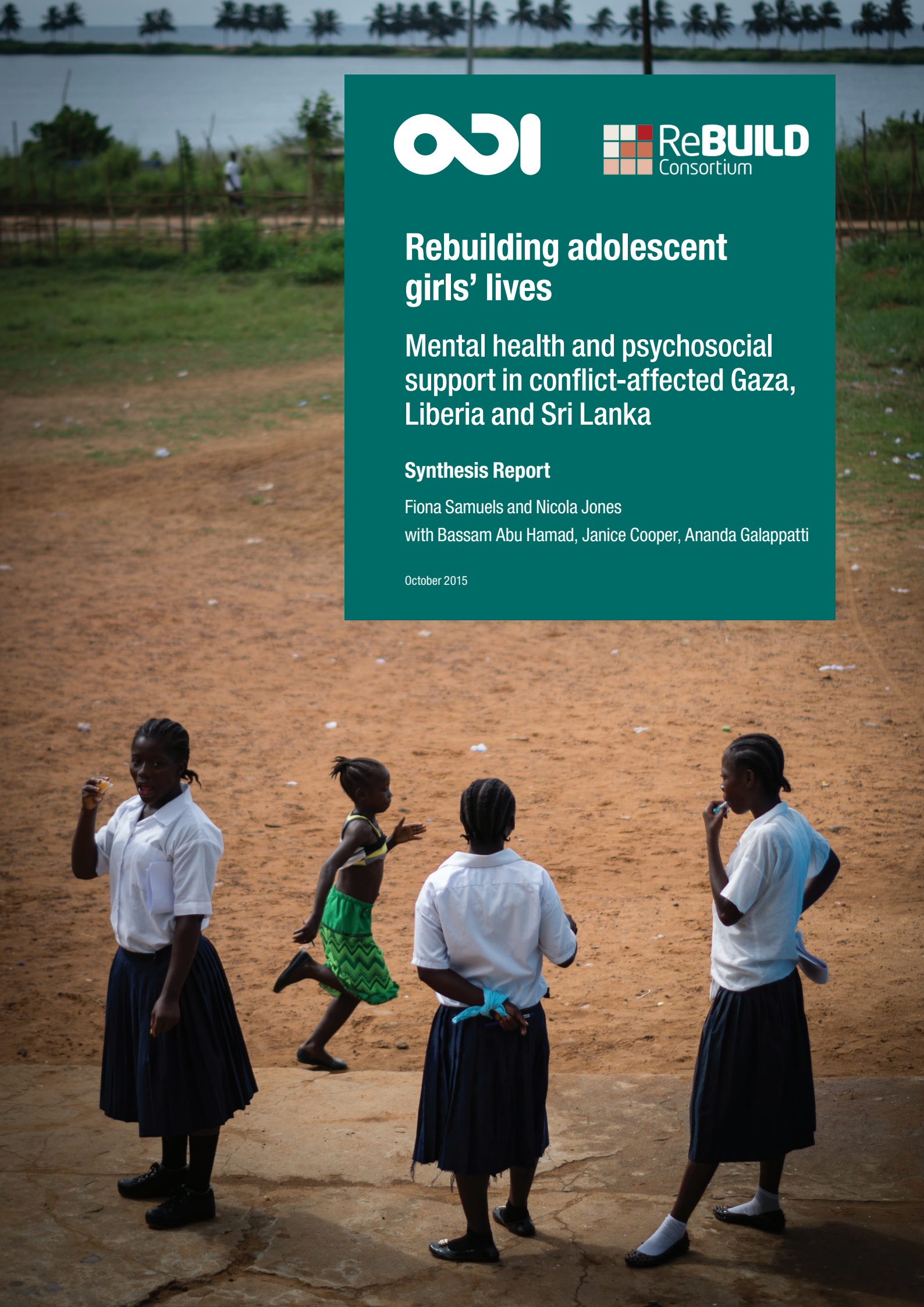

# Rebuilding adolescent girls' lives

## Mental health and psychosocial support in conflict-affected Gaza, Liberia and Sri Lanka

**Synthesis Report**

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# Acronyms

| | |
|---|---|
| **BPMHS** | Basic Package of Mental Health Services |
| **CMHP** | Community Mental Health Programme |
| **CRPO** | Child Rights Promotion Officer |
| **CSO** | Community Support Officer |
| **DHS** | Demographic and Health Survey |
| **DPCC** | Department of Probation and Child Care |
| **ESCO** | Eastern Self Reliant Community Awakening Organisation |
| **ESDF** | Eastern Social Development Foundation |
| **EVD** | Ebola Virus Disease |
| **FDI** | Foreign Direct Investment |
| **FGD** | Focus Group Discussion |
| **FGM/C** | Female Genital Mutilation/Cutting |
| **FHW** | Family Health Worker |
| **GBV** | Gender-Based Violence |
| **GDP** | Gross Domestic Product |
| **KII** | Key Informant Interview |
| **LTTE** | Liberation Tigers of Tamil Eelam |
| **LURD** | Liberians United for Reconciliation and Democracy |
| **MDG** | Millennium Development Goal |
| **MHPSS** | Mental Health and Psychosocial Support |
| **MoE** | Ministry of Education |
| **NECC** | Near East Council of Churches |
| **NGO** | Non-governmental Organisation |
| **NMHP** | National Mental Health Policy |
| **ODA** | Official Development Assistance |
| **PO** | Probation Officer |
| **PTSD** | Post-Traumatic Stress Disorder |
| **PWG** | Psychosocial Working Group |
| **SGBV** | Sexual and Gender-based Violence |
| **UNRWA** | United Nations Relief and Works Agency for Palestine Refugees |
| **WHO** | World Health Organisation |

# Executive summary

## Overview

This study explores the linkages between mental health and psychosocial wellbeing and social norms in the fragile and post-conflict settings of Gaza, Liberia and Sri Lanka with a particular focus on adolescent girls (10-19 years). In particular, the study explored the extent to which services and community and household responses to mental health and psychosocial problems in these settings are sufficiently informed by an understanding of the context, as well as gender inequalities and dynamics, and social norms. Although a large and growing body of evidence exists exploring, amongst other things, the linkages between mental health, development, gender and adolescence, and stressing also its significance to the overall wellbeing of individuals and societies, mental health and psychosocial well-being have been neglected in many developing countries. Similarly, insufficient attention has been paid to the mental health and psychosocial needs of adolescence girls in fragile and post-conflict settings.

## Conceptual framework

Informed by this body of evidence and building on psychosocial wellbeing frameworks, we view mental health and psychosocial wellbeing through the lens of social norms. This approach, we argue, helps to better understand girls' vulnerabilities, their coping strategies as well as the formal and in formal support and service environment available to them in terms of their psychosocial wellbeing. This environment is clearly influenced by the country contexts, historical dimensions and the dynamics of the fragile and post-conflict settings in these three countries, all of which are unique and have far-reaching and ongoing consequences.

## Study methodology

Our study findings are drawn from a literature review as well as primary qualitative data collection undertaken in Gaza, Liberia and Sri Lanka in 2013-2015 involving community mappings, facility checklists, individual interviews with adolescents and their caregivers, focus group discussions with adolescents, and key informant interviews with service providers.

## Markers of adolescence

To contextualise our findings, it was important to first identify what adolescence as a period of life meant to the study respondents in order to explore both psychosocial wellbeing and vulnerability of adolescent girls. Markers of adolescence according to respondents in all 3 countries include: physical bodily changes, often marked by puberty ceremonies; emotional changes, including the start of love interests; changing, and often more, responsibilities particularly for girls, but without corresponding space or voice to take part in community decision-making processes; changing behaviours and ways of thinking, both positive, i.e. thinking more seriously about the future, and negative, withdrawing from friends and family and contemplating suicide; increasing restrictions, particularly for girls related to e.g. dress and mobility; and early marriage, largely for girls.

## Drivers of adolescent psychosocial vulnerability

Drawing explicitly on the wellbeing framework championed by the University of Bath and modified in this study to include a stronger emphasis on gender and social norm dynamics, we then explored how adolescents perceive their wellbeing and risks of ill-being according to a number of domains. **Access to resources** – including education and economic opportunities – were all identified by adolescent girls as shaping their psychosocial wellbeing in important but divergent ways. While education was valued highly in Sri Lanka by both parents and adolescents, many adolescents dropped out because of household poverty, love affairs and elopement and early marriage. In Gaza, despite important achievements in gender parity in primary and secondary education, the education system suffers from quality deficits. In Liberia, despite significant supply (infrastructure, quality) and demand (financial constraints) challenges quality and infrastructure, the importance of education on an adolescent's future was stressed by all girls and boys and their caregivers in our study.

In terms of access to economic opportunities and assets, a girl's economic security in Sri Lanka depends on her family's economic stability or that of her husband when she marries. In Gaza, economic hardship seems to play the biggest role in adolescents' deteriorating psychological status. Similarly, in Liberia, adolescents are influenced by their caregivers' or parents' lack of access to economic opportunities and assets. Not only does this cause stress and psychosocial suffering for adolescents and their caregivers, but it also leads to adolescents engaging in risky behaviour, including transactional sex.

Another critical risk to adolescent girls' wellbeing was in the domain of **sustaining and building social connections and relationships**. While families played a critical role in shaping girls' wellbeing, the ways in which this played out in the three contexts differed markedly. Most adolescents in Sri Lanka said that one or both parents were the closest person to them and provided the most support. However, at the same time, many also felt a sense of frustration or disappointment with their parents. For some girls, extended family members, often grandmothers and aunts,

were key figures in their lives. Family disintegration or the death of a parent meant some adolescents were living with extended family members; some spoke about the relationships with them as being loving and caring, while others experienced ill-treatment or even trauma at the hands of these relatives. Relationships with non-relatives including neighbours, supportive teachers and peers were also important for adolescent girls in Sri Lanka for seeking advice, sharing secrets and having fun with. In Gaza, the role of family support was mixed. On the one hand a number of adolescents highlighted that they turned to family members for advice and solace. On the other, there were repeated concerns that parents do not listen to their children, with families seldom creating the space needed for adolescent children to express themselves and seldom pay attention to understanding their unique needs and concerns. In Liberia, a large proportion of adolescent girls did not live with their biological families even though they were alive, causing much anxiety and pain to the adolescents in the study. Even so, both boys and girls indicated that having relationships with close kin and extended family members, peers and neighbours played a vital role in their psychosocial well-being.

The inability to **participate in familial and community decision-making and to exercise agency** about important life decisions was another key psychosocial risk experienced by adolescent girls in our study sites. In Sri Lanka and Liberia, despite more responsibilities being assigned to both girls and boys as they reach adolescence, they are still considered as children in public life and are not given the space to participate and be heard in either household or community decision-making processes. Similarly in Gaza, in both normal and crises situations, adolescent girls' ability to participate is constrained largely by hierarchical social norms which place strong restrictions on their mobility and social activities outside the home on the pretext of 'family honour'.

An **inadequate sense of self-worth** is another risk to psychosocial wellbeing that adolescent girls repeatedly raised. Adolescents in Sri Lanka and Liberia (often against the odds) demonstrated a strong sense of self-worth. Enablers and indicators of self-worth in Sri Lanka included: having affection and support of parents and extended family members; having space to participate in school or community events; and having aspirations for the future. Barriers to self-worth included: remote locations and a lack of forums for young people to use their skills and talents; the absence of an encouraging environment or socially accepted spaces where girls can congregate; and negative labelling of adolescents. In Gaza, adolescent interview respondents repeatedly lamented that they were not accorded the same value as their male counterparts by family and community members alike. Similarly, girls reported feeling less valued than boys when it comes to sharing opinions and thoughts.

**Inadequate protection and security** – both in terms of physical and psychological harms – was a key theme in all three study sites, but especially in Liberia. Unhappy family relationships and physical and sexual abuse of girls emerged as major risks to girls' protection in Liberia. Nearly all adolescent girls in the study reported being subjects of physical beatings as part of how their parents or guardians disciplined them. And a significant proportion of the sexual violence discussed during the individual interviews and focus group discussions was perpetuated by family and relatives. According to study respondents in Sri Lanka, the physical and mental wellbeing of adolescents, especially girls, is closely linked to their security and protection. Some factors that affect this wellbeing derive from experiences of war and conflict faced by the adults in their lives. In many cases these experiences continue to affect the way adults negotiate relationships with their children even in a post-conflict situation. In Gaza, fear of sexual harassment is a stressor for girls and young women, especially those living in remote areas and close to borders. Other risks to physical and mental wellbeing found in all countries include aggression or violence at home, separation of parents and families, the migration of one or both parents and parents' remarriage. All can result in adolescents having to live with their extended families where they often have to take on heavy workloads, lack support to continue their education and are frequently subjected to scolding and insults. In the Gaza case, there was the added vulnerability of displacement, and distress at living in mixed sex shelters in the immediate aftermath of the 2014 Gaza-Israeli conflict.

## Coping strategies

In all countries adolescent girls had developed strategies or ways of coping with psychosocial vulnerability. In Gaza and Sri Lanka, these ways of coping were also affected by gender, social norms and the economic backgrounds of the households. Adolescent girls tend to only have a limited **individual-level coping** repertoire. In Sri Lanka, adolescent respondents spoke of coping positively with psychosocial ill-being by drawing on their inner strength. Reading, painting, writing stories, using social media and daydreaming is common amongst adolescent girls in Gaza, while boys tend to do exercise, sport and hang out with friends. A negative coping strategy found largely amongst boys in Gaza was resorting to substance abuse. In all three study sites, turning to religion, spirituality or traditional healing was an important means of coping. **Family level support**, both nuclear and extended, was an important coping strategy in all countries. Aunts were frequently mentioned since they were often closer in age to the adolescent girls and were more able to understand the issues and challenges facing girls than their mothers. In the case of Liberia, family support has for some adolescents been especially important in the context of the Ebola epidemic. However, our study found, especially

in Liberia and Sri Lanka, that families are not always a positive coping source and can undermine adolescent girls' psychosocial wellbeing in very detrimental ways, including through violence and neglect.

At **community level**, or beyond the family/household, friends, teachers and formal service providers were also mentioned by respondents as being an important part of a girl's coping repertoires. In Sri Lanka, for instance, supportive teachers were critical to inspire girls, give them confidence and listen to their problems. And in Sri Lanka and Gaza either obtaining support from a caring social worker or involvement in psychosocial support programme, were also mentioned by adolescent girls as being an important part of their coping repertoires. Socialising and engaging in recreational activities were important coping strategies in all countries. In Liberia participation in the activities of the *Sande* and *Poro* societies, which provide education on gendered traditions, roles and responsibilities of adults to adolescents, as well as promoting a sense of discipline and morale was also mentioned, was mentioned. While some were of the view that these were increasingly outdated and could even be detrimental to psychosocial wellbeing, for others they provide a critical sense of social connectedness and belonging.

## Service provision

While a relatively well-established system of formal MHPSS service provision exists in both Gaza and Sri Lanka, in Liberia the system is still in a fledgling state. There are over 162 organisations providing psychosocial and related services in **Gaza**, but only two provide specialist services. The MoH is the main provider, supervisor and regulator of mental health services. It has recently begun a process of integrating mental health services into all its 54 primary health care centres. The United Nations Relief and Works Agency for Palestine Refugees (UNRWA) is the second major provider, delivering mental health and psychosocial services through counsellors based at UNRWA health and relief centres. In addition, there are many non-governmental organisations (NGOs) that provide psychosocial awareness and support through counsellors and social workers, but much of the support is short-term.

After the 2004 tsunami in **Sri Lanka** there was an expansion of MHPSS services with approximately 374 organizations providing services in tsunami affected districts. After the tsunami the government approved a new national ten-year (2005-2015) mental health policy that supported comprehensive, decentralised, community-based services; established the National Institute for Mental Health and a national strategy to reduce stigma and discrimination; and called for mental health legislation to protect the human rights of the mentally-ill. By 2011 20 out of 26 health districts had acute care units within general hospitals and mental health outreach clinics were established in sub-districts enabling people with mental illness to be treated close to their homes. Other ministries are also providing related services: the Ministry of Social Services has deployed over 100 Counselling Officers; the Ministry of Child Development and Women's Affairs has over 200 Counselling Assistants working at district and divisional level, as well as National Child Protection Authority-affiliated psychosocial personnel in nearly every district; the Ministry of Education has over 1400 teachers appointed as guidance and counselling teachers; finally, facilities for juvenile offenders and rehabilitation of girls and women survivors of violence also have personnel assigned to provide psychosocial care.

In **Liberia**, after the end of the protracted civil war in 2003, mental health services were limited to the Grant Hospital in Monrovia, and there were no specialised services for children and adolescents. Several NGOs and faith-based organisations were providing psychosocial services; some targeted women and children survivors of sexual and domestic violence, others women with HIV/AIDS. There was only one practising psychiatrist in the country. Given evidence of the need for such services, in 2009 the National Mental Health Policy (NMHP) came into existence, followed in 2010 by the Basic Package of Mental Health Services (BPMHS) and in 2011 the Ministry of Health and Social Welfare, introduced mental health as integral to its new Essential Package of Health Services. It projected that by the end of 2015, 181 mental health clinicians would be trained. Since 2010 the Carter Centre has been working closely with the government to build a sustainable mental health system able to meet the increased population needs. One-hundred and sixty mental health clinicians have been trained under this programme.

While there has been considerable progress over the last decade in strengthening MHPSS systems in the three case study countries, the extent to which they **provide tailored age and gender-sensitive services and programmes for adolescent girls** is extremely limited. In **Gaza**, our findings indicate that despite there being many MHPSS providers, organisational, cultural and psychological barriers often prevent young people accessing those services. In 'normal' and crisis situations alike, adolescents are not proactively targeted by service providers and are in fact often overlooked by these programmes, which often focus on younger children. Similarly, in **Sri Lanka**, although a wide range of MHPSS services exist in the study area, many are not oriented to deal specifically with adolescents. Important exceptions are the GBV desks at hospital facilities which provide psychosocial support to survivors of GBV – both minors and adults. Additionally respondents in Sri Lanka noted that there is a need for a stronger focus on social rather than medical interventions to better support the vulnerabilities of adolescents, including self-harm and suicide. In Liberia, while there are some health and social services type programmes that target adolescents, they vary widely in terms of quality and their ability to make an impact.

The extent to which services are gender-responsive was equally limited across the three country contexts. On the one hand, in **Gaza** most service providers were enthusiastic, caring and motivated to help their service users and respondents generally seemed moderately satisfied with the quality of services. On the other hand, some providers were found to adopt judgemental attitudes towards adolescent girls and some (male) health providers were reluctant to treat adolescent girls unless they were accompanied by a family member, thus undermining patient confidentiality, and/or because of their sympathy with community attitudes which stigmatise mental illness especially among females. Similarly in **Sri Lanka**, attitudes of service providers were also strongly impacted by gendered social norms, and notions of appropriate moral conduct of adolescent girls, with resulted in their primary concern being to address 'risks' and to provide 'protection' for these girls rather than deal with their psychosocial wellbeing.

Our research findings identified a number of important **gaps and disconnects** in terms of MHPSS provisioning. First, there are few preventive activities targeting adolescents or activities to identify vulnerable groups at greater risk of mental health problems. Second, there are significant issues in all three contexts regarding service fragmentation and poor quality of MHPSS. Third, there is limited overarching strategic direction for MHPSS, including a short-termist perspective and lack of systematic follow up mechanisms and procedures within the sector. Fourth, our findings also reveal a lack of evidence-based practice that could maximise the impact of mental health interventions; in particular, it is difficult to measure impact on beneficiaries or service users due to an absence of baseline data. Fifth, in all three contexts, there is a significant problem with under-resourcing in terms of budget and competent human resources.

A consistent theme in our research was the **negative role of community attitudes** towards mental health service uptake in general and to the uptake of services by adolescent girls in particular. We found strong evidence that mental health problems and psychosocial ill-being are associated with high levels of stigma and discrimination. In the **Gazan** context, most study participants felt there is still stigma attached to psychosocial and mental ill-health, and although multiple strategies have been developed to try to reduce it, they have largely proved ineffective, leaving families themselves to decide when and how to seek services – resulting often in delayed access to such services and only after consulting traditional healers. In addition, adolescent girls faced additional barriers related to social norms, especially around marriage, i.e. the older the girl is, the less likely she is to receive mental health services because the stigma that comes with doing so (i.e. risk of heritable mental illnesses passed on to offspring) could affect her reputation and her chances of marrying. Similarly in the **Sri Lankan** case, social norms also played an important role in hindering effective uptake of MHPSS by adolescent girls with social and religious priorities often overshadowing a girl's right to access appropriate support services. In the Muslim community, for instance, religious institutions play a crucial role in mediating in situations of sexual abuse and early pregnancy, with the typical response being to instruct the man to marry the adolescent girl. In **Liberia**, despite the training of mental health clinicians in child and adolescent services, their practices have largely focused on adults and those with serious mental illness. There is however some optimism that services may be built back 'better' post-Ebola given some positive stories of psychosocial support during the Ebola crisis and a realisation by government officials that such support is vital following the trauma of loss and acute uncertainty that much of the population suffered during the Ebola epidemic.

Although adolescent girls' psychosocial wellbeing is a complex multi-dimensional phenomenon cutting across multiple sectors, in practice the provisioning of relevant services remains **siloed both within and across sectors and is relatively poorly coordinated**. In **Gaza**, our findings indicate that there is limited coordination among psychosocial and mental health programmes. Similarly, systematic follow-up of referrals, feedback and exchange of information is rare. In **Liberia**, synergies across sectors remain largely elusive. In **Sri Lanka**, in terms of formal policy and institutional mechanisms there is a reasonable degree of vertical integration between the health, education and child protection sectors from community-based services to DS division, district and national level mechanisms, with children's and adolescent girls' protection and medical requirements given particular consideration. However, in practice, service providers highlighted that the priority given to cross-sectoral collaboration is generally low. In terms of horizontal linkages, there is considerable variation. While some NGO and bilateral agency-state programmes are of relatively long-term duration, most are of short duration. Collaborations or inter-sectoral linkages among NGOs working in different sectors such as livelihood support and child protection also seem to be relatively weak, with most organisations work independently at ground level, despite networking at district and national levels. The collaborative linkages that do exist are related to child protection, legal services, safe house accommodation, providing limited economic support to families in need and sharing resource persons for training programmes. Such support is often ad hoc or reactive, responding to situations after a crisis or incident.

## Policy and practice recommendations

We identified four broad areas for action that are cross-cutting yet can be adapted to country realities as follows:

*Actions that need to be taken to address psychosocial vulnerabilities facing adolescent girls and to enhance*

*their existing coping repertories and mitigate against negative coping responses*

- Enhance proactive identification of vulnerable groups, including adolescent girls and tailor activities
- Design programmes for conflict-affected families and those who have experienced GBV
- Train adolescents and their caregivers on basic coping strategies such as stress-reduction methods, seeking family/ friends' support, critical thinking skills, building competencies
- Provide low-resource psychosocial interventions for adolescents and their parents that address their socio-emotional health
- Encourage the use of social networks, including family and friend networks
- Proactively monitor and target vulnerable groups at risk of developing negative coping strategies
- Support initiatives to promote self-confidence, self-esteem and self-efficacy, key builders of resilience
- Build on the role of supportive teachers and invest in education as a means to develop self-esteem and self-efficacy
- Encourage caregivers to support their adolescent girls to take up services and programmes to address their psychosocial vulnerabilities
- Address issues of stigma that hinder access to psychosocial services through integration of services, media and education outreach and community mobilisation
- Develop and finance an inter-sectoral national agenda for adolescent well-being to guide policy and programming.

*Actions that need to be taken in order to strengthen the service environment*

- Strengthen service provider capacities, including vis-à-vis the following:
  - early detection of psychosocial ill-being and mental health illness disorders
  - treatment of mental health disorders, distinguishing them from suffering related to adversity
  - the importance of constructive dialogue with adolescents that helps them explore this transitional life stage
  - the psychosocial vulnerabilities as people go through the life cycle
  - addressing GBV providing services and supports to prevent substance use disorders
  - providing services and supports to treat addiction (alcohol and drugs especially)
  - implementing effective case management
- Provide on the job training in order to link with formal training to ensure that it is applied at facility level and that appropriate benchmarks can be developed
- Services should include a broad spectrum of activities, including those that promote productive engagement in social activities and safe recreational activities
- More investment is required to ensure proactive, integrated services:
  - in education, strengthen the quality of school psychosocial support and counselling services and protocols for responding to vulnerabilities and life-challenges faced by adolescents
  - in the justice sector, ensure police are adequately training on GBV and how to support survivors in the health sector.

*Actions required to enhance policy strategies, regulation and coordination*

- Strengthen coordination, regulation and integration of MHPSS
- Reinforce coordination among actors and programmes at community and sub-national services
- Promote exchange of information among service providers
- Strengthen the role of national institutions and ministries as the legitimate regulator of psychosocial services, including improved licensing and accreditation processes
- Build the capacity of the relevant national institutions/ government agencies to monitor trends and statistics in service provision to respond accordingly
- Promote greater evidence-informed programming including more robust data collection on adolescents' lives – e.g. dropouts, suicides
- Develop, cost and implement a national strategy for adolescent well-being focused on resilience
- Include a mapping process for psychosocial and mental health services and resources to better inform planning processes, including for better continuity of care
- Strengthen managerial capacities of mental health care providers through training on management approaches, staff motivation/performance, and strengthening case management approaches
- Move away from the short-term time horizons and invest in robust management systems, including monitoring and evaluation mechanisms and feedback loops
- Encourage external organisations to ensure that adolescents remain a target group in their programming and funding, particularly in contexts of fragility.

*Actions needed in terms of broader engagement with peace processes and conflict prevention*

- Take measures to address gender and sexual violence through broader community education programmes addressing stigma surrounding sexual violence and hyper-masculinities leaving women and girls vulnerable
- Raise the awareness of citizens and service providers about the provisioning under UN Security Resolution 1325 especially vis-à-vis young people and extend these provisions to fragile state contexts

- Engage with peace, reconciliation and transitional justice processes to ensure the specific needs of adolescents and especially adolescent girls are supported and thay they in turn are supported to participate in these processes, to strengthen efforts to build back better.

# 1 Introduction and study overview

This study explores the linkages between mental health and psychosocial wellbeing and social norms in the fragile and post-conflict settings of Gaza, Liberia and Sri Lanka. In particular, the study explored the extent to which services and other responses to mental health and psychosocial problems in these settings are sufficiently informed by a thorough understanding of the context (including but not limited to the type and nature of the conflict, existing infrastructure, quality and levels of staffing), as well as gender inequalities and dynamics, and social norms. The primary focus of the study was on service provision and response for adolescents, particularly adolescent girls, with the aim being to demonstrate that unless factors such as context, gender and social norms are taken into account, responses to strengthen human resources for health are likely to be inadequate and may even perpetuate discriminatory norms and practices underpinning health services facing adolescent girls.

Bringing these themes together and exploring the linkages, causal pathways and impacts of human resource deficits on adolescent girls' psychosocial wellbeing in post-conflict contexts is an area which has been relatively neglected. While there are large bodies of work in some of these areas – for example, on mental health and psychosocial stress and problems in post-conflict situations, including needs assessments and responses – these tend to remain discrete areas of exploration. Linking these themes and focusing specifically on adolescence is an innovative and much-needed approach and findings from this study can help inform programmers, service-deliverers and policy-makers on culturally and gender-appropriate approaches and human resourcing for responding to mental health and psychosocial problems in post-conflict settings, particularly in relation to addressing the specific needs of adolescent girls.

## Why adolescents and in particular adolescent girls?

Although there are some variations in definitions and meanings, the United Nations defines adolescence as between 10-19 years of age (UNICEF, 2011). It is the period when girls and boys start experiencing physical changes, when they move from childhood to adult roles, such as spouses, parents, workers or citizens, and when the role and influence of gender norms strengthens (Levine et al., 2009; Jones at al. 2010; UNICEF, 2011). It is also during this period that health, social behaviours and attitudes, physical and neurological development and social, educational and work skills attainment are all decisive development and learning acquisitions. In short, this life stage is an extremely influential period in the life-cycle and is critical in determining life-course potential.

For many girls and young women, this key period remains one of deprivation, danger and vulnerability, resulting in a significant lack of agency and critical development deficits, often with life-course consequences. More than 100 million girls are expected to marry between 2005 and 2015 (Clark, 2004). Girls under 20 giving birth face double the risk of dying in childbirth compared with women over 20, and girls under 15 are five times as likely to die as those in their 20s (UNFPA, 2003). This leads to 60,000 to 70,000 girls aged 15-19 dying from complications of pregnancy and childbirth every year (WHO, 2008d, in Temin et al., 2010). Meanwhile, it is estimated that more than 130 million girls and women alive today have undergone female genital mutilation (FGM) or cutting (FGC) (hereafter referred to as FGM/C), mainly in Africa and some Middle Eastern countries. Moreover, young women are particularly vulnerable to coerced sex and are increasingly being infected with HIV and AIDS. Over half of new HIV infections worldwide are occurring among young people between the ages of 15 and 24, and more than 60% of HIV-positive youth in this age bracket are female (UNIFEM, 2010).

Adolescence and, in turn, pathways beyond are also deeply influenced by a number of contextual and societal factors including socio-cultural laws, norms and practices that govern behaviours and attitudes, as well as the external environment. In this study, the external environment is one of fragility and post-conflict in which a country, households and individuals are recovering or continuing to deal with a range of aggressors including violence, disruption, displacement, and loss of livelihoods to name but a few. In terms of social norms affecting adolescent girls, in many societies norms around gender

1 For more information and further examples see: www.chronicpoverty.org/publications/details/stemming-girls-chronic-poverty

often have negative outcomes for girls, particularly when families are affected by external shocks and stresses. For example, girls may be taken out of education, forced into early marriages and their mobility may become restricted in order to cope with a reduced or lack of income resulting from loss of livelihoods.[1] All of these norms tend to undermine the personal development of girls, they affect their opportunities to participate in social networks, further education and/or vocational training opportunities, and civic or political activities related to the governance and social development of their communities more generally (Jones et al., 2010).

## Organisation of the report

In Section 2 we begin by providing an overview of the literature on global mental health, poverty and inequality in developing and conflict-affected contexts. Informed by the literature, we then in Section 3 present our conceptual framework and in Section 4 describe our methodology and provide a brief description of the study sites. In Section 5 we review the specific country contexts in order to contextualise our primary research findings. Section 6 discusses psychosocial vulnerabilities of adolescent girls following our conceptual framework, starting with a brief overview of what marks adolescence in these different contexts. Section 7 explores the coping repertoires for dealing with gendered psychosocial vulnerabilities while Section 8 discusses the service environment – both formal and informal – highlighting both strengths and weaknesses. We conclude in Section 9 and present four broad sets of recommendations in terms of policy and practice actions.

**Sri Lankan school class, Lankatilake Temple**

# 2 Engaging with the literature

## 2.1 Conceptualising mental health

Mental health has been recognised as an integral part of broader definitions of health (see e.g. WHO, 2001), where mental health is not equated simply as the absence of mental disorder, but includes subjective wellbeing, self-efficiency, autonomy, competence, and realisation of one's potential. However, it was not until the 2001 World Health Organisation (WHO) flagship report that mental health started to attract some attention. This report raised awareness of the real burden of mental disorders and their costs, as well as the barriers which prevented people from receiving treatment, including stigma, discrimination and inadequate services. The report recommended the integration of mental health services into regular/ routine health services, particularly primary care, as well as the establishment of appropriate national legislation, policies and programmes. It also pointed out that in most parts of the world mental health was largely neglected or ignored. This neglect and treatment gap along with population ageing, worsening social problems and conflict were resulting in the increasing burden of mental disorder (WHO, 2001).

In addition to human suffering, mental illness has negative effects on development and economic growth: it often worsens poverty for affected individuals and families, increases inequality, reduces social capital, and hinders growth (WHO, 2010). Based on national mental health survey data from 10 developed and 9 developing countries, Levinson et al. (2010) estimated that between 0.3% and 0.8% of total national earnings are lost due to serious mental illness and related productivity loss. More recently, it was predicted that over the next two decades mental illness will account for the largest proportion (35%) of global economic losses from non-communicable diseases; in absolute terms, this means that the economic toll of mental illness will be over $16 trillion, of which $9 trillion is in developed and $7.3 trillion in developing countries (Bloom et al., 2011).

More broadly, the relationship between mental health and poverty is complex and multidimensional. Poverty and associated conditions such as low education, unemployment and homelessness have been identified as risk factors for mental illness. A review of the effects of mental health interventions on individual and household economic outcomes in developing countries confirmed the positive link between mental health and economic status (Lund et al., 2011). A range of other studies in low, middle and high-income contexts also confirm the link between common mental disorders and poverty and low socio-economic status (Patel et al., 1999; Patel and Kleinman, 2003). Nevertheless, causal pathways are not clear (see e.g. Das et al., 2007; 2008) and mental health problems in the developing world are likely to result from several contributory factors including, importantly, the country context and, particularly if it is fragile, a conflict-affected or post-conflict context.

It is generally accepted that exposure to violence, death and stressful living conditions including food shortage, disease outbreaks, displacement, disrupted support networks and weakened infrastructure increase the risk of mental health problems. Accordingly, mental health problems are widespread in conflict-affected contexts with between a third and a half of all affected people estimated to suffer from distress. The most frequently made diagnosis is post-traumatic stress disorder (PTSD), which is characterised by intrusive memories, avoidance of circumstances associated with the stressor, sleep disturbances, and lack of concentration (WHO, 2001). A systematic review of 181 studies of adults exposed to conflict and displacement found that more than 30% suffered from both depression and PTSD (Steel et al., 2007 cited in Reed et al., 2012). Conflict contexts also exacerbate sexual violence, largely directed against women and girls and used systematically as a weapon to terrorise and control civilian populations. In the post-conflict period, high levels of violence continue due to the normalisation of violence, availability of weapons and a culture of impunity. As discussed below, sexual violence is a risk factor for mental illness among women and girls. Another reason for the persistence of (both sexual and domestic) violence is related to male inability to live up to traditional gendered norms and subsequent frustration and aggression (Baksh et al., 2005).

Despite its significance for the overall wellbeing of individuals and societies, mental health has been largely neglected or even ignored in many developing countries (WHO, 2001), while it has also been absent from the Millennium Development Goals (MDGs) and other development-related health agendas (Samman and

Rodriguez-Takeuchi, 2013). Nevertheless, WHO has estimated that over 75% of the global burden of disability attributable to depressive disorders occurs in developing countries (WHO, 2008). In many developing countries mental health issues tend to be of low policy priority and relevant legislation is either absent or outdated. Moreover, funding is typically scarce, resulting in limited services being provided through a few centralised institutions, compounded by inadequate training of professional staff and low public awareness and understanding – especially in rural communities where many people resort to traditional healers. Equally concerning, stigma and discrimination continue to be widespread and to contribute to poor outcomes (WHO, 20011).

Indicative of the situation is that only 36% of people living in low-income countries are covered by mental health legislation (compared to 92% in high-income countries), that average annual mental health expenditure is less than 25 US cents per person (WHO, 2011), and that 'the number of psychiatrists serving the entire continent of Africa with a population of almost a billion is less than that practicing in the US state of Massachusetts with a population of less than 7 million' (Patel et al., 2013). In addition, there is a lack of scientific research on mental health issues in many developing countries, despite the need for context-specific research and culturally appropriate tools in order to inform effective mental health policy, planning and interventions (Sharan et al., 2007).

## 2.2 Mental health and gender

Although the overall prevalence of mental disorders is similar among men and women, anxiety and depressive disorders are more common among women, while substance use disorders are more common among men. Reported depression rates are almost always twice as common in women as in men, while lifetime prevalence rates of alcohol dependence are 20% for men but 8% for women (WHO, nd). Co-morbidity, the co-occurrence of anxiety, depressive and somatoform disorders, is also more common among women. Women also report a higher number of symptoms, and have higher rates of help-seeking behaviour and of prescribed psychotropic medicines. Substance use disorders are rapidly increasing among women, while men have higher suicide rates (WHO, 2001).

Several reasons have been put forward to explain these gender differences, and although the exact causal pathways are still debated, the complex interaction of several biological and social factors is accepted (Patel and Kleinman, 2003). Initially under the influence of Freud and the emphasis on endogenous processes, research has largely focused on the individual and biological factors and particularly on the causal relationship between women's reproductive functions and their mental health. Within this framework, the premenstrual syndrome, postpartum depression and menopause disorders attracted most attention. Yet research has gradually turned to the social factors that shape women's lives and explored the negative contribution of gender inequality, unemployment or work overload, poverty, lack of social support, and limited power and personal control; it also highlighted the role of domestic and sexual violence that disproportionately affects women (Dennerstein et al., 1993; WHO, 2000).

In this vein, studies have identified low-income single mothers and elderly women in industrialised societies as vulnerable to high and persistent stress imposed by chronic conditions of deprivation and discrimination (Dennerstein et al., 1993; WHO, 2000). Data from China also shows that suicide is the fifth leading cause of death in the country overall along with injuries, poisoning and falls, and it is the leading cause of death for young women (WHO, 2009). Analyses of data from a few developing countries also found strong linkages between women, low education, poverty and mental disorders (Patel et al., 1999). Additionally, recent evidence shows that, compared to the global average suicide rates, average rates in South Asia are higher, with the problem being generally more pronounced among men, but particularly severe among women in the 15-29 year age group, where several sources find it to be the leading cause of death; rates are especially high in Bangladesh, India and Sri Lanka (Jordans et al., 2014; Patel, 2012).

Likewise, a systematic review of studies about perinatal mental disorders in low- and lower-middle income countries also concluded that contributory factors include poverty and poor physical health; poor relationships with partners and exposure to domestic violence; limited family support; lack of close relationships; limited control and participation in decision-making over financial and reproductive health issues; and adverse life events such as economic difficulties or unwanted pregnancy. It also found that the prevalence of such disorders was highest among women with the highest social and economic disadvantage, and particularly those living in crowded households in rural areas with unequal gender norms (Fisher et al., 2012).

One of the topics that increasingly attracts attention is maternal mental health due to the established effects it has on child emotional development, intellectual competence, psychosocial functioning and mental morbidity. A number of studies from developing countries have found that the prevalence of maternal mental disorders is significantly higher in these countries, with between 18% and 25% of pregnant women and first-year mothers experiencing significant mental health problems, most often depression and anxiety. These studies also found that maternal mental disorders not only impact on infant psychosocial development but also result in low birth weight, reduced growth, malnutrition and lower immunisation (Rahman et al., 2013). This issue is also particularly important for adolescent girls given high rates of adolescent pregnancies in many developing countries.

Moreover, research has also provided clear evidence of the association between female depression and violence:

data from the WHO multi-country study on women's health and domestic violence against women show that women who experienced such violence at least once in their life reported significantly more emotional distress and suicidal thoughts and attempts compared to non-abused women (Ellsberg et al., 2008). A recent systematic review of such studies has also concluded that intimate partner violence is strongly linked to depressive symptoms and suicidal behaviour for women in both developed and developing countries (Devries et al., 2013).

In addition, it has to be noted that women are also those who traditionally bear the brunt of care for family members with mental health problems (WHO, 2001), an issue whose consequences on women's own mental health has not been adequately researched so far.

## 2.3 Mental health and adolescence

The majority of mental health problems begin during adolescence and continue into adulthood if not appropriately treated (WHO, 2007), with 10%-20% of children and adolescents experiencing mental health problems (Kieling et al., 2011). Suicide rates are increasing, with young people now being the group at highest risk of suicide in a third of countries, both developed and developing (WHO, 2007); suicide is in fact a leading cause of death among young people (15-19) in China, India and in South East Asia more generally (Patel et al., 2007; WHO, 2014). Apart from mortality and morbidity, mental health problems have other negative consequences for young people such as lower educational achievements, substance abuse, violence, and poor reproductive and sexual health. However, adolescent mental health needs are neglected and unmet, particularly in developing countries where the vast majority (nearly 90%) of the global population of children and adolescents live. The reasons include lack of government policy, inadequate funding, shortage of professionals, low capacity of non-specialist health workers and the stigma attached to mental illness (Patel et al., 2007; Kieling et al., 2011). The 66-country WHO project Atlas encountered considerable difficulty finding relevant information largely due to lack of services, absence of a national focal point for child and adolescent mental health services, fragmentation in the service systems and lack of appropriate systems for data collection. Funding as part of the national budget for such services was rare and out of pocket expenditures for child mental health services was 71.4% in African countries compared to 12.5% in European countries (WHO, 2005). Yet, the WHO Mental Health Gap Action Programme Intervention Guide has included methods to assess and manage disorders in children and youth along with guidelines for family, teachers' training and community-based intervention (Kieling et al., 2011).

The cause of mental health problems in children and young people is multifactorial, with several identified contributory biological, psychological and social factors, as shown in Table 1.

**School girls, Liberia**

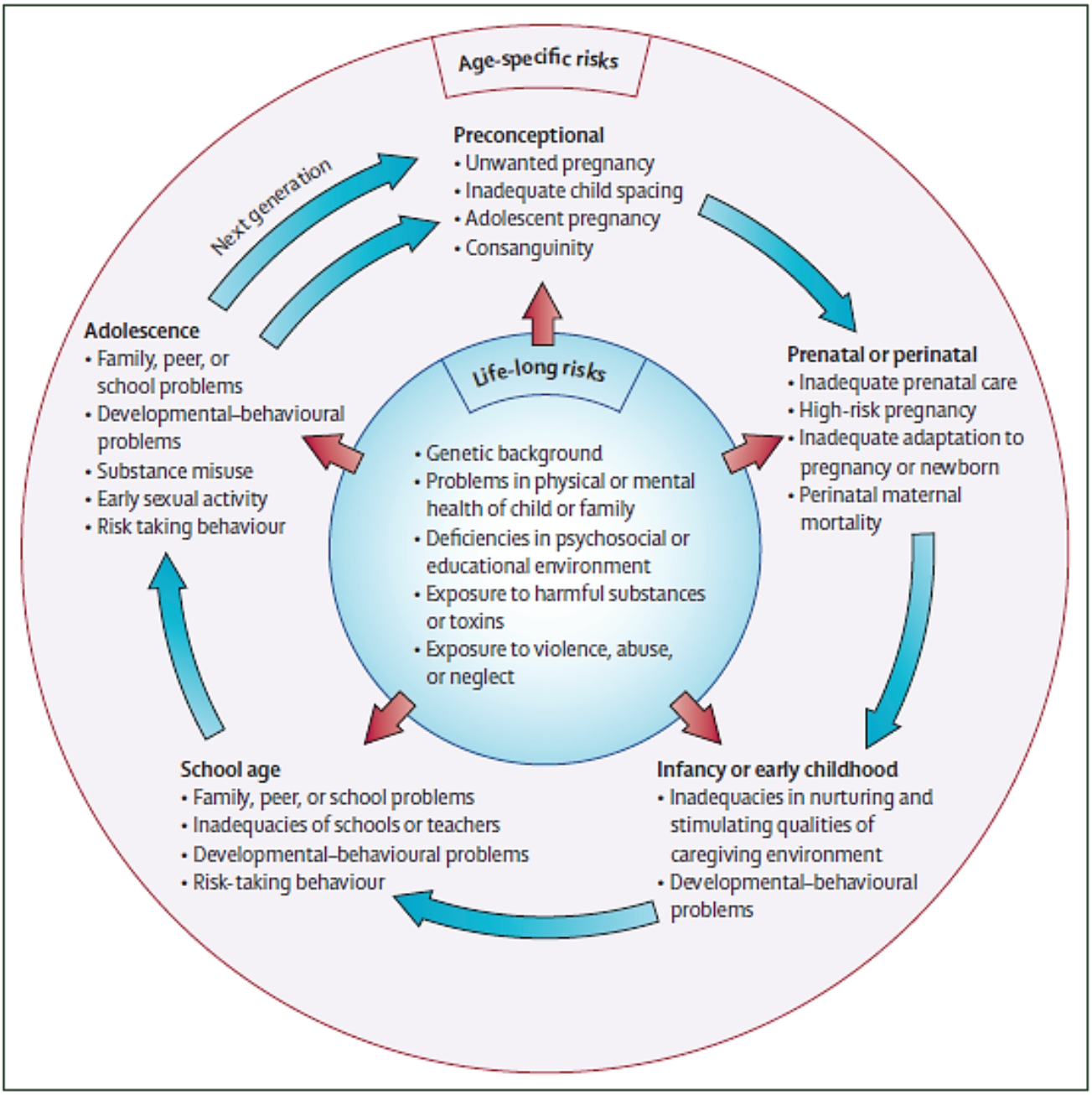
**Table 1: Selected risk and protective factors for child and adolescent mental health**

| | Risk factors | Protective factors |
|---|---|---|
| **Biological** | | |
| | Exposure to toxins (e.g. tobacco, alcohol) in pregnancy | Age-appropriate physical development |
| | Genetic tendency to psychiatric disorder | Good physical health |
| | Head trauma | Good intellectual functioning |
| | Hypoxia at birth and other birth complications | |
| | HIV infection | |
| | Malnutrition | |
| | Substance abuse | |
| | Other illnesses | |
| **Psychological** | | |
| | Learning disorders | Abulity to learn from experiences |
| | Maladaptive personality traits | Good self-esteem |
| | Sexual, physical, emotional abuse and neglect | High level of problem-solving ability |
| | Difficult temperament | Social skills |
| **Social** | | |
| Family | Inconsistent care-giving | Family attachment |
| | Family conflict | Opportunities for positive involvement in family |
| | Poor family discipline | Rewards for involvement in family |
| | Poor family management | |
| | Death of a family member | |
| School | Academic failure | Opportunities for involvement in school life |
| | Failure of schools to provide appropriate environment to support attendance and learning inadequate or inappropriate provision of education | Positive reinforcement from academic achievement |
| | Bullying | Identity with school or need for educational attainment |
| Community | Transitions (e.g. urbanisation) | Connectedness to community |
| | Community disorganisation | Opportunities for leisure |
| | Discrimination and marginalisation | Positive cultural experiences |
| | Exposure to violence | Positive role models |
| | | Rewards for community involvement |
| | | Connection with community organisations |

*Source: Patel et al. (2007)*

Particular identified social factors include: rapid social change, migration, social isolation, unemployment and poverty, increasing social pressures to perform well, peer pressure, individual and family crises, changes in traditional values and conflict with parents (Patel et al., 2007; WHO, 2010). An alternative lifecycle approach (see Figure 1) has also recognised as risk factors genetic background, physical health and nutrition problems, maternal depression and lack of psychosocial stimulation, carer loss, deficiencies in the psychosocial environment, exposure to toxins, violence and conflict, migration or forced displacement, gender inequality, abuse or neglect (Kieling et al., 2011). Using a lifecycle approach, studies also found that behaviour problems at 7 years of age are related to poorer educational attainment at 16 and poorer employment outcomes at 22 and 33 years of age (WHO, 2010).

**Figure 1: The lifecycle approach to risk factors for mental disorders**




*Source: Kieling et al. (2011)*

Research has also focused on protective factors. Longitudinal studies in various settings found that factors such as a sense of connection, low levels of conflict and an environment encouraging expression of emotions and providing support offer protection against the development of mental disorders (Patel et al., 2007).

Conflict and post-conflict situations can be particularly stressful for children and adolescents. While adolescence is an already stressful phase in human development in which people develop their sense of self-identity and decide on their future as adults, in conflict/post-conflict situations, children and adolescents may also face the traumatising impact of direct exposure to violence as well as stressful living conditions. Thus this transitional period becomes even more difficult with children and adolescents not only missing education, economic and social opportunities, but many being exposed to violence, losing their parents, being abused, abducted or forced to get involved in fighting (Boyden and de Berry, 2004). As mentioned above, girls and young women are particularly vulnerable to sexual violence and abuse. All this can lead to serious mental health and emotional consequences, changing the ways

adolescents see themselves, relate to each other and think of their future. Some evidence even indicates that adolescent girls are up to six times more likely than their male counterparts to develop PTSD symptoms, despite the fact that the latter report more exposure to violence (Springer and Padgett, 2000).

## 2.4 Advances in mental health services for children and young people

Over the past 25 years treatments for mental disorders in young people have improved and include several forms of psychosocial interventions which focus on the individual, family or group with encouraging results (Patel et al., 2007). Various school-based programmes to prevent mental health problems also seem to have positive outcomes (Kieling et al., 2011). However more generally, in many developing countries there is limited availability of child and particularly adolescent mental health services available, especially in rural or disadvantaged areas, with adolescence being directed either to child or adult services that focus on younger and older patients respectively and are thus unable to effectively address their needs (Patel et al., 2007).

While many studies of young people exposed to conflict indeed found high levels of depressive symptoms and emotional distress, research also confirmed child resilience and identified several protective factors even in the case of children involved in fighting. These factors include family and in particular parental support, community acceptance, relationships with peers, educational opportunities and restoring a sense of normality in a child's life (Betancourt et al., 2013; Bragin, 2005; Kryger and Lindgren, 2011; Kalksma-Van Lith, 2007; Tol et al., 2013).

Since 1996, when the ground-breaking Machel study on the needs of children affected by armed conflict recommended that psychosocial considerations should be taken into account at all phases of emergency and reconstruction assistance programmes, and that instead of separate mental health programmes, culturally relevant programmes should be established as part of relief and development programmes (Bragin, 2005), a range of clinical and psychosocial interventions have been used. These include the creation of child-friendly spaces (de Winter, 2007), youth clubs, recreational activities, and even training teachers on subjects such as the impact of loss and stress on children (Kalksma-Van Lith, 2007).

# 3 Conceptual framework

Although initially neglected in the largely humanitarian responses to conflict and post-conflict situations, evidence from the late 1980s onwards began showing that conflict, displacement and associated conditions not only caused mental health problems such as anxiety, depression and PTSD, but exacerbated pre-existing ones. Further, severe and far-reaching psychological and social stressors arising from conflict can result in reduced resilience in the face of adversity, even when symptoms of specific mental illness are not diagnosed (Bragin, 2014; Ward, 2006, Wessells, 2008). Similarly, neglecting these issues was shown to undermine the effectiveness of all other interventions in the post-conflict context. Thus, over the past two decades the impact of conflict or disaster on the mental health and wellbeing of affected populations has been increasingly acknowledged by the humanitarian community and has led to the emergence of the mental health and psychosocial support (MHPSS) sector. The turning point was, arguably, the 2004 tsunami which brought to global attention 'the enormity of suffering associated with psychological anguish, social disruptions and forced life transformations' caused by the disaster (Wessells and van Ommeren, 2008 in UNHCR, 2013) and established the need to systematically address the mental health needs of those affected by conflict or natural disaster. This recognition led to an increasing number of activities developed by humanitarian and international development organisations addressing both individual mental distress (taking more of a clinical/psychiatric approach) and psychosocial issues at community level (taking a more resilience-focused approach) (UNHCR, 2013; Stavropoulou and Samuels, 2015).

Thus, ways of framing and developing interventions within the MHPSS have varied, ranging between more medicalised approaches to those focusing on resilience at community level, with the establishment of the Psychosocial Working Group (PWG) also advancing these debates. Linked to this, a number of conceptual frameworks have emerged, including the one developed by the PWG which focused on three key resource areas affected by conflict: human capacity (physical and mental health, knowledge and skills of an individual); social ecology (social relationships that enable people to function as a community, social capital); and culture and values of the community (Strang and Ager, 2003). This was then modified to include a fourth component – the material and physical situation or material wellbeing dimensions that people found themselves in – as this was also seen to be critical in affecting psychosocial related outcomes and interventions (Galappatti, 2003).

Taking these approaches, but also broadening out the debate to one of wellbeing (White, 2009), the Wellbeing in Developing Countries Research Group,[2] drawing also on the Psychosocial Assessment of Development and Humanitarian Interventions (PADHI) wellbeing framework,[3] identified seven domains or pathways to wellbeing: (1) access to resources; (2) building social connections; (3) sustaining close relationships; (4) exercising participation/agency; (5) experiencing self-worth; (6) enjoying spiritual wellbeing; (7) enhancing physical and mental wellness and security. Our study uses these seven domains as a starting point through which to explore adolescents' perceptions of wellbeing. These perceptions are teased out from speaking both to adolescent girls and boys, but also to people around them, including their parents, grandparents, other community elders and key informants.

Where our approach adds particular value is in the application of a social norms lens to these frameworks. In particular, we draw on findings from a multi-country (Ethiopia, Nepal, Uganda, Vietnam), multi-year body of work exploring how gendered social norms affect the life choices and options of adolescent girls.[4] In line with some of the framing above, we argue that social norms affect all domains of life including issues related to education, marriage, access to (economic) resources, health and wellbeing and in civic participation (agency and voice). By superimposing a social norms lens, we argue it helps both to contextualise and understand the various pathways to wellbeing over the course of gendered adolescence, the kinds of challenges and barriers that adolescent girls (and boys) face in trying to achieve them, and similarly the kinds of approaches and interventions that may be necessary in order to address these barriers and challenges. In this regard, we pay particular attention to the role of

2 See www.welldev.org.uk.

3 PADHI was set up in 2006 as a two-year programme under the Social Policy Analysis and Research Centre (SPARC) affiliated to the University of Colombo. See PADHI (2009).

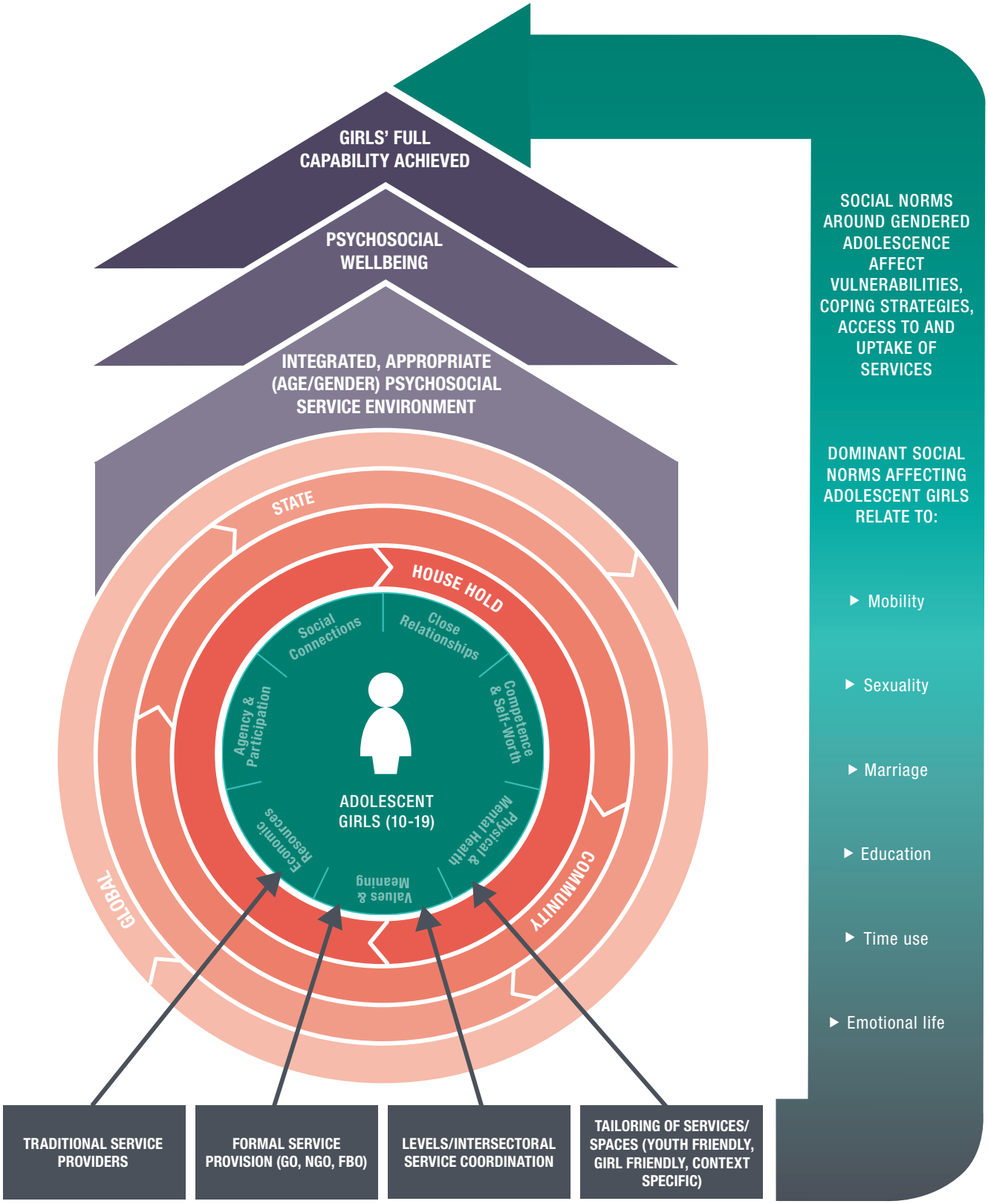
4 See www.odi.org/projects/2590-discrimination-social-institutions-girls-young-women-adolescence.

'reference groups' or 'gatekeepers' and the role they play in upholding and reinforcing gendered norms, and in turn the critical importance of engaging with such groups if transformational norm change is to be achieved.

As can be seen in figure 2, adolescent girls are placed at the centre, surrounded by key wellbeing domains. The girls themselves are then situated within their households or families, their communities and the state – which in this case is characterised by fragility, either related to ongoing conflict or post-conflict dynamics or other crisis triggers (e.g. Ebola in Liberia or the tsunami in Sri Lanka). These different layers are in turn influenced to varying extents by a changing global context, including global trends and learning with regard to adolescent programming and MHPSS programming.

The service environment plays a key role in girls' ability to achieve psychosocial wellbeing. In order for this service environment to be effective, it needs to take into account and tailor services towards the specific needs of adolescent girls, including informing service provisioning with an understanding of intersectionality (e.g. the intersection of ethnicity and gender – a dynamic of particular significance in Liberia and Sri Lanka) and integrating a mix of formal (including government {GO}, non-governmental {NGO} and faith-based providers {FBO}) and informal providers and services. Such providers must be supported with the resources to enable them to become competent and that these same people receive regular supportive supervision, education and training. As importantly, girls' vulnerabilities', their access and uptake of services and their ability to cope and reach their full potential are all influenced by contextually specific social norms around adolescence. These include norms around mobility, sexuality, marriage and education. Thus, we argue, only where services are appropriately integrated and targeted towards adolescents girls will their psychosocial wellbeing be achieved which will ultimately enable them to reach their full human capabilities.

**Figure 2: Pathways towards adolescent girls' psychosocial and broader wellbeing**



# 4 Methodology

## 4.1 Overarching research questions and objectives

The overarching research question explored is whether current services for dealing with mental health and psychosocial problems experienced by adolescent girls in post-conflict settings are sufficiently informed by context, gender and social norms. A set of sub-questions includes the following:

- What formal approaches/responses are available for dealing with mental health and psychosocial stresses and what paradigms do the practitioners working in these services adopt?
  - To what extent are they informed by a gender perspective? By socio-cultural specificities?
  - How does the supply of mental health/psychosocial services (and failures to prioritise these aspects) in post-conflict contexts affect the experiences of adolescents in dealing with psychosocial problems?
- What mental health and psychosocial problems do adolescent girls face in post-conflict settings?
- How do the perceptions of these by stakeholders (i.e. service providers, community members, family and girls themselves) affect both formal and informal responses?
- How are/were adolescent girls affected by the conflict?
  - Variations according to age, sex, residential location, household size, rural vs. urban, rich vs. poor, occupation just prior to, during and after conflict (e.g. girls and boys who were child soldiers, people who left during the conflict, came back)
  - Short-term vs. long-term effects
  - What were the common or significant pathways to impact? (i.e. maternal loss leading to new vulnerabilities, etc.)
- How were relationships within the family/household and broader community affected by the conflict?
  - Have intra-household roles and responsibilities shifted? If so, in what ways?
  - Have social norms particularly for girls and women (around education, marriage, divorce, pregnancy, children birth, economic activity, expected behaviours) changed/adapted? How are these changes perceived by different kinds of people – men, women, girls, boys?
  - Trust, belonging, social capital (has it been built post the conflict and how? What is the nature of the social capital now? Are different groups/families better able to access/build social capital than others?)
- What informal coping strategies are adolescents and their communities adopting to deal with mental health and psychosocial problems?
  - Which are promising/adaptive? Which are potentially negative/risky?
- To what extent have service providers and practitioners been kept abreast of such changes? What sorts of capacity-building opportunities have they been offered, if any? What are the key gaps in their training and approaches?
- How could formal approaches for providing support or promoting wellbeing be strengthened and tailored to take into account longer term psychosocial needs of adolescent girls in post-conflict settings and the gaps that need to be bridged in current human resourcing?

A set of objectives, also mirroring the research questions, include the following:

- To identify existing formal responses (including levels of staffing, capacity-building approaches and modalities for staff) for dealing with mental health and psychosocial problems.
- To explore the mental health and psychosocial problems experienced by adolescents in post-conflict settings, especially those resulting from sexual and gender-based violence (SGBV) and conflict impacts.
- To explore how social norms and family and community structures in post-conflict contexts impact on the gendered wellbeing and vulnerability of adolescents.
- To explore formal and informal coping mechanisms among adolescents and their communities for dealing with psychosocial problems (especially those resulting from SGBV and conflict impacts).
- To provide recommendations on culturally and gender appropriate approaches for responding to mental health and psychosocial needs of adolescents, especially girls, in post-conflict settings, with a particular emphasis on human resource needs.

## 4.2 Study design

The study design was comprised of three main components as follows:

### Secondary literature review

In order to situate and contextualise the study within broader debates around adolescence, post-conflict and mental health and psychosocial support services, a literature review was commissioned. Drawing on global

literature as well as country specific literature,[5] this review helped to identify existing gaps in the evidence base as well as how to frame the current study. Some of the earlier sections of this report draw on this literature review (Stavropoulou and Samuels, 2015).

### Quantitative analysis of secondary data sources

In addition to this global and country specific literature review, analysis of existing data sets with a specific focus on Liberia and Sri Lanka (Dasandi et al, 2015) was commissioned in order to explore quantitatively the impacts of the conflicts on health more generally and on the provision of health services. Data sets explored included: the Uppsala Conflict Data Program's Georeferenced Event Dataset; the Social Conflict in Africa Database; the IMF Government Finance Statistics; the Demographic and Health Surveys (DHS) for Liberia and Sri Lanka; and Data Collections including the World Development Indicators dataset collection and Google Public Data. In the end, only the latter two data collections were used; the others were found to be unreliable, did not have data for the countries in question and the years in question and/or the research team was not allowed access to the latest round of DHS (in the case of Sri Lanka, thus making it difficult to compare results with Liberia).

### Primary qualitative data collection

Complementing the secondary literature review and quantitative analysis, was our primary qualitative data collection in three conflict-affected contexts. Following the completion of draft research instruments developed in a participatory write-shop with the country teams, the research proposal and instruments were reviewed by the ODI research ethics committee as well as relevant national research ethics boards in our partner countries.

Two rounds of data collection were initially envisaged to take place in Sri Lanka and Liberia, with the second round going into further depth on issues not covered in the first. Given the unfolding Ebola situation in Liberia at the time of the study it was decided to discontinue work there and select another country in which to carry out the research. Gaza was selected for a number of reasons: given the longevity of the conflict there, as well as its off-and-on nature, psychosocial issues are emerging as an area where more research and related responses are required; related to this, with relatively large amounts of funding going into Gaza, findings from this study could potentially influence and direct the funding to this somewhat neglected response area; the Overseas Development Institute research team had already carried out a number of research projects in Gaza (e.g. on children, social protection) which formed a solid knowledge base for the current research; finally, it was felt that adding Gaza would complement the Sri Lankan and Liberian case studies, adding a Middle Eastern dimension to the study. Gaza also represents an important location wherein to study mental health since the population faces complex compounding psychosocial vulnerabilities which result from over-population, political turmoil, chronic exposure to conflict, economic hardship and strict conservative social norms.

With the emergency situation in Liberia being lifted and the Ebola situation coming under control, it was decided to go back and do a rapid mapping of the psychosocial support environment within the context of a country dealing with the Ebola response.

In the first phase of data collection, the main objective was to map adolescent and adult perceptions of well-being and factors that have an impact on adolescent well-being. In the second phase (also building on the first phase in Sri Lanka), the focus was more on the service environment and exploring how sensitive MHPSS services were to adolescents' needs, particularly those of girls, and how services could to be improved.

### Data collection instruments

A range of qualitative tools were used in the fieldwork, including in-depth interviews, key informant interviews, focus group discussions and intergenerational trios.[6] Visual techniques were included in some of the focus group discussions (FGDs) including the use of community timelines and mapping exercises; participatory photography, where adolescent girls were taught to use cameras and then tell their stories through photographs, was also conducted in Sri Lanka[7]. In Gaza and in the second round of fieldwork in Sri Lanka, a mapping of mental health and psychosocial services was also carried out alongside a Health Facility Checklist to assess the appropriateness of the mental health and psychosocial services provided at facilities and to identify gaps in human resources, equipment, and other resources at the facilities. All data collection instruments can be found in a separate document on the study site[8].

Interviewees included adolescents, both boys and girls, between the ages of 10-19. A sub-set of the adolescents (especially in Gaza) were also MHPSS service users. Family members of these adolescents were also interviewed including

5 For Liberia and Sri Lanka only since this was commissioned before the inclusion of Gaza.

6 Where a grandmother/grandfather, mother/father and daughter/son are interviewed, either individually or in pairs, to obtain information about change across the generations. For further informatino seehttp://www.odi.org/publications/9817-doing-qualitative-field-research-gender-norms-adolescent-girls-their-families

7 A selection of the photographs is available on line at http://www.odi.org/projects/2728-adolescent-girls-mental-health-psychosocial-liberia-sri-lanka

8 http://www.odi.org/projects/2728-adolescent-girls-mental-health-psychosocial-liberia-sri-lanka

parents, grandparents, siblings and other caregivers. Other key members of the community who took part in the study include community elders (also to provide a longer-term perspective of the conflict) and youth leaders. Government and non-governmental service providers who provide mental health and psychosocial services as well as services in other sectors (e.g. education, running a girls' home) at different levels (community/local, district and central) were also interviewed. All names used are pseudonyms.

In terms of respondent numbers, in Sri Lanka during the first round of data collection a total of 60 adolescents and 65 adults were interviewed across the two locations. The second round of data collection involved 11 key informant interviews (with adults), two FGDs with service providers, five facility checklists and one workshop where the mapping of services was done. In Gaza, a total of 56 adolescents were interviewed (12 of whom were MHPSS service users), 33 adults, 5 facility checklists and a mapping exercise was carried out.[9] In Liberia in-depth interviews were conducted with a total of 13 adults (6 care givers and 7 service providers) and 27 adolescents (18 girls and 9 boys), with a further 9 FGDs conducted with adolescents.

### Study limitations

The absence of baseline data prior to conflict episodes made it difficult to attribute the study findings to the consequences of the conflict and/or to confirm the outcomes of the mental health and psychosocial services provided to adolescent girls. In addition, it was challenging to recruit service users of mental health institutions because of confidentiality requirements and their psychological status, which restricted their ability to interact with data collectors.

Given that we emphasise the importance of context specificity, different research teams gave different emphasis to the various study components as appropriate to their settings. For example in Liberia there is more of a focus on mental health and psychosocial support for sexual violence, which reflects the way the fledging sector has emerged.

## 4.3 Description of study sites

### Sri Lanka

Phase one was carried out in two villages: Diyagama[10] in the Polonnaruwa District, North Central Province, and Kadalkiramam [11] in the Batticaloa District, Eastern Province, in December 2013 and January 2014. These locations were purposively selected as post-war communities and because the communities had pre-existing relationships with community organisations who could support the research process as well as follow up any serious concerns that came out through the research in terms of security and risks for the participating adolescents. In terms of development indicators, according to the Sri Lanka Human Development Report 2012, Batticaloa District is among the three lowest ranked districts in the Human Development Index and the Gender Inequality Index. Income poverty had increased from 10.7% in 2006/07 to 20.3% in 2009/10. According to the poverty head count index, Batticaloa district had the highest level of poverty in the country (20.3%) and the highest poverty gap index (5.1 compared to a national average of 1.7).[12]

Diyagama is situated in the Welikande DS division which borders the Batticaloa district to the East and Trincomalee District to the north. Sharing a border with Thoppigala forest in Batticaloa, a Liberation Tigers of Tamil Eelam (LTTE)[13] stronghold until 2006, the villages of Welikande were often caught in the middle of various encounters. Diyagama has a population of 640 and 150 households which are predominantly Sinhala Buddhist and is a settlement of the Mahaweli Development Programme.[14] According to community elders, people had been living in nearby villages from as far back as 1956 and these early settlements had mixed ethnic groups with Sinhala and Tamil families sharing the same neighbourhood. However, when settlements were started under the Mahaweli Scheme in the 1970s, they were divided into ethnic-specific communities and resettled in separate villages. From 1988 to 1990, families were brought to Diyagama mainly from the Central and Sabaragamuwa provinces.

9 Please see Gaza and Sri Lanka reports for further detail: http://www.odi.org/publications/9831-mental-health-psychosocial-service-provision-adolescent-girls-post-conflict-settings-case-gaza-strip ; http://www.odi.org/publications/9831-mental-health-psychosocial-service-provision-adolescent-girls-post-conflict-settings-case-gaza-strip ; http://www.odi.org/publications/9770-mental-health-psychosocial-support-service-provision-adolescent-girls-post-conflict-settings-culturally-sensitive-response ; http://www.odi.org/publications/9647-adolescent-psychosocial-wellbeing-post-conflict-context-sri-lanka

10 Pseudonym used to protect privacy of the community.

11 As above.

12 This does not include several conflict-affected districts in the north of Sri Lanka.

13 A militant separatist movement that was engaged in a brutal conflict with the Sri Lankan state for three decades.

14 The Mahaweli Development Programme was Sri Lanka's largest physical and human resource development project, initiated in 1970 and 'accelerated' in 1977 for hydropower generation, irrigation and agriculture. The project also entailed the relocation of mainly Sinhala settlers to cultivate the newly irrigated land (Werellagama et al., 2004).

Kadalkiramam is in the North of Batticaloa District and is situated within the Koralaipattu DS division. Traditionally a fishing village and located close to the main access road to Batticaloa, it has easy access to services. Its population of 2,464 is majority Tamil.[15] In the second phase of the study, Kadalkiramam was chosen because of its better prospects of access to service providers, based on experiences during the first round of fieldwork.

Experiences of war/armed conflict are in the social narratives of both the villages selected. Diyagama saw some degree of conflict from the Southern *Janatha Vimukthi Peramuna* leftist insurrections of 1971 and 1988-1989, and LTTE terrorism after 1983. At different points the community of Diyagama faced restrictions on mobility, disruptions to public services including healthcare, and they lived in fear of attacks and suffered acts of violence. Kadalkiramam has always been in a high-security area with large military camps and has a history of child recruitment during the war years by the LTTE and the breakaway *Tamil Makkal Viduthalai Pulikal* since 2004. As such, it also has a history of several child rights organisations working in the area.

### Liberia

The first ReBUILD field site, New Kru Town, is a north-western coastal borough of Monrovia, located on Bushrod Island. It is a densely populated area with over 70,000 people living in shacks of corrugated steel, with many households lacking access to safe drinking water, basic toilet facilities and electricity. Threatened by erosion, New Kru Town faces major health and sanitation problems. The area serves as an entry point to Monrovia from the West and as such was a major point of transit during the war. During the second phase of the Civil War, the area changed military leadership twice by opposing forces and with each phase recaptured civilians were subject to rampant violence, the scale of which attracted examination for potential prosecution for war crimes.

A very poor community, during the Ebola virus disease (EVD) outbreak 89% of its residents reported signs of food insecurity, nearly 50% reported that they forgo health care when they are sick, and 61% reported reduced incomes as a result of EVD.[16] New Kru Town is made up of 25 communities and was among the hardest-hit communities from the EVD outbreak. Its major hospital is the government-run Redemption Hospital which itself lost 12 health care workers. Though established as a community for those belonging to the Kru ethnic group, it has grown to become a multicultural and diverse community comprising an array of people from various walks of life, backgrounds, and ethnicities. As such, there are ethnic tensions among its inhabitants.

The second field site, Tubmanburg (also known as Bomi Hills or Vaitown) is the capital of Bomi County at the northwest of Monrovia. Bomi County is among the poorest counties in Liberia and among the worst affected by the war, because of its closeness to Montserrado County - various warring factions fought in Bomi in an attempt to take over Monrovia. As such, the County suffered extensive damage to infrastructure and basic social services as well as mass displacements and loss of life. Currently infrastructure is inadequate and there are insufficient schools, health centers, and skilled health professionals. There are poor water and sanitation systems, roads and bridges, and limited access to technology. The population of Bomi is 84,119 with female representing 48.9%, approximately 40% of the population are Christian and 60% are Muslim. An iron-ore mining centre Bomi was long associated with the Liberian Mining Company which constructed an electric generating plant, schools, a hospital and a railway. Mining operations closed in the late 1970s and much of the infrastructure was destroyed in the first phase of the conflict or the First Liberian Civil War. In the second phase or the Second Liberian Civil War, it was used as the headquarters of the rebel group LURD (Liberians United for Reconciliation and Democracy). The majority of inhabitants belong to the Gola, Mandingo and Vai tribes. During the EVD outbreak, Tubmanburg also was hit hard. Predominately a market town, citizens reported problems accessing food supplies from Monrovia and increases in the cost of food and transportation. In addition, at the beginning of the outbreak it was subject to a blockade as a public health measure. Its hospital, Liberian Government Hospital, lost 6 staff members to Ebola.

### Gaza

After reviewing the main events and consequences of the most recent conflict in 2014 alongside the demographic, geopolitical and socioeconomic characteristics of Gaza's population, Shajaia was selected as the study site. The area came under heavy shelling by the Israeli military in July 2014, with around 120 Palestinians killed in one day alone. People from the area were forcefully evicted from their homes with nowhere to go and ended up living in collective centres (UNRWA schools).

The neighbourhood of Shajaia, with more than 120,000 residents, is located at the eastern border between the Gaza Strip and Israel. Its strategic location makes it more exposed to Israeli incursions. A total of 21,736 households live in 9,273 crowded buildings (Gaza

15 Divisional Secretariat data, accessed in 2014.

16 Data for Ebola Recovery-Results from A Population-Based Survey for Monrovia. Retrieved from: http://www.data4ebolarecovery.org/ on October 13, 2015.

Municipality database 2014); refugees represent less than 25% of Shajaia's population (Near East Council of Churches [NECC], NECC, 2014). Average family size is 5.8, and most families (more than 61%) have children or adolescents (NECC, 2014). Shajaia is also known as a conservative community with strict social norms and traditions. Most women marry at a young age (the median marriage age for women is under 20) and most women do not participate in the labour force.

There is widespread unemployment in Shajaia, especially among women. In 2008, around one-third of people were receiving social assistance, mostly through the Ministry of Social Affairs (non-refugees) and the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) (refugees); today, more than half of Shajaia's residents receive social assistance (NECC, 2014). Shajaia was not traditionally a poor area; historically, the main sources of income were trading of clothes, working in Israel and agriculture. Since the blockade, the main source of income is employment with government social services.

Almost all households are connected to electricity, water and sewage networks (NECC, 2014) and have basic assets such as refrigerators, cooking gas and furniture. Shajaia is served by Gaza municipality. The area has four government-run primary health care (PHC) centres, three NGO-run clinics, and the only rehabilitation hospital in the Gaza Strip (MoH, 2014). One PHC centre and the hospital were totally demolished during the 2014 conflict. In addition, residents receive services from nearby UNRWA, NGO and government premises. There are 42 regular schools in Shajaia for basic education, mostly owned and managed by the Ministry of Education (MoE).

**Girls after Sunday school at Hindu Kovil, Sri Lanka**

# 5 Country contexts

## 5.1 Sri Lanka

### General context

Sri Lanka's population of 20.3 million is diverse ethnically, religiously and linguistically, with three quarters of the population being Sinhalese and largely Buddhist, with a majority living in the Western Province where the capital city, Colombo, is located. The Tamils are mostly Hindu and comprise 16.5% of the population: almost 12% of them are Sri Lankan Tamils, while the rest are Indian Tamils. The majority (nearly 44%) of Sri Lankan Tamils live in the Northern Province and 28% in the Eastern Province. There are also Muslims (the vast majority are classified as Sri Lankan Moors) who comprise, according to the 2011 national census[17], 9.3% of the population and are Tamil speaking; one-third of them live in the Eastern Province (UNDP, 2012).

Since its independence from British rule in 1948, the country has experienced several political disturbances along ethnic and socioeconomic lines due to unequal distribution of the benefits of economic growth, language legislation, and ethnic grievances in terms of political representation, power sharing and access to land. Immediately after independence many Tamils demanded a federal state but from the 1970s the demand was increasingly for a separate Tamil state in the north and east of the country. Despite the recognition of Tamil as an official language along with Sinhala and changes in parliamentary elections, Tamil grievances escalated into the armed uprising of the LTTE in 1983. After several short-lived ceasefires the armed conflict finally ended in May 2009 with the military victory of the government forces (UNDP, 2012; Vasudevan, 2012).

Despite almost three decades of conflict and the 2004 tsunami which killed around 35,000 people, Sri Lanka achieved middle-income status in 2010. Economic growth reached 6.3% in 2012 and by 2014 it had reached 7.4%[18]. Although unevenly distributed across the country, economic growth has contributed greatly to a substantial decline in poverty: from 26.1% in 1990-1991 to 8.9% in 2009-2010; in 2009-10 there were 1.8 million people living below the official poverty line compared to 4.3 million in 2002 (UNDP, 2012). Similarly, Sri Lanka's Human Development Index (HDI) increased by 28% between 1980 and 2012 and the country was ranked 92 out of 187 countries with a value of 0.715 in 2012 (UNDP, 2013a).[19] Data from 2009-10 show that gender parity has been achieved at primary education while slightly more girls continue and enrol to junior and upper secondary education. Girls also dominate collegiate education (46% compared to 33% of boys)(UNDP, 2013a).

Although national averages show progress, human development indicators are still lagging in several provinces and rural areas. In Batticaloa, the study location, poverty actually increased from 10.7% in 2006-2007 to 20.3% in 2009-2010. In terms of multidimensional poverty (measured by 10 indicators focusing on health, education and living conditions), Jaffna has the highest incidence at 11.5%, followed by Batticaloa at 11.3%.

### Gendered effects of the conflict

The prolonged conflict resulted in loss of thousands of lives, injuries and disability, destruction and displacement, poverty and food insecurity, particularly in the Northern and Eastern Provinces (UNDP, 2012). The heavy military presence increased girls' and women's vulnerability to harassment and violence, and restricted their freedom of movement with negative impact on their education and livelihoods (IGC, 2013). On the other hand, the conflict changed traditional gender roles: girls and women became combatants, some joining willingly to avoid family control or a bleak future (Somasundaram, 2003). Women, particularly in the north and the east, had to take on roles outside the household, cross roadblocks, get men out of detention, go to markets to sell their products and run their households (Fernando and Moonesinghe, 2012).

### Violence against women and girls

Sri Lankan women and girls are highly vulnerable to several forms of violence. Although adequate data are not available, domestic violence seems to be widespread: data from the 2006-2007 Sri Lanka DHS show, for instance, that over half (53.2%) of Sri Lankan women accept that a husband is justified to hit or beat his wife. Sexual abuse of children within the domestic sphere is also prevalent in Sri

17 www.statistics.gov.lk/PopHouSat/CPH2011/index.php?fileName=Key_E&gp=Activities&tpl=3

18 http://data.worldbank.org

19 In the 2012 Social Institutions and Gender Index (SIGI) the country was ranked 53 out of 86 countries, second best in South Asia after Nepal (OECD, 2012). In the 2012 Gender Inequality Index (GII) focusing on reproductive health, empowerment and economic activity, Sri Lanka was ranked 75 out of 148 countries but first in South Asia.

Lanka, but accurate data are lacking. Girls account for the majority of incest victims; poverty, lack of infrastructure, family conflict, low parental education level, substance abuse, maternal migration, and displacement have been identified as significant risk factors (Remnant and Cader, 2008). In UNICEF's survey nearly 10% of early adolescents and 14% of those in middle and late adolescence (14-19 years) in school reported that they had been sexually abused. In addition, about 10% of out of school adolescents also admitted that they had been sexually abused. Perpetrators of abuse in early adolescence were family members or relatives; in older ages family members were still the perpetrators in most cases but in almost one in three cases the perpetrator was an outsider. Abuse seems to be higher among poorest adolescents (UNICEF, 2004).

### Mental health services

Although mental health has been recognised as a key component of primary health care in Sri Lanka since the 1980s, until the mid-2000s mental health services were largely provided in medical institutions located in urban centres, particularly in the capital city. Mental health personnel were scarce, no formal psychology service existed and the majority of mentally ill people were unable to access any treatment. In the aftermath of the tsunami and in response to media attention and flowing resources, important steps were taken towards the development of a comprehensive community-based mental health system (WHO, 2013; Siriwardhana et al., 2011). The government approved a new national ten-year (2005-2015) mental health policy that supported comprehensive, decentralised, community-based services; established the National Institute for Mental Health and a national strategy to reduce stigma and discrimination; and called for mental health legislation to protect the human rights of the mentally-ill (WHO, 2013). In 2006 the Ministry of Health commissioned the National Mental Health Survey (Siriwardhana et al., 2011) and in 2008 the National Mental Health Advisory Council was created to oversee implementation of the new policy. Using the latter as a guide, several programmes were implemented at national and district levels with international financial support and guidance. In addition, primary health care doctors received mental health training (WHO, 2013).

Despite considerable progress, however, mental health resources are still comparably low and concentrated in the more urbanised districts. In 2007 there were 41 psychiatrists for 40,333 people suffering from mental disorders; 59% of these psychiatrists were based in Colombo District, while only a limited number of specialised personnel were found in the districts affected by the conflict (UNDP, 2012).

## 5.2 Liberia

### General context

Liberia has a population of 4.19 million.[20] It is the oldest republic of West Africa, founded in 1822 by freed slaves from the United States. The descendants of these African-American freed slaves, called Americo-Liberians, comprise 2.5% of the population; descendants of rescued slaves referred to as the Congo People an additional 2.5%; and the vast majority of the population (95%) are indigenous. Christianity is the state religion although only 40% are of the population are Christians: 20% are Muslims and 40% hold indigenous beliefs. The language is Liberian English, but there are also local languages.

The fourteen years (1989-2003) of civil conflict destroyed the country's infrastructure and institutions, killed between an estimated 250,000 to 300,000 Liberians and displaced thousands more, and reduced Gross Domestic Product (GDP) by 50%. In the last decades, however, the Liberian economy, largely relying on mineral resources and agriculture, has been growing with a growth rate of 7.5% registered in 2014[21]. Stability and positive economic conditions enabled Liberia to receive $4.6 billion in debt relief. The country continues to rely heavily on external funding, mainly official development assistance (ODA) and foreign direct investment (FDI). Between 2007 and 2011 FDI accounted for almost 46% of GDP, and in 2010 net ODA received accounted for over 175% of Gross National Income (UNDP, 2013).

Although Liberia has made significant progress in recent years, there are still major challenges, including widespread poverty (affecting 64% of the population, with 48% living in extreme poverty), high unemployment (particularly among the youth), persistent food insecurity, significant urban-rural disparities in access to health and education, and high levels of sexual and gender-based violence (UN Liberia, 2013). In the latest UNDP's Human Development Index, Liberia was ranked 175th out of 187 countries with a HDI of 0.412 in 2013 (UNDP, 2014).

20 World Bank Liberia country profile, see www.worldbank.org/en/country/liberia.

21 http://data.worldbank.org/country/liberia

**Sri Lankan school class, Lankatilake Temple**

## Conflict overview

From its beginning in the nineteenth century, the Liberian state was characterised by inequality and lack of social cohesion between the minority of the freed American slaves and the majority of indigenous Liberians (TRC, 2009). During the 1950s the country's economy experienced a high annual growth of 12% largely due to exports of iron ore, rubber, forestry products, cocoa and coffee, yet only the ruling elite benefited from the economic growth. The global economic crisis of the 1970s along with corruption and mismanagement of natural resources led to economic stagnation, widespread unemployment and public discontent. Economic and political inequalities deepened, and social exclusion and marginalisation, particularly among the youth, increased. Violence started to permeate social relations from the late 1970s with widespread social discontent, resulting in the military coup in 1980 led by the indigenous Samuel Doe who established a brutal and corrupted military regime. From 1980 to 1989 indigenous ethnic groups turned against each other and social cohesion was destroyed.

In December 1989, Charles Taylor, an Americo-Liberian, and his National Patriotic Front of Liberia launched an armed rebellion in which thousands of people were displaced and massacres were committed against civilians. Although there were efforts by the international community towards a national unity government and a West African peacekeeping force was installed by the Economic Community of West African States, the fighting caused a mounting humanitarian crisis. In August 1995 the war finally ended with the Abuja Agreement and Taylor won the presidential elections that followed in 1997 (GoL, 2011; TRC, 2009). However, two years later war began again when the rebel group LURD entered northern Liberia from Guinea, while in the south another rebel group, the Movement for Democracy in Liberia (MODEL), also emerged. Under domestic and international pressure, Taylor resigned and the Accra Comprehensive Peace Agreement in 2003 officially ended the second conflict. The UN Security Council established the United Nations Mission in Liberia to support the peace process. In the 2005 Ellen Johnson-Sirleaf won the elections and became the first female African president (GoL, 2011).

At the end of the conflict, in addition to over a quarter of a million deaths, 700,000 people had been forcibly displaced in neighbouring countries and 1.4 million internally displaced. Thousands had been abducted and forced to participate in brutality and killing; others had witnessed terrible acts and were traumatised by such experiences; and sexual violence had been widespread and systematic (GoL, 2011). According to several studies (WHO in 2004, 2005 and 2006) the large majority of Liberian women had experienced sexual violence during the war: between 61% and 77% had been raped. Likewise, studies among Liberian girls and women in refugee and IDP camps also reported a high percentage of sexual abuse during the conflict. A study of women former combatants also indicated that over 40% had experienced sexual violence. Sexual violence and abuse had serious physical, psychological and social consequences for survivors, such as reproductive health problems, sexually transmitted infections and HIV and AIDS, low self-esteem

and self-confidence, ostracism and social isolation (GoL, 2011). While women and girls were the prime target of sexual violence, a study found that in a sample of 1,666 respondents, nearly 33% of adult males associated with fighting forces and 7% of civilian men had also been subjected to sexual violence (Johnson et al., 2008).

## Gendered effects of the conflict

The conditions created during the conflict transformed traditional gender roles and relations. As men were killed or forced into hiding, women took on more household and livelihood responsibilities, with many turning to petty trade to make ends meet (GoL, 2011) and others joining the fighting forces.[22]

A common picture emerging in many media reports is that in the post-conflict period Liberian women have increased their access to education, strengthened their economic roles, participated in various initiatives such as the County Development Forums, and are involved in new political and social spaces under the leadership and example of President Johnson-Sirleaf. Indeed, the country has achieved considerable progress on its MDG gender targets (MDG3) and in 2010 it was awarded the MDG3 Award for outstanding leadership, commitment and progress towards achieving this goal (MoPEA, 2010).

However, despite taking up new roles during the conflict and increased responsibilities, the majority of Liberian women have not improved their situation and status in the post-conflict period. A recent study argued that only a small number of women, mainly those in urban centres, have been able to use the skills they acquired during conflict to take advantage of social or economic opportunities. The majority of women, particularly in rural areas, continue to be disadvantaged in vulnerable employment, having high illiteracy and low skills, while they are vulnerable to domestic violence and gendered traditional beliefs and customary practices (GoL, 2011).

The government has taken significant steps to address gender inequality through a number of laws, policies and programmes, including the 2003 Inheritance Law, the 2006 Rape Law, the 2006 National Gender-Based Violence Plan of Action (revised in 2011), the 2006 National Policy on Girls' Education, and the 2008 National Rural Women's Program (CEDAW, 2009b). Indicative of official efforts is also the fact that Liberia is one of the only six African countries (and 22 globally) that have developed National Action Plans for the Implementation of UN Security Council Resolution 1325.

## Violence against women and girls

Despite several positive changes, Liberian girls and women continue to be vulnerable to several forms of gender-based violence, including sexual and domestic violence, FGM/C,[23] early marriage,[24] and polygamy.[25] Sexual violence and abuse, largely against girls and women, has persisted in the post-conflict era, making Liberia one of the countries with the highest incidence of sexual violence against women. Rape against girls and women has continued and is the most frequently reported crime, accounting for more than one-third of sexual violence cases; targets are largely young people aged 10-19, while almost 40% of perpetrators are men aged 20-39, and known to the victim (GoL, 2011). Similarly, a WHO survey in four counties in 2005 found that almost 82% of women reported having experienced one or multiple acts of violence during and after the conflict; and over 34% reported domestic violence from their partners (Greenberg, 2009). Data from the 2007 Liberia DHS show that almost one in three young women aged 15-24 reported having experienced physical violence since age 15, with the highest percentage reported in Monrovia (over 40%) (Population Council, 2009). Overall, the 2007 DHS data show that 44% of women aged 15-49 reported experiencing violence since the age of 15, 18% have experienced sexual violence in their lifetime and 10% reported that their first sexual encounter was forced (LISGIS and Macro International, 2008). More recent data shows that sexual violence against children and adolescents remains high. Over 85% of all rapes in

22 Many girls and young women either voluntarily or forcibly also joined the fighting forces: it was estimated that between 25,000 and 30,000, that is 30% and 40% of all people involved with the fighting forces were girls and women (Specht and Attree, 2006).

23 Female genital mutilation/cutting (FGM/C) continues to be practised in parts of the country, particularly in rural areas (CEDAW, 2009b). Although the Ministry of Internal Affairs bans the practice through its Zero Tolerance Policy, there is no specific law prohibiting it (CEDAW, 2009b), and the Ministry issues permits to practitioners (CEDAW, 2009a). The practice of FGM/C is embedded in the traditional secret societies, the *Poro* for boys and the *Sande* for girls. These were the main institutions to initiate boys and girls into adulthood and transmit cultural and social values. As part of these initiation processes adolescent girls experienced the cutting of their genitalia to keep them clean, and engaged in other activities in order to 'join, bond and gain identity' and prepare for marriage and adulthood (Greenberg, 2009). In the past, young boys and girls attended bush schools for up to 3 or 4 years. As a result of government laws and policies, formal education is now compulsory for all children and thus bush initiation schools only last a few weeks and not a few years. Their influence is also diminishing in urban areas (GoL, 2011). According to the 2007 DHS over 58% of Liberian women aged 15-49 (40% in urban areas and 72% in rural areas) are members of the *Sande* society and thus have undergone FGM/C.

24 Although the minimum legal age of marriage is 18 for women and it is unlawful for parents to choose their daughter's husband, early marriage continues to be an acceptable practice and some girls are forced into marriage by their parents without their own consent (CEDAW 2009b). Data from the 2007 LDHS show that among those 15-19 years, almost one in five Liberian girls was married or in a union. The lowest percentage was found in Monrovia (8%). Early marriage was more common in rural areas: in 2007, 15% of rural girls were married by 15 and 49% by age 18, compared to 6% and 25% of urban girls respectively (Population Council, 2009).

25 One in four Liberian rural women is in polygamous marriage, although the number of such unions is declining (GoL, 2011).

2014 were committed against children ages 2-16, and the data for 2015 suggests that this trend persists with 91% of all rapes to date committed against children (MOGCSP, 2015 in Kweke, 2015). According to Ministry of Gender, Children and Social Protection data, in 2014, there were 5 child deaths resulting from rape (MOGCSP, 2015 in Kweke, 2015).

### Mental health services

The first formal mental health services were developed in the 1960s and, with financial support from national and international sources, a modern psychiatric centre was built close to Monrovia. The centre was completely destroyed during the war. In the period between the two phases of the conflict, the Grant Memorial Mental Hospital was created and operated as a private hospital where patients had to pay fees (MoHSW, 2009). After the end of the conflict mental health services continued to be limited to the Grant Hospital, and there were no specialised services for children and adolescents. Several NGOs and faith-based organisations were providing psychosocial services (Lekskes et al., 2007); some targeted women and children survivors of sexual and domestic violence, others women with HIV and AIDS (CEDAW 2009b). There was only one practising psychiatrist in the country and primary health personnel lacked appropriate training. People with mental health problems faced stigma and social isolation, obtained assistance from traditional healers, and were even subjected to harmful practices (Carter Center, nd).

In response to this situation, mental health was included as one of the six focus areas of the Basic Package of Health Services and in 2009 the National Mental Health Policy (NMHP) came into existence (Lee et al., 2011). The NMHP aimed to: integrate mental health into the primary health system with free and confidential services; fight stigma and discrimination associated with mental illness; and provide special services to specific population groups in risk of mental health problems – children and adolescents, victims of SGBV, and the seriously mentally ill (MoHSW, 2009). In 2010 the Basic Package of Mental Health Services (BPMHS) followed. The NMHP and BPMHS specified the range of services that should be provided from clinic to hospital level and outlined issues related to staff and standardised diagnostic evaluation. The Ministry also decided to enable trained mid-level primary care providers to serve as mental health clinicians (Lee et al., 2011). Since 2010 the Carter Center has been working closely with the government to build a sustainable mental health system able to meet increased needs.[26]

In 2009 a Mental Health Needs Assessment of Liberian children (those aged 5-12), adolescents (13-18) and young adults (19-22) was conducted. In the previous year many of the 171 respondents had been exposed to sexual violence, poverty, domestic violence and inadequate education. In particular, respondents reported that adolescents and young adults had high rates of unprotected sex, alcohol and drug use, delinquent behaviour, gang participation, sexual violence, bullying and hopelessness (MoHWS, 2009). Yet there are still no systematic data about mental health problems in the country,[27] let alone particularly among Liberian children and adolescents.

## 5.3 Gaza

### General and political context

The Gaza Strip is one of the most densely populated areas in the world, with more than 5,000 people per square kilometre (MoH, 2014). The population is estimated at 1.71 million, 66% of whom (1.2 million) are refugees. Nearly half of the population are under 15 years of age (PCBS, 2012a). The proportion of young people has risen considerably in just five years; in 2010, children and young people aged 10-17 accounted for 20.4% of Gaza's population (Hamad and Pavanello, 2012).

In the past 20 years, the Gaza Strip has been 'autonomous', experiencing a partial transfer of authority from the Israelis to the Palestinian Authority. But Israel still has overall sovereignty, controlling borders, trade, movement of goods and people, the commercial market, water, the main sources of energy, the means of communications and security. In late 2007, Israel declared the Gaza Strip a 'hostile entity' following fighting between Hamas and Fatah, and since then, a tight air, sea and land blockade has been imposed which has severely constrained sectors such as health, education, social services, industry, agriculture and construction, which were already struggling before these events. Despite the partial lifting of import bans in 2010, together with other measures aimed at relaxing restrictions, the blockade is still in force today (MoH, 2014).

Since 2008 Israel has also carried out three military operations against the Gaza Strip which have resulted in deaths, injuries and population displacement, and have also caused major disruption to basic services and compromised people's livelihoods and food security. The mental health and wellbeing of the population has worsened further with each offensive, manifested in higher levels of stress and

26 The Carter Center has three main objectives to complete by 2015: train mental health clinicians, including community mental health workers; help the Ministry to implement the NMHP and increase coverage of mental health services to 70% of the population; and organise anti-stigma campaigns and improve public understanding of mental illness (Carter Center, nd).

27 In their study Lee et al. (2011) note that the Global Burden of Disease report estimated unipolar depression deaths at 0.1 per 100,000 population and disability-adjusted life years at 612 per 100,000 population in Liberia. They argue that these were rather conservative estimates due to the absence of reliable data and they mention again the 2008 nationwide survey that suggested a large mental health burden.

anxiety, violence against children, gender-based violence, and family separation (Ma'an Development Centre, 2014).

### Violence against women and girls

Women face high levels of domestic violence. According to the PCBS (2012b), 51% of women who had ever been married reported experiencing violence at the hands of their husband in the 12 months preceding data collection. Of these women, 76.4% had been exposed to psychological violence at least once, 78.9% had been exposed to violence in their wider community, 34.8% exposed to physical violence, 14.9% exposed to sexual violence and 88.3% exposed to economic violence (such as disposing of the property of others, destroying livelihood assets).

### The impact of chronic stress

The unique circumstances of Gaza mean that the population experiences high levels of chronic stress, which affects people's lifestyle choices. For example, around 40% of men and 30% of adolescents smoke (MoH, 2014). This increases their vulnerabilities and exposure to other health hazards. Reflecting this chronic stress, the area is experiencing an 'epidemiological transition', whereby non-communicable diseases linked to lifestyle and stress (including heart disease, cancer, hypertension and cardiovascular diseases, and diabetes) are gradually replacing infectious diseases as the leading cause of death. In 2013, for example, the leading causes of death were heart disease (25.1%), cancer (13%), cerebrovascular disease (8.8%), perinatal conditions (7.3%) and accidents (6.4%) (MoH, 2014).

### Mental health service provision

In Gaza, mental health services are an integral component of general health services. The four major providers are the Ministry of Health (MoH), UNRWA, NGOs, and private for-profit operators (MOH, 2014). The MoH is responsible for a significant portion of primary, secondary, and some tertiary health care (providing more than 50% of services) (MOH, 2014). It runs 54 PHC centres and 13 hospitals, including the only psychiatric hospital in Gaza. The Ministry buys tertiary services from other providers, locally and abroad (MoH, 2014). UNRWA plays an important role in the sector, delivering free PHC services through 22 centres and buying secondary and tertiary services for registered Palestinian refugees (UNRWA, 2014). It also contracts NGOs to provide certain services, mainly specialising in secondary and tertiary care (MoH, 2014). The NGO sector also plays a vital role, complementing the work of the MoH in providing (often costly) tertiary services that the Ministry is unable to provide. NGOs do a great deal of work to make health care accessible to vulnerable and marginalised groups, running more than 50 centres providing health and health-related services. They also contribute to bridging the gaps and perceived inequalities in the health system. In particular, NGOs are an important provider of psychosocial and mental health and rehabilitative services in Gaza (Yaghi, 2009). The private sector is largely unregulated and tends to focus on obstetrics and surgical intervention (MoH, 2014).

**Girls play in narrow street in Al-Shalti refugee camp, Gaza**

# 6 Understanding adolescent psychosocial vulnerability

## 6.1 Markers of adolescence

In order to explore both psychosocial wellbeing and vulnerability of adolescent girls, it was important to first identify what adolescence as a period of life meant to the study respondents. As can be seen from Box 1, there is a range of terms used to depict the transitional nature of this life course stage.

Physical bodily changes were mentioned by both girls and boys in all countries as being a marker of adolescence. For girls developing breasts, pubic hair and getting their menstrual period were all mentioned as physical bodily changes. Girls also noted in Sri Lanka the fact that they were now having pimples, and felt that they had 'looked nicer as children'. Boys in Sri Lanka and Liberia, on the other hand spoke about the growth of facial hair and also hair on other parts of the body, growth spurts, a deepening voice and the development of muscles. In Liberia the boys also mentioned the need for changing clothes and being clean:

> *When I was a kid I used to wear set of clothes over and again, but right now I have reached the age to know that when I wear a set of clothes today, I have to change it and wear another one the next day. Every day I want to be clean among my friends, because when you are dirty among your friends, they will not like you. Even the girls will not like you; they will refuse you; they will say you are too dirty.* (Boy, 15, Bomi)

**Box 1: Terms used to depict adolescence**

Adolescents in Sri Lanka were generally called by terms carried over from early childhood. In both communities, usually it was 'son' or 'daughter' or for boys thambi (Tamil) or malli (Sinhala) – younger brother. In Kadalkiramam the boys in the FGD mentioned that girls were sometimes called pettai (which was a demeaning form of address usually used by elders and sometimes by boys to tease them) or podien (small person) and girls and boys were called maney (endearment like dear). Boys were commonly called maapillaimaar (groom), ilanthaarimaar (young man), or uthavaakaraikal (useless fellow). In Diyagama adolescents were usually called by name, or were called lamai (children) or vedihiti lamai (adult children).

In Gaza, the term to describe adolescent, both male and female, is moraheq, which means literally approaching or being close to adulthood, which includes being wise and mature. Although the literal meaning of the term is not negative, it may be used negatively to describe behaviours that are not wise, immature or childish. Additionally, talking about adolescence does not usually happen and when it does, it is usually linked in some way to sex, which is a highly taboo subject. Moreover, community expectations and social norms do not recognise this period; children are expected to behave as adults without going through a transitional period.

In Liberia, many girls and boys are ready for the Poro or Sande society where initiation and rites of passage ceremonies mark the transition to adulthood. One female adolescent in our study in Liberia described it this way: 'At this age; the male begin to 'fan around'; once they see breasts on your chest, they start to 'fan around'. She further explains that, 'Fan around means to come around; men start to come around young girls at that age.' Another young woman chimes in, 'They usually say they like me; I am 'fill', and explains that 'fill,' 'means that you are ready for man and woman business; that your body is flexible.'

The girls spoke about some of these specific changes as altering their outlook on life and behaviours, as this narrative from a 17-year-old girl in Liberia shows:

> *When I was not experiencing my menses, I was very rude. I used to play around and wrestle with the boys. But since I started experiencing it, I am calmer, I no longer behave rudely, I no longer play among the boys, I no longer play among the little children who I played with before.*

This period is also marked by puberty ceremonies in Sri Lanka where the girl is kept in seclusion for a number of days, followed by a ceremonial bath with herbal leaves – a cleansing ritual. After the cleansing bath, there is a social function and, if the family can afford it, they invite the whole village for a meal. Similarly, in Liberia, girls often mentioned the initiation ceremonies that girls and boys undergo in the bush to become part of the *Sande* secret society (for girls) and the *Poro* society (for boys) (see also below and footnote 23).

In the Palestinian context the same markers were reported, but when adolescents – especially girls – go through natural growth and development, 28% of them stated that this process causes them problems (UNFPA, 2013). For instance, 22% had no any idea about monthly periods; 40% were afraid when they first experienced monthly periods and 19% felt embarrassed; and 43% were self-taught on how to clean themselves during a monthly period (UNFPA, 2013).

Emotional changes were also mentioned. In Sri Lanka, girls in particular said they were getting angry and shouting more often than when they were younger. It is also a period when love interests start developing, although boys mentioned this more than girls and were mostly considered the instigators. This was also the case in Liberia, with boys seen to start coming 'around the girls' at that age and looking to have sexual relationships with them. In Gaza it was noted by respondents that adolescents found it difficult to express their emotions and attraction to the opposite sex due to cultural taboos and restrictions. Similarly, some girls (as well as some boys) live virtual emotional stories, or stories in their minds to satisfy their unmet emotional needs.

An important change and marker of adolescence for both boys and girls in all countries was the changing responsibilities they face. These usually relate to taking on more household responsibilities for the girls, including cooking, cleaning, collecting firewood and water and looking after younger siblings, and taking on work outside the home for the boys, with the boys also noting that the possibility of earning at an early age was an incentive for them to drop out of school. It should be noted, however, that there is also value placed on education, with parents encouraging girls in all countries (but especially in Sri Lanka) to focus on their education, with some girls even saying that they are not asked to do any household chores: everything is done for them and they are told that their main and only responsibility is to study.

Changing behaviours and ways of thinking was also noted by both girls and boys as a maker of adolescence. Changes in behaviours ranged from not bathing outside any longer (for both boys and girls in Liberia in particular) to thinking more maturely about their futures. Boys in Sri Lanka, for instance, spoke about thinking more clearly and seriously at this age; similarly, a girl in Sri Lanka mentioned that in this period she started thinking about 'her future and setting targets: to study well, to become a teacher, to build a house for herself and look after her parents'. Others also mentioned emotional maturity in terms of having a better understanding of the society, how to talk and behave as well as how to assess people and their intentions and choosing who to associate with. In Liberia, for instance, girls also spoke about the need to start making decisions for yourself and becoming more independent:

> *At the age of 18 years [you need to start] making decisions for yourself and standing on your own such as doing business, paying your own school fees and not to depending too much on your parents to do everything for you, especially when you are in a relationship.* (Girl, 17, Bomi)

On the other hand, and what came out particularly among parents and adolescent girls in Sri Lanka, was the perception that boys begin to drink alcohol, smoke and engage in sexual activity as they reached adolescence, something which was also facilitated by their being able to earn and income, particularly if they drop out of school. The lack of opportunities for vocational training or useful occupations for adolescent boys was identified as a reason for their unhealthy lifestyles.

What emerged strongly from all study sites were the restrictions that start to be placed on girls during this stage in their lifecycle – for example, restrictions on their appearance and their ability to move around. Thus girls in Sri Lanka noted that, despite adolescence being a period when they become more aware of fashion and dress styles, they were expected to dress in long skirts or dresses, whereas wearing tight jeans, for instance, was criticised. This was understood by study respondents as a way to avoid attracting the sexual interest of men.

> *We all dress the same ... dresses with long sleeves – we never wear sleeveless. We also don't like to wear short skirts or frocks and dresses which display our belly and legs.* (Diyagama)

Adults in Sri Lanka echoed this as they saw girls dressing inappropriately, noting the influence of the media, film and the tourism industries. As the school principal in Kadalkiramam described: '*I have told the teachers to talk with [girls] about their dress. We need to change that … sometimes it affects the culture here, boys also*

*get affected*'. The youth club president agreed: '*Girls are changing towards the foreigners' culture … Some are wearing shorts … their hairstyles are like the foreigners' … they are doing facials*.'

Similarly, in Gaza, girls are expected to adhere to a certain outlook and appearance, reflecting greater commitment to cultural/religious norms and preferences. Issues related to dressing can, however, be confusing; some families for instance object to their daughters wearing *hejab* (a scarf to cover the hair) while the daughters want to wear it, but generally it is much easier to get the family's consent to wear the *hejab* as this is in line with the dominant culture and religious norms.

In order to discourage contact with boys, girls in Sri Lanka are advised, mostly by their mothers or other female members of their family (grandmother, aunt), to ensure that they lock the doors of the house when alone at home, not 'be idle' in the street, not to stay out late and generally to restrict their mobility both within and outside the village. Similarly, in Liberia girls spoke about the fact that girls can no longer play with boys when they reached adolescence. They were also often restricted in where they went as one adolescent explains – *I can't go anywhere I can just be in the yard here. I can't go to school. I can be here all day*' (15 year old girl, Bomi).

Reflecting on these restrictions, girls in Sri Lanka tend to consider growing up as a stage when they begin to be more careful about their behaviour in public and think more of protecting themselves. On the one hand they seem to consider restrictions as normal but on the other hand they also expressed the fact that their freedom was actually increasing as they reach adolescence as they can now meet some of their own needs, help each other and do things with their friends. Moreover, there were some socially acceptable public spaces for adolescents, including the Buddhist temple or Hindu Kovil.

In some Sri Lankan families boys are also protected and prevented from mixing with other boys who have dropped out of school, and told not to 'roam around' for fear of them getting involved in 'bad things' such as drinking, smoking and hanging out with older men. Generally, though, boys are more mobile and freer to move around than girls. They often do not inform parents where they are going, they hang out with friends, play outdoors and roam around the village more freely: '*Village people are more curious about the behavior of girls than boys. Even if we [girls] do the slightest thing wrong they make it bigger and spread it around the village. Therefore we are afraid to make even a small mistake*' (Harshika, Diyagama).

An important marker for girls around adolescence in all countries is the possibility of early marriage, which leads to a range of restrictions and limitations including dropping out of school, losing friendships, and living with in-laws. In Gaza 53% of girls were 18 or younger at their first wedding and 43% were 18 or younger at their first pregnancy (UNFPA, 2013). Although early marriage was strongly criticised by adults in Sri Lanka, and remains illegal below the age of 18, it nevertheless remained a common experience across the generations, with some people registering false ages on the marriage certificates. Sometimes the marriages were arranged by the parents to deal with economic difficulties and cultural practices such as dowry. Another cause for parents pushing for early marriage is a response to mothers migrating to West Asia for work. The mother feels that once an adolescent daughter is married, she can leave with peace of mind. According to one of the school teachers in Kadalkiramam, parents also worry that the continuation of schooling after puberty increases the risks of children getting into love affairs, so they do not encourage their children to continue schooling. Even though there is a lack of official and comprehensive data on child-marriage in Liberia, adolescents mention early marriage and its damaging effects on an adolescent's life. A 19-year-old boy from Bomi explains why children are encouraged to wed at an early age: *'Just to add up, early marriage is prevalent here; some parents here force their children to get married or to engage in early sex activities; these are the sort of violence that we see here; children don't reach the required age but their parents may be coercing them to start contributing to family support'*.

Box 2 below describes how a girl's life in Sri Lanka changes upon marriage.

**Box 2: An adolescent girl facing early marriage and a change in life**

In Kadalkiramam, a young girl who married at 16 talked about her life after marriage. Dilani was a very active girl in school and was involved in a lot of sports. After she reached puberty, she was not allowed to leave the house, except to go to school.

> *'I started volleyball at the age of 13 … I have played volleyball cricket and I was on the school team … I can run well … I got selected for the music competition too. After I age attained they did not allow me to come to the road, I was not allowed to go to church, I only went to school and I stayed at home, they did not allow me to go for tuition, they did not allow me to go anywhere.'*

The pressure to marry came from her mother, even though initially Dilani wanted to continue her studies. However, after she completed her O-levels and managed to pass only three subjects, her mother started arranging the marriage with a young man from Colombo who was living in their village for some time.

> *'My father … after alcohol he fights with my mother, he drinks and it is not good. They do not spend for educational expenses, if I ask they say you can stop schooling. My parents did not help me with my education. I did not want to marry, but because of my mother I had to marry early. I do not like love marriage: I have seen people in the village, if we marry we have to be under them (men) … If I passed my O-levels I wanted to study more ... if I didn't pass I was planning to work in weaving. My mother and father are not well off. I wanted to work and earn for myself.'*

The grandmother explained that the mother was keen on the marriage because she was unable to raise the money required for her daughter's dowry, but this boy's family had agreed the house could be used as her dowry.

Since the day she married her husband, Dilani has been beaten. The couple initially lived in her parents' house, but after continuous violence and conflicts with the mother, Dilani and her husband moved out and are now squatting on a neighbour's land and living in a small temporary hut. When the research team met her, she had just returned from being in the hospital for 18 days after attempting suicide by drinking kerosene, as she could not deal with the domestic violence and abuse.

Even though Dilani was now 18, the marriage had not yet been legally registered. Even though the house was promised to her as her dowry, it was still not signed over. The mother explained that she is worried her daughter's husband will sell the house.

## 6.2 Domains of psychosocial ill-being as perceived by adolescents

In this section we draw on our framework and explore how adolescents perceive their wellbeing and risks of ill-being according to a number of domains. Due to the overlapping of some of the domains identified in figure 2, we group some together.

### Access to resources

In this section we explore how adolescent girls perceive access to various kinds of resources and how they in turn affect their wellbeing. Access to education, economic opportunities, health services, transport services, safe spaces and leisure activities were all identified by adolescent girls as shaping their psychosocial wellbeing.

While education was valued highly in Sri Lanka by both parents and adolescents, many adolescents dropped out before or after the O-level examination. Reasons for dropping out include poverty, parents' low levels of education, and love affairs and elopement (*Definitely they won't come back to school when they elope*' – 14-year-old girl, Diyagama).

Parents' desire to marry their daughters early – defining their future wellbeing in terms of a 'good marriage' rather than having an education – also resulted in school drop-out. Girls who do manage to continue education often have the support of at least one family member and other structural factors in their favour, such as the school being within accessible distance and having access to school materials.

> *I want to study and become a judge …My uncle and grandmother will support me …My uncle wants me to do science. He told me to study to be a doctor. I told him if a doctor has a problem he has to come to the courts.* (Jeewa [pseudonym], 15, Kadalkiramam, who lives with her uncle and grandmother because her mother abandoned her when she was 3 and her father remarried)

In Gaza, despite some important achievements (full gender equity in enrolment in basic education, near universal access to basic education and high literacy – the highest among all Arab countries), the education system suffers from quality deficits, poor scholastic outcomes, overcrowded schools and classes running in double shifts, and lack of understanding among teachers and counsellors of the specific needs and perspectives of adolescents, especially girls (UNICEF, 2012). Although there are counselling staff in female schools, many girls reported not being able to trust them and they are perceived as another source of stress for them (Pereznieto et al., 2014).

In Liberia, the education sector is facing reform. Massive failures at the secondary school level are captured in the failure of students to pass basic university entrance exams. In 2013, all 25,000 prospective students to the University of Liberia failed the entrance exams.[28] The subsequent year, 2014, only 15 of the 13,0000 prospective students who took the exam passed.[29] Only 31% of students who took the West African high school examination passed.[30] A recent World Bank study cited a 2010-11 school census which highlighted that Liberia has the lowest proportion of qualified teachers in Sub-Sahara Africa.[31] One study reported that only 40% of Liberian teachers are formally trained as teachers.[32]

The importance of education on an adolescent's future were stressed by all girls and boys and their caregivers in our study in Liberia. Adolescents believe to be able to benefit from education and rank it amongst the most important service available to them. Caregivers believe that education will help their children to make appropriate life decisions. The following statement during a FGD with adolescent girls in New Kru Town illustrates this: *Because my mother used to advise me then; she advised me not to go around boys that once I had a good education, no man will be able to bluff me'*.

Adolescents who are unable to attend school consider this a significant disadvantage. Ironically one of the girls who had never been to school had a father who was a professional and high school graduate. The extent of dismay of some of the young women exhibited was palpable. *'Anytime me and my friends make palaver (argue) they can say 'big girl like you not going to school'* lamented an adolescent girl in New Kru Town.

Financial limitations mean that many adolescents cannot attend school and, according to key informants, are reasons for girls to look for partners and engage in transactional sex (often with older men). In this vein, a 14 year old girls explains how*: 'a boy proposed to me; I accepted him because of the money; my parents never provided for me at school; so I accepted the boy; the boy then began providing lunch for me; I had money to go to the cook shop to purchase my own food; the boy used to pay my transport fare and from the school'*. Because of limited use of contraception, sexual relationships of teenage girls often cause pregnancy and consequently, early drop-out.

In terms of access to economic opportunities and assets, the Sri Lanka study found that a girl's economic security depends on her family's economic stability or that of her husband if and when she marries. Due to lack of formal education and poor employment opportunities in the area, most girls have to work in unskilled or semi-skilled work, earning relatively low incomes. Those who had dropped out of school spoke about working in the garment factories, in nearby plantations, petty trading, working as cleaners in hotels in the nearby tourist resorts and becoming migrants. They were earning very little and were often in risky situations (e.g. girls in the Middle East as domestic workers). Employment was largely viewed as a temporary measure, enabling them to buy jewellery, furniture and electronic items to make up their dowries for marriage. Girls who drop out of school and typically work for a relatively short time do not develop sufficient skills to get promoted, earn more or generally develop future aspirations and a career.

In Gaza, economic hardship seems to play the biggest role in adolescents' deteriorating psychological status. Key informants linked the bleak economic situation to a rise in domestic violence and to dysfunctional relationships between adolescents and their parents. Parents feel helpless given the general political and economic situation and to avoid being blamed by their children they respond either with violence or neglect. The stress caused by lack of money was mentioned by girls and boys alike but from different perspectives: boys seem to think more about how they can support the family breadwinner but do not give any thought to how to reduce household spending; girls do not think about how they can support the family breadwinner but do think of ways to curb spending and try to make fewer demands when they feel their parents are not able to provide them with what they need.

28 Rogers, A.,' 15 of 13,000 Successfully Pass University of Liberia Entrance Exam' *Frontpage Africa*, October 22, 2014, downloaded October 14, 2015 from http://allafrica.com/stories/201410221209.html

29 Rogers, A. op. cit.

30 Anon, WEAC May/June 2014 Results Record Another Massive Failure, Daily Observer, August 12, 2014, downloaded October 14, 2015 from http://www.liberianobserver.com/education/waec-mayjune-2014-results-record-another-mass-failure

31 World Bank, (2013). International Development Association, International Finance Cooperation, Multi-Lateral Investment Guarantee Agency Country Partnership Strategy for the Republic of Liberia for the Period FY 13 – FY 17. Report No. 746d18-LR.

32 World Bank. 2012. Liberia Poverty Note: Tackling the Dimensions of Poverty, Report No. 69979-LR. PREM 4. Africa Region. June 15, 2012.

In Liberia, adolescents are influenced by their caregivers' or parents' lack of access to economic opportunities and assets. During adolescence, boys and girls are expected to support their parents and become an essential 'helping hand'. Many adolescents in both urban and rural areas are expected to 'sell market' (petty trading of water, scratch cards, homemade candy, ground pea nuts) before, after and sometimes during school hours. In rural areas, adolescents are expected to help their parents on the farm or with household tasks. Girls are more often required to help their parents with household activities than boys.

Lack of money causes stress and psychosocial suffering for adolescents and their caregivers and causes risky behaviour, including transactional sex:

> *We engage on sexual activities because at times, the things we wish to have our parents are not able to afford them; we engage in sexual relations with the boys because we want to have things for ourselves; things that our parents cannot provide for us… At times our parents coerce us to get involved in early sex; when girls at our age start to give things to their mothers for instance, our mothers will start to tell us, don't you see your friends going out there.* (adolescent girls FGD, New Kru Town)

Another young woman opined, '*We engage on sexual activities because at times, the things we wish to have our parents are not able to afford them; we engage in sexual relations with the boys because we want to have things for ourselves; things that our parents cannot provide for us.*'

In both study sites in Sri Lanka, primary health care is available to adolescent girls and there are active family health workers (midwives) reaching out to the girls to raise their awareness about sexual and reproductive health and provide them with contraception; this in turn appears to be keeping the rate of teenage pregnancies low. In Gaza, despite high health insurance coverage and good access to health services in normal situations, adolescents' right to survival is compromised in a number of ways, including direct exposure to death and injuries as a result of the prevailing conflict, exposure to diseases caused by bad sanitation, and high rates of non-communicable diseases. According to the literature, 16% of youths including adolescents had a health problem during the two weeks preceding data collection; 3% had at least one chronic disease (UNFPA, 2013). In Liberia, girls indicate that they are able to access primary health care, including basic contraception services. During the Ebola outbreak however, many hospitals were closed and basic services were not accessible.

Poor transport infrastructure in Sri Lanka and Liberia affects adolescent girls' mobility and access to services outside the village. Access to safe spaces and leisure activities for adolescent girls varies across the study sites in Sri Lanka, but is generally limited and social norms affect girls' participation (e.g. in sports activities). In Gaza, there are some organisations such as the Ministry of Youth and Sport, UNRWA, schools, mosques and NGOs that provide children and adolescents with some recreational opportunities such as summer camps. However, older adolescent girls' access to these recreational activities is restricted by social norms. Moreover, the most reported adolescent leisure activities are watching television and spending time with friends, and meeting in their homes or the homes of friends and relatives (UNICEF, 2012).

### Sustaining close relations / building social connections

Another critical risk to adolescent girls' wellbeing was in the domain of sustaining and building social connections and relationships. Most adolescents in Sri Lanka said that one or both parents were the closest person to them and provided the most support: *'I tell everything to Amma (mother). I tell Amma first and then after the others' (girl, 16, Kadalkiramam)'*. However, at the same time as feeling support, closeness and loyalty, many also felt a sense of frustration or disappointment with their parents, for instance due to a father's drunken behaviour or being punished by a parent. For some girls, extended family members, often grandmothers and aunts, were key figures in their lives. Family disintegration or the death of a parent meant some adolescents were living with extended family members; some spoke about the relationships with them as being loving and caring, while others experienced ill-treatment or even trauma at the hands of these relatives. Where adolescents felt isolated at home, they tended to form close relationships with outsiders.

Adolescents in Sri Lanka also spoke about relationships with non-relatives including neighbours, supportive teachers and peers: all had at least one or two same-aged peers, a friend from school or neighbourhood, with whom they shared their secrets, had fun with, and from whom they sought advice (e.g. on love affairs). Many valued their closest friends' support on a par with the support of their parent/s; for some, the support of their friends figured greatly in their lives, especially if relationships with their parents and siblings were strained.

More broadly, given the markers of adolescence identified above for Sri Lanka, once girls reach a certain stage in their life cycle, notions of respectability along with restrictions on their mobility affect the ways in which girls make and keep friends, establish social connections and access support through these connections – all of which generally have a negative impact on girls' confidence. Where there is a supportive family member, though, girls are better able to build social connections.

In Gaza, the role of family support was mixed. On the one hand a number of adolescents highlighted that they turned to family members for advice and solace. On the other, there were repeated concerns that parents do not listen to their children. According to key informants, families in Gaza seldom create the space needed for

**Box 3: Protecting family honour**

Family honour is a source of stress for many girls, especially those living in the most conservative communities (not necessarily the poorest or the least educated families). The issue is particularly pressing for girls aged 13 and older. According to one 17-year-old adolescent girl from Shajaia, her family forced her to stop going to school when they knew she was talking to a male school friend and that she had special feelings towards him. She was beaten by her cousins and she is now watched by everyone in the family when she goes out. She lamented: 'I don't know what to do with myself. They don't want me to do anything in life. My brother stops me and looks at what I wear before I go out. I feel uncertain about what should I do with myself so that they are okay with me.' Striving to behave in accordance with strict social and religious norms inevitably means that adolescent girls have to contend with unmet personal emotional needs.

Key informants revealed that family expectations of daughters are always higher than their expectations of sons. This puts girls under a great deal of pressure to behave properly and never make mistakes. Also, it partly explains why mistakes made by sons are treated more leniently. This point was made by most of the experts and counsellors interviewed. Additionally, adolescent girls themselves reported worrying that they will fall short of family expectations, explaining that 'we don't want to fail our families'.

adolescent children to express themselves and seldom pay attention to understanding their unique needs and concerns. This was frequently reported by adolescents, psychosocial and mental health service practitioners, and policy-makers. As one female counsellor working for an NGO noted: '*Parents don't listen to their children. They don't think about how harmful this could be. When I talk to mothers, they say, 'we have never thought about this before and we are thankful to you for opening our eyes to that'*.' Another key informant (social protection specialist) pointed to the obvious gaps between adolescents and their parents, saying '*Adolescents feel that they are not adequately valued by the family and the community. Families don't understand the needs of adolescents. There are many communication gaps between adolescents and their families: adolescents don't understand parents' concerns and worries about them and also parents don't understand needs, aspirations and desires that adolescents have. It's a mutual misunderstanding.*' Girls are more likely than boys to feel that they are not heard or understood by their parents and by fathers in particular. One 14-year-old girl said: '*If I share my problem with mother, the problem could become bigger because I know mom will inform my dad of it*.' See also Box 3 on protecting family honour.

In Liberia, a defining factor in the study is the proportion of adolescent girls who did not live with their biological families even though they were alive.[33] This separation caused much anxiety and pain to the adolescents in the study. A 13-year-old in New Kru, sees this separation as normal although she lives with her aunt when both parents live less than 20 minutes away. She clings to her father's promise that they will live in the same house again. Similarly, a 14-year old, reported that, '*the woman I (am) living with, she is treating me bad, she is not sending me to school only her children*.' When asked what she does about her situation, she responds, '*I can't do anything, tears can just sit in my eyes*.'

Even so, both boys and girls in Liberia indicated having relationships with close kin and extended family members, peers and neighbours. Adolescents recognize the importance of relationships with friends and peer education. As a 17 year old girl from Bomi states: *'we also learn from our friends; we learn from other people; how they behave; we learn the good things from our friends not the bad things; because we may aspire to do more than what we see them doing, but not the bad things'*.

Adolescents also noted that family played a vital role in their psychosocial well-being. Key informants indicated that they would first turn to a relative when in need. Especially during the Ebola outbreak, and in the post-Ebola recovery phase, many Ebola survivors and family members of survivors suffered financial, mental and physical stress. The lack of state support during the crisis situation meant that many had to rely on family members to survive. Respondents recount numerous accounts of family members providing financial support or taking in children to relieve parents from caring duties in time of need.

## Exercising participation and agency

The inability to participate in familial and community decision-making and to exercise agency about important life decisions was another key psychosocial risk

33 There is also strong cultural bias towards children not living with their biological family in order to attend school. A 2011 study of communities that included Montserrado (New Kru Town) and Bomi (Tubmanburg), 12% of parents had at least one child under age 14 living outside of the home, with 52% having had a child at one point live outside of the home (Ruiz-Casares, 2011). Access to education (48%), lack of basic needs (15%) and poverty were the main reasons for sending children to live with other people according to the study.

experienced by adolescent girls in our study sites. In Sri Lanka, despite more responsibilities being assigned to both girls and boys as they reach adolescence, they are still considered as children in public life and are not given the space to participate and be heard in either household or community decision-making processes. Similarly, in Liberia, despite adolescents having to fulfil gendered roles (with girls, for example, having to cook, clean, do housework, sell goods in the market and look after younger siblings), they highlighted the fact that they are unable to make their own decisions, that their parents often decide 'what is best' for them, including in relation to early marriage and forced sexual relationships. Neither are they listened to in community decision-making processes, as this interview with a 15-year-old boy in Bomi highlights:

*Q: Do you take part in community decision-making?*
*A: No*
*Q: Why?*
*A: When we go there, they us that we are young so we should leave from there*
*Q: How do you feel about that?*
*A: We feel bad. We usually want to assist but they drive us away and that makes us to feel bad.*

Findings in Gaza show that in both normal and crises situations, adolescent girls' ability to participate is constrained. Hierarchical social norms, limited economic resources and lack of affordable resources/premises also represent major barriers to adolescents' participation; girls in particular face strong restrictions on their mobility and social activities outside the home on the pretext of 'family honour'. The prevailing hierarchical social norms have limited adolescent girls' opportunities to participate in family decisions, schools and other community entities, and have even constrained their awareness of their rights. Adolescents with a disability suffered the most because of their limited opportunities to participate in everyday life, including going out to meet friends and generally socialising with their peers (Pereznieto, et al., 2014).

Adolescents perhaps have most agency in informal spaces, such as in their immediate and extended family, among friends and in the neighbourhood. For instance, adolescents in Sri Lanka tell of having been able to talk about difficult parental behaviour with relatives, or being able to advise friends going through difficult periods. Adolescents also take part in informal community activities such as funerals and weddings, where their advice and opinion is often sought.

According to respondents in Sri Lanka, where adolescent girls *are* able to participate and to exercise a certain level of agency, enabling factors include: having increased awareness and access to information; having family support and permission from family to participate in community events; having parents who are respected members in the community; being respected for their good qualities and educational attainment and being recognised for good judgement; and being active in youth or children's clubs. Factors that hinder agency, on the other hand, include: adults treating adolescents as children; personal problems, especially family disintegration and sense of rejection; over-protection of girls; and stringent gendered norms around girls' participation more broadly.

## Experiencing self-worth

An inadequate sense of self-worth is another risk to psychosocial wellbeing that adolescent girls repeatedly raised. Adolescents in Sri Lanka demonstrated a strong sense of self-worth as assessed by their responses to questions about how well they liked themselves and what their positive qualities were –such as being helpful to others and talking politely. Among those who expressed conflicting feelings about their confidence, self-worth, self-esteem and abilities, many had faced difficult family situations and lacked parental affection and caring. Thus enablers and indicators of self-worth according to study respondents in Sri Lanka included: having affection and support of parents and extended family members; having space to participate in school or community events; and having aspirations for the future: *'I wish to study well and be a teacher, build a house and look after my parents'* (girl, 14, Diyagama). Barriers to self-worth included: remote locations and a lack of forums for young people to use their skills and talents; the absence of an encouraging environment or socially accepted spaces where girls can congregate; and negative labelling of adolescents.

In Gaza, adolescent interview respondents repeatedly lamented that they were not accorded the same value as their male counterparts by family and community members alike. Girls at the later adolescence stage (15-19 years) reported feeling less valued than boys of the same age when it comes to sharing opinions and thoughts. One 15-year-old girl who seemed to be wise and open-minded said: '*My grandfather, when we want to speak, says, 'You shut up, what do you think you know? You keep yourself out of things that aren't your business*".' She explained that her grandfather holds similar attitudes towards boys but shows more understanding and willingness to listen to them. More generally, in terms of the Hope Scale, which measures an individual's belief in their ability to complete tasks and reach goals, 43% of girls had low Hope Score; the self-esteem index, which reflects adolescents' perceptions about their house, clothes, school items and work, showed a moderate score 72% (Pereznieto, et al. 2014). Despite the contextual and cultural constraints, the vast majority (96%) of adolescent girls in Gaza reported making plans for future study and work; 98% of them said that hard study would be rewarded with a better job and 60% of adolescent girls thought they were doing pretty well (a lot, most and all of the time). Despite difficulties they face, adolescent girls in Gaza scored high on the self-efficacy scale, and higher than their male counterparts.

In Liberia, adolescents against the odds have a high sense of self-worth. For example, a 14-year old from New Kru Town who wants to be President, says that she is in school doing her lessons for that. She also reports that her older sister who is a police officer is her role model. In the case of another adolescent girl in Bomi, she asserts: '*I want my own house. I want my own money. I want to be working for myself. Because this time [nowadays] man them [men] when they be providing in the home (and) woman not bringing something, there then that [causes] different trouble*.'

## Protection and security

Inadequate protection and security – both in terms of physical and psychological harms – was a key theme in all three study sites, but especially in Liberia. According to study respondents in Sri Lanka, the physical and mental wellbeing of adolescents, especially girls, is closely linked to their security and protection. Some factors that affect this wellbeing derive from experiences of war and conflict faced by the adults in the lives of these adolescents. In many cases these experiences continue to affect the way adults negotiate relationships with their adolescent children even in a post-conflict situation.

Unhappy family relationships and physical and sexual abuse of girls emerged as major risks to girls' protection in Liberia. Nearly all the female adolescents in the study reported being subjects of physical beatings as part of how their parents or guardians disciplined them. These young people's sense of security and protection, where it exists, is extremely fragile. As mentioned above, transactional sex is reportedly common in Liberia, especially in the urban slum environment of New Kru Town. The following quote illustrates a typical situation:

> *When my parents were alive, he came asking for my love but I never agreed to it because then I had all I needed. But later when my parents died and I didn't have anything when he came and was helping me… Really, there was a day I was very broke and needed some money desperately and I went to this man's house to ask him for some money. I met him in his living room and he said to me that he would only give me some money in return for sex, which I first refused. He called me in the living room, thinking that he was only going to give me the money and let me go, but that never happened – instead he forced me to have sex with him.* (17-year-old girl, Bomi)

In another example in Tubmanburg, Bomi, an adolescent girl aged 14 noted that 'in school if the girls fails a particular subject and asks the teachers to help her, the teacher will want to sleep with her; the girl too may not want to fail; she may accept to sleep with the teacher; then the teacher exploits the girl.'

In Gaza, FGDs revealed that fear of sexual harassment is a stressor for girls and young women, especially those living in remote areas and close to borders where there is an added fear of military action. Some adolescent girls reported feeling scared when they travel to school because of the risk of sexual harassment. One male FGD participant said: '*Girls may not be safe if they go outside alone. People are not trustworthy*'.' He added, '*If my sister would like to go out, I, my brother or father go with her because we care for her safety. She may be exposed to harassment in the street. Anyone can annoy her or ask her to give him her phone number, for example*.'

Other risks to physical and mental wellbeing include aggression or violence at home, separation of parents and families, the migration of one or both parents and parents' remarriage. All can result in adolescents having to live with their extended families where they often have to take on heavy workloads, lack support to continue their education and are frequently subjected to scolding and insults. In the Gaza case, there was the added vulnerability of displacement. Adolescents frequently cited losing their homes and having to live in a collective centre as major sources of stress. It is not merely the material loss of the house but the loss of the protective space that homes represent for children, as well as loss of the family's entire assets. As one girl at a UNRWA collective centre said during a FGD: '*We need to regain our respect and dignity, to be liberated and have freedom as others, not the same as we are now.*' She added: *'I always say to my father that I would like to go back home, and he usually says the same answer: 'We will'. Then he informed me that our home was destroyed, so I told him to make a tent for us on the rubble of our home*.'

See Box 4 for a case study from Gaza on the kinds of threats to safety an adolescent girl and her family face.

**Box 4: Surviving under rocket fire**

A few days before the massacre in Shajaia, my mother and I were standing at the kitchen preparing food (it was Ramadan). The Israelis shot one rocket which hit our next-door neighbours. I was in the front of the window and saw injured people, everyone was screaming, girls were crying, and we were also covered in dust and stones but I was able to see the injured people until the second bomb came in a few minutes. I stepped back and attached my body to the fridge and took my mother's hand. She also was watching silently. My mother told me, 'Come on, we have to go and see your little brothers, they must be scared from the sound now'. I told her, no, I am not moving. In fact, I was shaking and unable to move or to let her go.

In a few minutes, while I was still shocked, a third rocket exploded and this was so big. My mother left me and went to see the kids, and then we heard voices asking us to go out of the house because it was burning. My uncle's wife saw the fire in the top of the building, and we left the house in a rush. I can't describe how I left the house. We moved to our neighbour's house…in the other street and stayed there for a week, then my father decided that we should return to our home. While there, we were suffocating because we received their relatives who were displaced from the eastern part of the town. We were about 140 people in one house.

On the night of the massacre, all of us and my uncle's family who live on the third floor, came down and we all sat together in our home. All the children were in one room, bombing was everywhere and one rocket partially damaged one side of the house, so we all came into one room and didn't move. My father brought a bucket and the one of us who needs the bathroom was using the bucket inside the room.

I called the ambulance when we were inside the house… The ambulance didn't come. I called for a second time and they said they would try to come but didn't. I knew then when we were walking that they will not send another ambulance because I saw two ambulances bombed. Almost all houses were partially destroyed and we started to run from one house to the other. We wanted to see people and to try to leave the area with them.

My mother and us were reading Quran while running. She said don't stop reading Quran and we were also repeating the Shehada [words Muslims say immediately before dying] because we expected death at any moment. We kept running and running. We saw burned houses, pieces of bodies, a hand over the tree, and a stomach/intestine of a man. We saw all that and we were shaking but kept running. We were running as if dogs were running after us. While running, my sister, my mother and I saw a dead body similar to my sister, same size and length of hair, but the body was completely burned and the hair was white. We didn't recognise her but tried to keep moving. My mother then wasn't able to walk and fell down fainting on the ground.

I didn't know what to do. I had my little sister holding my hand and my mother on the ground. I just caught my sister stronger and ran faster until I reached my father and told him. I saw my sister with him and he was carrying my three-year-old brother. My sisters stood together, while my father and I returned to bring my mother. I carried her from one side and my father from the other side until we became all together again. We kept walking to nowhere. No one knew where to go. We finally got close to my grandfather's house and he said we had to go to the hospital. At the hospital, many dead bodies were there! (14 year-old-girl, Shajaia)

# 7 Coping repertoires and obstacles to deal with psychosocial vulnerability

In all countries, two broad categories of coping strategies can be identified: (1) problem-solving strategies that aim to actively alleviate the cause of the stressful circumstances, and (2) strategies designed to regulate the emotional consequences of stressful events. Most responses in our study fall within the second category, because adolescents and their families can do little to address the reasons behind the countries' fragile contexts. In both Gaza and Sri Lanka, the ability and ways of coping were also affected by gender, social norms and the economic backgrounds of the households. Thus, for instance, in Gaza, many adolescents (over half) have computers at home and other new technologies and can cope by using social media, and joining relatively expensive recreational activities. One senior key informant said: '*Rich people have more access to coping approaches than poor.*' He continued, '*Coping reflects the norms and when the norms are terrible, then the coping is also terrible.*'

## 7.1 Individual level

Overall, our research case studies suggest that adolescent girls tend to only have a limited individual-level coping repertoire. In Sri Lanka, adolescent respondents spoke of coping positively with psychosocial ill-being by drawing on their inner strength. Similarly, there was a sense that adolescents seemed to take responsibility for their own wellbeing, either by seeking out positive relationships and experiences or by actively avoiding negative behaviour.

Individual or personal-level coping is also an important means by which adolescents in Gaza manage their psychosocial wellbeing. Positive coping strategies are often gendered, taking into account prevailing social norms. Thus, reading, painting and writing stories is more common among adolescent girls, while boys tend to do exercise, sport and hang out with friends. Daydreaming or imagining what life could be like and imagining living that life, particularly for girls, was also mentioned frequently as a coping strategy in Gaza. Use of social media was seen to be a coping mechanism in Gaza among adolescents, with girls tending to use it for longer because they spend more time inside the house than boys.

In Gaza a number of negative copings strategies were also mentioned, with boys associated more than girls with these negative strategies. Thus boys in Gaza were more likely to become addicted to substances or painkillers, to suffer from depression and anxiety and/or commit suicide. One key informant said: '*I saw few females who use drugs; but saw males equal to the number of my hair.*' He added, '*Females' coping strategies are constructive, they focus on education – females spend more time studying.*' Another key informant (a service provider) said: '*Females are predestined to cope well by Allah.*' He added: '*Negative coping is common among males more than females.*' Isolation was also a means of coping, with some adolescents, mostly from poor families in Gaza, cutting themselves off from others, especially family members.

In all three study countries, turning to religion, spirituality or traditional healing was an important means of coping. In Gaza, adults and adolescents (boys and girls alike) referred to spiritual values and ideologies that help them cope. For instance, religion can help deal with grief at losing a loved one by attributing the loss to a noble cause such as 'martyrs for freedom', with martyrs going to an eternal paradise. Also, mindfulness and association with an omnipotent power is a widely used coping method. Adolescent girls have strong notions of God as a superpower and frequently use the services of traditional healers, including those practising Ruqia (specific religious-oriented practices like reading the Quran and saying specific words).

In Sri Lanka adolescents spoke about turning to religion and spirituality when faced with difficulties: they would visit temples, participate in religious festivals and other events such as traditional healing practices, reading oracles and making offerings to gods. This participation was also an important means of social interaction, especially for girls who had more limited options for social interaction when compared to boys:

> *'The temple is the most important place to me. I like the calm environment it has'* (Hasini, 19, Diyagama)

*When I was at my sister's place I had no one to share my problems with and I used to go to Galthalawa [a nearby rocky hill] and sit there alone for some time and return home.* (Ajantha, Boy, 18, Diyagama)

Similarly, in Liberia, turning to religion is a key mechanism through which young people and their care-givers seek to cope with psychosocial ill-being. The following narrative highlights how in times of adversity turning to religion can help adolescents find inner strength:

*I go to church to praise God for all he continues to do for me, because the life we have was never bought: God gave it to us freely; God saves us from troubles and all the sin we commit; we pray to God to forgive us. In times of temptation, there may be people who will intervene to save us. God is the one who works through these people; this is why I go to Church. At times, the devil may attack us and once we call the name of God, we are relieved. These are the reasons why it is important to attend church services … It does many things for me; knowing protects me, God guards me and saves me from many things; it is God who does all these things for me.* (15-year-old adolescent girl, Bomi)

Traditional healers also emerged repeatedly as a key source of solace in times of trouble in Liberia. Caregivers often take their children to healers, including to tackle experiences of trauma related to experiences of sexual violence.

## 7.2 Family level

Seeking support from family members, both nuclear and extended, was an important coping strategy in all countries. A key coping strategy in Sri Lanka is to obtain support from a trusted adult, which sometimes means moving to go and live in a household where there is a caring adult. Adolescents who had the affection, care and support of at least one parent or one or two extended family members, despite often facing different forms of hardship, were more resilient and felt they could achieve a better future.

Girls interviewed in Gaza and Liberia, also spoke about turning to family members as a means of coping. Thus girls talk to their aunts who are close to them in age, and therefore more likely to understand the issues and challenges facing girls than their mothers. They also feel comfortable talking to their mothers, although, as one 15-year-old from Gaza noted, *'I don't share problems with my mother. For one thing, she tells my father and the problem gets bigger!'* In Liberia girls often also prefer aunts to friends because since the aunt shares the same family name they will not betray the girl, while a friend may be tempted to do so if the friendship becomes strained. *'I'm asking God and my aunt to help me and to take care of my child while I'm in school'* (17-year-old adolescent mother, Bomi).

In the case of Liberia, family support has for some adolescents been especially important in the context of the Ebola epidemic. Even in the case of parental loss, extended family members – e.g. grandparents, aunts and uncles – are providing a source of support for adolescents.

However, it is important to highlight that families are not always a positive coping source and can undermine adolescent girls' psychosocial wellbeing in very detrimental ways. Our qualitative findings in both Liberia and Sri Lanka showed that sexual violence, including incest, occurs and can undermine girls' ability to rely on family support. This is powerfully illustrated by the example in Box 5.

## 7.3 Community level

Seeking support from individuals beyond the immediate and extended family was also an important coping strategy in all countries. In all three study sites, friends are an important part of a girl's coping repertoires. In Sri Lanka, for instance, they study together in order to support each other. If they have a problem they seek advice from friends and generally hang out together and have fun. Similarly, in Liberia, adolescent girls often turn to friends for advice in times of crisis, especially around culturally sensitive issues, as this example highlights:

*Q: Would you advise your friend to do such when she becomes pregnant and does not wish to keep the pregnancy?*

*A: I will tell them to keep the pregnancy; if ants on the ground can find food to eat; they too will eat even if the boy disowns the pregnancy; by God's grace they will find support for their pregnancy.* (Adolescent girl, New Kru Town, Monrovia)

A supportive teacher also appears to be critical to girls in Sri Lanka. Not only are they seen to inspire girls and give them the confidence to continue their education and hold on to their aspirations for their future, but they also take time to listen to their students' problems, inquire about their health problems and provide advice.

Seeking help from formal sources is another important coping strategy in both Sri Lanka and Gaza. In Sri Lanka, respondents spoke about the importance of a caring social worker who visits the girls regularly, who shows interest in their school grades and educational material needs and with whom they can talk confidentially. In Gaza, many adolescents (particularly girls) became involved in psychosocial support programmes. Girl pupils tend to make more use of school counsellors more than boys, who find it difficult to approach school counsellors for various reasons, including stigma and perceptions of weakness. By contrast, in Liberia, formal psychosocial support programmes are much more limited. While the Carter Center has supported the government to establish mental health clinics attached to local hospitals, according service users interviewed for the study, they primarily receive medical support (e.g. access to post-rape prophylaxis) and sometimes support with judicial proceedings, rather than

providing in-depth counselling. Moreover, even though there is formal entitlement to follow-up sessions with the clinics, rape survivors explained that they rarely avail themselves of this support for various reasons, including transportation cost barriers and related stigma, even within their own families.

An important coping strategy in both Gaza and Sri Lanka is to socialise and engage in recreational activities. This, however, is easier for boys in Gaza as girls are not allowed to hang around outside their home or visit others, unless they are close relatives. Similarly, adolescent boys and younger girls (under 12), are able to take part in hobbies and folk dancing, while if older girls want to dance they have to do it secretly. One of the girls, aged 14, said: '*When we gather, we feel it is boring and want to create some fun, so we close the room and dance without anyone except my mother knowing. We keep the music low…*'. She added, '*During the war, we did not have chances to do this because of crowdedness and fear, of course.*'

**Students at Al Shami girls secondary school, near Ramallah**

**Box 5: Nowhere to turn**

Johnnetta is a 17-year-old girl living in New Kru Town, Liberia. After being repeatedly raped by her father and abandoned by her family because they are too scared of her father to help her, she is currently living with her 21-year-old boyfriend. Now pregnant, she is hopeful that when she delivers she can trust her boyfriend's parents to mind her baby so that she can return to 10th grade.

Her father's violence has defined Johnnetta's life since before she was born. She said that her mother was only 14 'when my father captured her during the war and took her to the interior and made her his wife'. His violence only escalated after marriage. He 'used to brutally beat my mother and hurt her severely with a knife'. While community members could see what was happening, they were afraid to intervene 'because my father used to take a knife for anyone' who tried to help. Johnnetta said that the last straw for her mother was the lack of protection afforded by the local court system. Because 'my father's uncle was the magistrate…it was not taken seriously'. When Johnnetta was 12, her mother left the family and returned to her own parents. She left her seven children behind so that they could continue their schooling.

Soon after her mother left, Johnnetta reported, her father 'jumped on me and forced me into the bush and raped me'. When she returned to town she 'reported the news to my aunt', who only 'advised me not to let anyone know about it'. While Johnnetta tried to keep her 'secret', the rape had been witnessed by another villager who told the community. Soon the 'news spread in the entire town and school' and Johnnetta said she felt shame because her 'friends provoked her'.

Two weeks later her father tried to rape her again. This time she managed to escape and went to the local pastor and told him what was happening. He agreed to take her in. Her father, however, 'went to the court and reported that the pastor had kidnapped her'. To avoid trouble, the pastor told her that she had to go home. 'Then my father took me back to the interior and raped me again'.

Seeing no other alternative, Johnnetta ran away to the city. While she was 'at first afraid to tell the truth', eventually she told the police what her father did to her. 'My father was arrested and was taken to the court and was later jailed'. Thinking that her ordeal was over, Johnnetta spent seven happy months living with her mother and going to school, but then her father was suddenly released.

Afraid for her young siblings, Johnnetta returned to live with her father to ensure that her little sisters were safe. Her father became even more violent. He 'locked me up in the room' and 'forcibly had sex with me'. When she was able to escape, she approached a police officer, who took her to the station. 'After I explained what happened to me, the station assigned me a social worker…and took me to the safe home' in Monrovia.

Even there, however, she was not safe. At the urging of her father, the Women and Children Office in Buchanan called Monrovia and 'asked me to go back to my father'. When she did, her father tried to rape her again. This time, Johnnetta fled to her grandmother's house. However, 'my grandmother refused me at home because she was afraid of my father'. Next she tried her father's niece, but she also refused to help.

Now, despite the fact that she believes that she is 'still too small to live with a man' and have her own baby, Johnnetta lives with her boyfriend who makes enough for 'for daily living' with his phone kiosk. While her boyfriend's parents are kind, and have promised to mind the baby and 'send me to school when it reopens', Johnnetta wonders why her own family and the courts have abandoned her.

Even though she is willing to go to court to testify against her father, 'the court did not go through the case and did not even call me'. Still more painful is the fact that when she tried to talk to her grandmother about the rapes, her grandmother refused to listen and 'asked me to go away from her'.

In Liberia, multiple respondents also highlighted the way in which they participate in the activities of the so-called secret societies – the *Sande* and *Poro* societies – which provide education on gendered traditions, roles and responsibilities of adults to adolescents, as well as promoting a sense of discipline and morale. While some were of the view that these were increasingly outdated and could even be detrimental to psychosocial wellbeing, for others they provide a critical sense of social connectedness and belonging as these narratives show:

*R1: As for the Poro and Sande, they don't account for much when it comes to training young people to be good citizens; the people who go there usually spend 3, 4, 5 or 6 days there; what young people learn from their parents and from the schools is quite better that what they learn from the Sande or Poro Societies; at times people go to the Sande Bushes and become worse than they had been.*

*R2: As a matter of fact, people believe in those secret societies; because in terms of education, those were the*

*place people relied for education before the advent of modern education; hence parents appreciate sending their children there to learn how to become good citizens in the future; young people are taught to be good husbands and wives in those societies.* (Bomi, Boys FGD)

In addition, in our Liberian research sites, boys and girls mentioned engaging in social and recreational activities such as football and kickball. It was however, easier for the boys to escape household tasks than girls. According to a 19- year-old boy in Bomi, this is because: '*parents do not pay too much attention to the boys*'.

Box 6 gives a picture of the type of challenges and difficulties experienced by one family in Gaza during and after the July 2014 fighting, including the kinds of coping strategies they used and the nature of the support they were able to access.

**Box 6: Life in a shelter: psychosocial challenges, coping strategies and access to basic services**

Hassna, aged 41, has seven children (three daughters, four sons). The family live close to the border between Gaza and Israel in a reasonably well-established house. Hassna's neighbourhood was heavily bombed during the war in July 2014. Her house was severely damaged and the small business (breeding animals) to which she turned after she become unemployed was completely destroyed. During the fighting, Hassna and her family fled to a UNRWA collective centre and stayed there for a week. Although supposedly a safe place, it too was bombed and many people were killed. Three of Hassna's sons (aged 20, 16 and 4) were injured.

UNRWA moved people to a different shelter. Hassna described this as a new 'tragedy', saying: 'I had lived the worst 45 days in my life at the shelter'. She and her family, including her three injured sons, lived with 128 people ('mostly strangers') in a small classroom at a UNRWA school. Hassna's family were given two square metres to stay and sleep in. All of her family were crying when they first arrived there.

Around 12,000 people were living at the school, a place that was not designed as a shelter. There was not enough tinned food or bread, and the goods that were provided did not uphold people's dignity. There was no soap or other items for personal hygiene at the beginning, so Hassna had to buy these items. She said: 'Three times I bought anti-lice shampoo because my children had been infected with lice due to the bad hygienic situation… Later on, UNRWA provided it.'

Hygiene and sanitary conditions at the shelter were also far from adequate, with no clean water. Hassna described the situation: 'You have to wait at a long queue, at least for around one hour to use the toilet. It is very dirty and disgusting.' 'I also had a clash for the first time in my life with another woman who hit my 12-year-old daughter because she wanted to use the toilet before her and my daughter refused. I was standing nearby to protect my daughter and I become very angry when I heard my daughter crying.'

When asked how her adolescent daughter (aged 12) coped, Hassna mentioned that she slept most of the time, she hardly communicated or interacted with others. She refused to eat, preferring to sleep. Up until the time of the interview (two months after leaving the shelter), her daughter was still refusing to talk about what happened during their stay at the shelter.

After 45 difficult days in the shelter, Hassna's family decided to leave and went back to live in their badly damaged house. They felt that living in the shelter was degrading, and they had lost their dignity. At the time of the interview, five months after the ceasefire, the area they were living in still had no water, electricity or communications. The building they were in was leaking water through the roof.

Hassna reported that her family had not received any psychosocial support or services, except for the youngest son (aged 4) who took part in some activities inside the shelter organised by a local community-based organisation. 'My 16-year-old son was injured too, but he didn't receive any psychosocial support and my daughter who is in a bad condition didn't receive any support either till now.'

Hassna is not sure how her adolescent daughter is coping. She thinks that she is not okay but her problems are not manifesting themselves in the same way as her brother. For now, at least, Hassna's priority is her son, who is resorting to a range of negative coping strategies – smoking and hanging out with 'bad friends'.

'I feel very sad about what happened to us, all our life aspects have been distorted. Our family was okay and always we used to be together. But not anymore. My children are outside the house most of the time. Our experience in the shelters is unforgettable tragedy. We all need psychosocial support.'

# 8 Formal service provision

## 8.1 Overview of mental health and psychosocial service provision

Although there is ample room for improvement, especially in terms of coordination and regulation, a relatively well-established formal MHPSS service provision system exists in both Gaza and Sri Lanka, whereas in Liberia the system is still in a very fledgling state. We begin here by presenting the key characteristics of the existing MHPSS service infrastructure in our three case study countries before discussing the strengths and weaknesses vis-à-vis provisioning for adolescent girls. Annex 1 contains tables from Gaza and Sri Lanka outlining service provision: for Sri Lanka it focuses on service provision across the different sectors, for Gaza the focus is on mental health/psychosocial services.

### Gaza

There are more than 162 organisations currently providing psychosocial and related services in Gaza. Only two – the Ministry of Health (MoH) and the Gaza Community Mental Health Programme (CMHP) – provide specialist services. The MoH is the main provider, supervisor and regulator of mental health services. It has recently begun a process of integrating mental health services into the non-communicable disease departments of all its 54 primary health care centres.

The United Nations Relief and Works Agency for Palestine Refugees (UNRWA) is the second major provider, delivering mental health and psychosocial services through counsellors based at UNRWA health and relief centres. UNRWA focuses on preventive care and on counselling and debriefing rather than providing consolidated case management for individuals. Both UNRWA and the Ministry of Education run a large-scale school counselling programme with more than 500 counsellors.

In addition, there are many NGOs in Gaza that provide psychosocial awareness and support through counsellors and social workers, but much of the support is short term. The most recent conflict (July 2014) substantially affected routine mental health care services: services provided by PHC centres were suspended, with the focus shifting to life-saving interventions. Afterwards, however, at least 59 psychosocial programmes were implemented by local and international NGOs in the Shajaia area alone, serving more than 25,600 children. The most common interventions after the conflict were structured group activities, psychosocial first aid [34], awareness raising, debriefings, and fun days. It is important to note, though, that these peaked immediately after the conflict but were not oriented towards developing a sustainable and comprehensive system of tailored support.

### Sri Lanka

The history of mental health and psychosocial interventions in Sri Lanka's conflict goes back to the late 1980s, with the initial services established by civil society organisations. In the late 1990s and early 2000s, there was significant development of initiatives to provide services to displaced populations and especially for children affected by conflict. Mapping exercises in 2001 identified 71 initiatives (Galappatti, 2003), and a follow-up in 2003 identified nearly double that number. After the 2004 tsunami there was a further expansion of these services with the Tsunami Evaluation Commission listing 374 organisations providing services in the tsunami-affected districts of Sri Lanka. The growth in emergency-related MHPSS services contributed to development of interventions in diverse areas such as the care and protection of children, sexual and gender-based violence, serious mental disorders, disability and other forms of adversity (Galappatti, 2014a, 2014b).

Recent efforts to map psychosocial services in the state and non-government sector (Sivarajah, 2012; Consortium of Humanitarian Agencies, 2013; Institute for Health Policy, 2013; The Good Practice Group, 2013) have demonstrated the existence of a variety of MHPSS service providers across the country, but also revealed significant gaps in provisioning. Anecdotally, there has been a decline in the number of non-government service providers for psychosocial services in the years following the end of the war. However, in the aftermath of the tsunami, the Sri Lankan state did recruit significant numbers of new staff across the health, education, social welfare, women's and children's sectors whose on-going responsibilities included providing psychosocial and mental health support.

Thus, after the tsunami, the government approved a new national ten-year (2005-2015) mental health policy that

34 This has included measures provided at shelters and has involved helping people to feel safe, connecting them with others, and providing emotional and social support.

supported comprehensive, decentralised, community-based services, established the National Institute for Mental Health and a national strategy to reduce stigma and discrimination, and called for mental health legislation to protect the human rights of the mentally ill (WHO, 2013). In 2006 the Ministry of Health commissioned the National Mental Health Survey (Siriwardhana et al., 2011). In 2008 the National Mental Health Advisory Council was created to oversee implementation of the new policy. Using the latter as a guide, several programmes were implemented at national and district levels with international financial support and guidance. In addition, primary health care doctors received mental health training (WHO, 2013).

By 2011, 20 out of 26 health districts (77%) had acute care units within general hospitals; there were 16 intermediate stay rehabilitation units; mental health outreach clinics were established in sub-districts enabling people with mental illness to be treated close to their homes; and the Mental Hospital at Angoda in Colombo District was no longer the 'lunatic asylum' but the National Institute of Mental Health (WHO, 2013). However, challenges persist, particularly in terms of trained mental health professionals. To address the situation, several types of mental health professionals have been introduced. A one-year diploma course providing training in psychiatry has been provided by the Ministry of Health without external support and graduates are already working in both hospitals and outreach clinics, with each of 25 districts now having at least one doctor with a diploma in psychiatry. In addition, two types of cadres, Medical Officers of Mental Health and Medical Officers of Psychiatry also receive mental health training and work under the supervision of district psychiatrists. Community mental health nurses and psychologists also provide services. Finally, in areas affected by the tsunami, locally recruited mental health workers – the Community Support Officers (CSOs) – have been trained and assigned in their communities in order to increase acceptance and trust, reduce stigma and ensure that interventions are culturally appropriate and acceptable. An evaluation confirmed that CSOs have significantly improved access and coverage of mental health services to communities, particularly in areas with limited or no previous access (WHO, 2013).

The Ministry of Social Services has deployed over 100 Counselling Officers working through district or divisional secretariat offices, as well as significant numbers of social service officers (Institute for Health Policy, 2013). The Ministry of Child Development and Women's Affairs has over 200 Counselling Assistants working at district and divisional level (The Good Practice Group, 2013), as well as National Child Protection Authority-affiliated psychosocial personnel in nearly every district. Facilities for juvenile offenders and rehabilitation of girls and women survivors of violence also have personnel assigned to provide psychosocial care, and Women Development Officers, Child Rights Promotion Officers and Probation Officers are also often expected to provide psychosocial support to their respective target groups. The Ministry of Education currently has over 1,400 teachers appointed as guidance and counselling teachers in schools across the country. In addition, there are counsellors attached to courts through the Ministry of Justice, as well as plans to train existing cadres of the Ministry of Foreign Employment Promotion and Welfare to provide counselling at divisional level. This is not a comprehensive account of the government personnel with direct mandates to provide MHPSS service, as the available information on service providers is fragmented and often incomplete.

### Liberia

In Liberia, while the MHPSS system is still fledgling, there has been a growing recognition over the last decade of the importance of addressing mental health and psychosocial ill-being. In 2008 a nationwide household survey of 1,666 adults aged 18 years and older was carried out to assess the prevalence and impact of war-related psychosocial trauma, including sexual violence. One in three respondents had participated in fighting forces and one in three of these were women. The survey found that 44% of participants had PTSD symptoms, 40% met the criteria for major depressive disorder, 11% reported suicidal ideation, 8% social dysfunction, and 6% a prior unsuccessful suicide attempt. The majority of both combatants and non-combatants indicated the unavailability of mental health care (Johnson et al., 2008).

In addition to the 2008 nationwide survey, a number of other surveys have been carried to assess the mental health status of the population, or the effectiveness of psychosocial interventions implemented by NGOs (e.g. Vinck and Pham, 2013; Galea et al., 2010; Lekskes et al., 2007). Findings include that women were found to have higher prevalence for symptoms of depression (18%) and PTSD (19%), compared to men (3% and 6% respectively) (Vinck and Pham, 2013). In one county (Nimba), almost half of respondents had experienced the murder of a family member or friend, the overall prevalence rate of PTSD was 48.3%, reaching 100% in one village, and despite the passing of almost two decades after the end of the atrocities, there was still a high prevalence of PTSD (Galea et al., 2010). Even where interventions were taking place, not only were counsellors unclear of what was necessary for women survivors or conflict-related sexual violence, but they themselves reported severe symptoms of stress and trauma (Lekskes et al., 2007).

After the end of the conflict mental health services were limited to the Grant Hospital in Monrovia and there were no specialised services for children and adolescents. Several NGOs and faith-based organisations were providing psychosocial services (Lekskes et al., 2007): some targeted women and children survivors of sexual and domestic violence, others women with HIV and AIDS (CEDAW 2009b). There was only one practising psychiatrist in the country and primary health personnel lacked appropriate training. People with mental health problems faced stigma and social isolation, obtained assistance from traditional healers, and were even subjected to harmful practices (Carter Center, nd).

As result of these findings, mental health was made one of the six focus areas of the Basic Package of Health Services (BPHS), and in 2009 the National Mental Health Policy (NMHP) came into existence (Lee et al., 2011). The NMHP aimed to integrate free and confidential mental health services into the primary health system, fight stigma and discrimination associated with mental illness, and provide special services to specific population groups at risk of mental health problems: children and adolescents, victims of SGBV, and the seriously mentally ill (MoHSW, 2009). The Basic Package of Mental Health Services (BPMHS) followed in 2010. The NMHP and BPMHS specified the range of services that should be provided from clinic to hospital level and outlined issues related to staff and standardised diagnostic evaluation. The Ministry also decided to enable trained mid-level primary care providers to serve as mental health clinicians (Lee et al. 2011). In 2011, the Ministry of Health and Social Welfare, citing high prevalence rates of depression, post-traumatic stress disorders and substance abuse and low rates of clinicians trained to provide mental health services (18%) made mental health an integral part of its new Essential Package of Health Services (MoHSW, 2009). It projected that by the end of 2015, 181 mental health clinicians would be trained. Since 2010 the Carter Center has been working closely with the government to build a sustainable mental health system able to meet the increased population needs; 160 mental health clinicians have been trained under this programme[35].

The Government of Liberia recently separated children's services from the Ministry of Health and created a new Ministry of Gender, Children and Social Protection. A 2011 Children's Law was enacted based on the United Nations Convention on the Rights of the Child. It places a heavy emphasis on the protection of children and their rights to education, protection and representation. However, one study found that only 30% of caregivers in one survey knew that there were laws protecting children and 15% knew about the Children's Law (Ruiz-Casares, 2011). Only 7% knew about mandated community child welfare committees and of those only 25% found them effective.

## 8.2 Tailored adolescent services and programmes

While there has been considerable progress over the last decade in strengthening psychosocial and mental health systems in the three case study countries, the extent to which they provide tailored age and gender-sensitive services and programmes for adolescent girls is extremely limited.

In terms of addressing adolescent-specific vulnerabilities, we found that there was very little attention provided both in terms of research and actual programming. In Gaza, our findings indicate that despite there being many psychosocial and mental health service providers, organisational, cultural and psychological barriers often prevent young people accessing those services. Donors often provide reactive psychosocial programmes as part of their emergency response immediately after a period of intensified fighting. These services do not tend to meet people's needs and are generally not proactive in screening, identifying and supporting those most in need. In 'normal' and crisis situations alike, adolescents are not proactively targeted by service providers; in fact, adolescents tend to be overlooked by these programmes, which often focus on younger children. Of the programmes implemented during the most recent post-conflict period, only 0.9% targeted young people (aged 15-29 years), despite a much talked about 'youth bulge' in the country, with 53% of the population aged 15-29 years (UNFPA, 2013).

In Sri Lanka, the mapping of services demonstrates that the Batticaloa district has a wide range of MHPSS service mechanisms in place. However, many of these mechanisms are not oriented to deal specifically with adolescents and therefore do not adequately address the complex issues that adolescents face in the post-war context. Important exceptions are the gender-based violence (GBV) desks at hospital facilities which provide psychosocial support to survivors of GBV – both minors and adults (see Box 7).

Mental health professionals interviewed for the study in Sri Lanka emphasised that although medical care and mental health services are provided for adolescents, there is a need for as stronger focus on social rather than medical interventions to better support the vulnerabilities of adolescents, including the social issues at the root of self-harm. The mental health unit employs a range of therapies, from counselling to psychiatric care, but these are not always focused on the areas of greatest need. For example, the failure to recognise suicide as a critical issue affecting adolescent girls in the study area reflects a broader failure to recognise the adversity and stresses of adolescents' lives that push some of them to attempt suicide. For adolescent girls, experiences such as early

35 The Carter Center has three main objectives to complete by 2015: train mental health clinicians, including community mental health workers; help the Ministry to implement the NMHP and increase coverage of mental health services to 70% of the population; and organise anti-stigma campaigns and improve public understanding of mental illness (Carter Center, nd).

**Box 7: Gender-based violence desks in Sri Lankan hospitals: a source of psychosocial support for adolescent girls**

The GBV desk is a specialised centre for providing psychosocial support to survivors of GBV and is located at the hospitals in Valaichenai and Batticaloa. According to the KII with the GBV desk officer at the Valaichenai hospital, the services they provide range from meeting with families of affected persons and coordinating case conferences to providing counselling and making referrals for medical and legal support. The GBV desk works closely with the Medical Officer (Psychiatry), the mental health unit and the paediatric ward of the hospital. Apart from the hospital based services, the GBV desk officer also conducts basic training on counselling to school teachers; raises awareness on prevention of GBV and avoidance of teenage pregnancies in schools and in communities through different NGOs; and makes home visits to follow up on service recipients, where necessary. The GBV desk at Valaichenai hospital typically deals with about 25-30 cases a month and links with about 1,500 people per year, comprising affected persons and their families or other significant people in the affected patients' lives. Currently the centre is served by one Social Welfare Officer who is generally known in the hospital as the GBV desk officer. She has received counselling training through the Institute for Human Relations, Counselling and Psychotherapy through the Christian Counselling Centre, Vellur, India and GBV and psychosocial support training through short-term NGO training sessions. She feels that the service is particularly important to adolescent girls who come to the hospital because they do not often have a trusted person with whom they can discuss their problems. The GBV desk is managed by the Medical Superintendent of the hospital and reports monthly to the Regional Director of Health Services and quarterly to the Ministry of Health, which validates it as a state health sector service although it is supported financially and technically by NGOs. The GBV desk works closely with NGOs to access support for GBV survivors as well as for technical expertise on gender-related analysis of cases.

marriage, teenage pregnancy, economic hardship or being abandoned by their spouse contribute to an increased risk of suicide.[36] A lack of recognition of suicide as a priority issue in turn leads to a lack of acknowledgment of the need for psychosocial interventions and other mechanisms that provide emotional support to reduce the stress caused by these precipitating or contributory factors. One service provider captured this issue when she said that the emphasis is on post-crisis care and support while less attention is paid to prevention. This illustrates a need to acknowledge adolescents' suicide attempts as the tip of the iceberg of problems and stresses that erode adolescents' wellbeing. In other words, ongoing group psychosocial support that strengthens capacity and resilience is missing but urgently requires greater resourcing.

In Liberia, the age-sensitivity of services provided is mixed. On the one hand, the location of the mental health units in hospitals has been designed to reduce stigma – i.e. users will be seen to be using health services in general rather than mental health services specifically – but on the other hand it was clear in both the study sites that awareness of the services provided was very low. In Bomi, transportation costs to reach the hospital were mentioned as a concern and a barrier to appointment follow-up by adolescents, especially those seeking support for culturally sensitive support (e.g. post-sexual violence). In addition, the health and social services type programmes that target adolescents, ranging from peer sex education to girl empowerment through the media, vary in quality, level of evidence for the strategies employed and length of the intervention necessary in order to make an impact. Many of the adolescents in our study were not aware of these more 'population-based' initiatives.

The extent to which services are gender-responsive was equally limited across the three country contexts, again highlighting the need for competent education, training and supervision of service providers. In Gaza, our research revealed mixed findings about the attitudes of health care providers. On the one hand, most were found to be enthusiastic, caring and motivated to help their service users. Although patient satisfaction is not systematically measured, respondents generally seemed moderately satisfied with the quality of services provided in the Gaza Strip, particularly around accessibility; but there were missed opportunities for adequate counselling and providing information to service users (see Box 8).

On the other hand, however, particularly at the service delivery level, providers are not gender-sensitive. Verbatim comments indicate that some providers had projected their own personal issues and problems onto service users. In other cases, it would appear that prevailing social norms have influenced providers' perspectives, with many

36 The legal age for marriage is 18. Girls who start co-habiting, which is customarily regarded by the community as marriage, may face abandonment after a few years. They have to struggle to survive, often bringing up one or two children. Their ability to engage in a viable livelihood is limited as they have not completed schooling and therefore have to work as unskilled/semi-skilled workers. Although they may be supported by their families with shelter and food, the parental families are also often poor and have difficulty in meeting the additional economic burden of caring for the adolescent mother and her child/children.

**Box 8: UNRWA's school counselling programme in Gaza**

Counsellors at UNRWA schools help children to learn basic life skills such as appropriate forms of communication, as well as to develop coping mechanisms for stress and build their self-confidence through a range of exercises. According to the Ministry of Education (MoE), 56% of UNRWA-managed schools are covered by counselling services (MoE, 2014). The MoE also employs school counsellors, covering 82% of MoE. Despite good coverage, key informants from both UNRWA and the Ministry admitted there are several weakness in the counselling services they provide. One said: 'The school counselling is helpful to pupils. However, it is far from achieving its goals... Now it focuses on behavioural issues and academic achievements... We intensified training on counselling through support from international organisations.'

Many key informants referred to schools as the best place in which to address adolescents' psychosocial vulnerabilities (for boys and girls alike). One policy-maker reported: 'There is a missed opportunity to improve the psychosocial status of adolescent girls through school counselling. To target adolescents, you need to go at the places they are naturally available – the schools. It is the place that is not associated with stigma and the place at which early discovery of problems could take place.'

Counsellors working in UNRWA health centres provide education about psychological issues and help chronically ill patients manage their condition through making lifestyle changes. Beneficiaries receive educational sessions, counselling services and debriefing activities. At one UNRWA facility, 80% of cases are referred to the counsellor by health staff working with patients seeking non-mental health services; 10% by UNRWA school counsellors; and the rest are family- or self-referrals. UNRWA reports indicate that its CMHP programme contributes to training health staff to be more aware of issues surrounding gender-based violence (UNRWA, 2015). As mentioned earlier, there are several UNRWA and MoE schools in Shajaia, as well as a UNRWA health centre (Al Darraj). UNRWA school counsellors tend to target pupils with low academic achievement or behavioural issues as well as those experiencing emotional problems. However, given its current structure and the number of counsellors at UNRWA schools, it is impossible for the CMHP to proactively identify and address the needs of the most vulnerable adolescents.

adopting judgemental attitudes towards adolescents in general and gender issues in particular. One counsellor based at a clinic, showing a lack of empathy, said:

> *'I don't show any empathy to females who fall in love and behave against culturally mainstream behaviours. How can I support a girl who falls in love during the war in a collective centre…'. The same counsellor said, 'All stories we hear are related to love, stories on mobile and things that may God protect us from them.'*

Some male health providers also reported feeling reluctant to treat adolescent girls unless they were accompanied by a family member, undermining patient confidentiality, and/or because of their sympathy with community attitudes which stigmatise mental illness especially among females. This is also related to perceived concerns around heritability of mental illness that negatively impact on girls' marriageability (see also below). One caregiver cited for example the negative attitudes of a health provider when they sought care for their daughters: '*The general physician stopped following up my daughters, especially the older one, and he asked me to stop treating her because she is now a young lady, and continuing receiving mental health services will affect her reputation and she will be* stigmatised forever.' He told the caregiver, '*It is enough. Don't take her to any doctor. This will affect her if people know about her case.*'

In Sri Lanka, the gender-responsiveness of support services was also mixed. On the one hand, teenage pregnancy is acknowledged by health service providers as a prevalent health and social issue affecting adolescent girls. Measures taken to deal with this include awareness-raising programmes in schools and in the community and training for adolescents and family health workers (FHWs) promoting the use of contraceptives to married teenagers. However, while the hospital staff treat teenage pregnancies as a health risk that needs medical intervention and monitoring, families struggle often more so with issues of social stigma and the need to conceal the pregnancy from relatives and neighbours. Families often conceal a teenage pregnancy as long as possible from neighbours and have the teenager admitted to a hospital in a distant location, but there are few related psychosocial support mechanisms in place for teenage girls going through this situation.

The attitudes of service providers were also strongly impacted by the gendered social norms and value systems prevalent in the community. Services to adolescents, especially girls, were influenced by considerations of moral conduct. More specifically, the primary concerns of communities and service providers responding to adolescent issues in the post-war context were to address 'risks' and to provide 'protection'. These were

**Box 9: The blurred line between service providers' professional support and moral policing in Sri Lanka**

Despite a policy environment where state and non-state service provision aim to promote equal access to services, the moralistic and gendered attitudes of many service providers influence the nature of service delivery otherwise. Below are some illustrative examples that are among the experiences of adolescent girls in the community studied:

***Concerns around girls' protection and respectability***
Access to vocational training and tuition for adolescents, especially girls, is mediated by protection concerns. Girls' access to vocational training or tuition, especially in the A level class, is limited if it requires travelling too far or if an adult caregiver cannot accompany them. The fact that the tuition classes are mixed spaces, allowing for the possibility of love affairs, also stops parents from sending girls. Even if parents are supportive, there is social pressure and criticism if girls are allowed to travel outside of the community to pursue wider educational options. In youth-focused spaces, particularly in the Muslim communities, the boys themselves do not allow girls to participate.

***Girls more often penalised for disregarding moral codes***
The School Disciplinary Committee of the local school handles issues related to adolescents' conduct in school, including romantic relationships. If an adolescent girl and boy are noted as having a love affair, they are advised by the disciplinary committee to focus on their studies instead. If it still continues, the parents are informed and if the parents' advice too is not heeded, one or the other of the children was asked to leave the school. Most often it is the girl who is given a leaving certificate.

***Using the 'best interest' of the child to challenge hindering notions of respectability***
There is no legal barrier or official rule to prevent girls who have dropped out of school due to sexual abuse or pregnancy from being re-admitted. However, they are often prevented by the gender norms of school authorities. The schools sometimes ask for guarantors to vouch that the adolescent will behave well and will not negatively influence other students.

largely framed as the regulation of adolescent girls' (and boys') questionable or immoral behaviour. It was also striking that the adolescents themselves demonstrated an internalisation of emergent social norms and normalised the processes by which their morals and behaviour were socially regulated (see Box 9).

In Gaza, a lack of community awareness and sensitisation of the different strategies involved in helping people with psychosocial or mental health support also emerged, resulting in socio-cultural judgements interfering with the kind of treatment approach used with vulnerable groups, including adolescent girls. One senior expert explained a situation he had encountered: *'A policy-maker described mental health and psychosocial services teams from an NGO as bad, impolite, rude, and strange because one counsellor/social worker organised dancing sessions for girls at collective centres for IDPs. That policy-maker prevented the NGOs from supporting the IDPs at collective centres because he believed that these NGOs are doing terrible unethical things and spoiling the girls.*' The interviewee added, *'This is a problem in the mentality of people regardless of their education and position.*'

In Liberia, there is a strong link between the mental health support being provided at community level and support to survivors of SGBV. In 2012, the Ministry of Gender and Development (now Gender, Children, and Social Protection) began an initiative to train mental health clinicians to provide services to survivors of SGBV. Mental Health Clinicians are able to provide thorough examinations, key to the prosecution of cases, and address the psychological effects of sexual violence.[37] Amongst the survivors interviewed in this study, many felt that more support was needed in liaising with the criminal justice sector and also with medical professionals, especially vis-à-vis physical trauma and ensuring receipt of post-rape prophylaxis. Awareness of the importance of longer-term psychological counselling was however very low.

37 The training also resulted in greater cooperation between the different providers on the referral pathway and in more skilled workers, but it has yet to go to scale. In addition, a joint UN plan for addressing SGBV has experienced wavering levels of support to address some of the entrenched flaws with the current system to stem the epidemic in violence against women and girls. For example, strategies to abate the tendency to 'settle' cases outside the law, such as providing immediate funding for the survivor's family for basic supplies, known as the endowment fund, was recently terminated. In addition, short-term and one-off programmes plague the system. For example there was a one-time training of Women and Children Protection Services staff in basic interviewing skills which most of them did not possess. Most of these best practices are donor-fund driven and not embedded into the national budget or a long-term funded strategic plan.

**Box 10: The preventive role of school clubs in Sri Lanka**

FGDs conducted with adolescents in Stage 1 of the study underlined the importance adolescents place on positive social interaction as a contributor to their wellbeing. Run largely by NGOs, the main approach to promoting children's participation and agency is through children's clubs, which facilitate awareness raising, training, educational support programmes and opportunities to explore their talents and to interact socially. Organising community activities such as religious and new year celebrations or sports and cultural events gives the members opportunities to develop their leadership skills and creative talents.

Children's participation in club activities, according to KIIs with NGOs, is affected by children attending private tuition classes after school or during the weekend as well as some parents' disinclination to send their children to these clubs. As such, according to KIIs with NGO staff, only a relatively small percentage of children in the community are members. The clubs are open to both girls and boys, but in some areas where mixing of sexes is seen as a risk to girls' protection and respectability, families discourage girls from participating. NGOs such as ESCO, ESDF and the Church of American Ceylon Mission have been responsive, meeting families to obtain permission for girls' participation and operating within the social norms of the area. As NGOs are keen to operate the children's clubs within the parameters of cultural appropriateness, there is less inclination to encourage school dropouts and working adolescents to become members of children's clubs, while married teenage girls generally do not participate. Service providers reported that the DS of Valaichenai has recently asked NGOs to open children's clubs to school dropouts so that they also have access to training and awareness-raising opportunities that other children access through schools and children's clubs.

## 8.3 Gaps and disconnects

Our research findings identified a number of important gaps and disconnects in terms of psychosocial and mental health service provisioning. First, there are few preventive activities targeting adolescents or activities to identify vulnerable groups at greater risk of mental health problems. In Liberia, for instance, where school counsellors exist in some schools, adolescents emphasised that their role was to intervene only in cases of crisis. *'The counsellors we have in the schools only counsel us when we fail – that's when they call us to talk'* (adolescent girl, 16, Bomi). There are, however, important adolescent-focused programmes which could be seen to serve indirectly as preventative of psychosocial ill-being – children's and youth clubs – which are relatively widespread in both Gaza and Sri Lanka but not in Liberia (see also Box 10).

Second, there are significant issues in all three contexts regarding service fragmentation and poor quality of psychosocial and mental health services. Part of the problem lies in a dearth of nationally endorsed protocols or technical guidelines in Gaza, except at PHC centres run by the MoH. In the same vein, there is no clearly defined therapeutic model to guide clinical practice, and no structured 'continuum of care'.

Third, there is limited overarching strategic direction for psychosocial and mental health services. This includes a short-termist perspective and lack of systematic follow up mechanisms and procedures within the sector despite the fact that recovery from mental illness does not necessarily mean a complete cure; rather, it means that service users are regaining their ability to function on a day-to-day level and their quality of life.

Fourth, our findings also reveal a lack of evidence-based practice that could maximise the impact of mental health interventions. In particular, it is difficult to measure impact on beneficiaries or service users due to an absence of baseline data. Most of the organisations involved in the study did not use assessment tools, for adolescents or other groups. However, a number of participants did report positive impressions of the services they received, which delivered outcomes in helping them to cope and increase their wellbeing.

Fifth, in terms of resourcing, we identified significant if unsurprising differences between the health care spend in Gaza and Sri Lanka – both middle-income countries – and Liberia, one of the globe's poorest countries. Compared to other countries at a similar level of economic development, Palestinian[38] and Sri Lankan overall health outcomes are relatively good, partly due to strong performance of most basic public health and PHC functions. While people are generally able to access health services under ordinary conditions, access becomes challenging during conflicts and emergencies.

38 The PNA typically devotes an unusually large share of its scarce resources to the health sector, ranging from 13%-16% of gross domestic product over the past five years (GDP) (MoH and PCBS, 2014). Annual per capita health expenditure has increased from $120 in 1994 to $311 in 2012 (MoH, 2014). However, around 80% of Palestinians' contributions to health expenses are out-of-pocket payments (43% of total spending on health)(MoH and PCBS, 2014). The fact that households carry such a large burden of costs for meeting family health needs suggests a serious system failure.

**Box 11: Service deficits in the context of Ebola**

Leymah is a 16-year-old orphan. Last year, after her parents and baby brother died of Ebola, she and her 7-year-old sister spent weeks living alone on a porch because no one, neither service providers nor family, would offer them shelter.

Last 26 July, Leymah came home from church and found her father, a taxi driver, 'lying in the room feeling chill'. When she and her mother took him to the hospital, 'the doctor said his chest was blocked because he used to smoke'. After days of injections, however, her father grew steadily worse. Finally, the community convinced them 'to call the Ebola team' and leave the house. The Ebola team, however, did not come, so the family was told 'to go to JFK Hospital in Monrovia' to be tested. When they arrived they learned there would be no testing until the following week and, via a phone call, that their house was now under quarantine because their father had died of Ebola.

Leymah's mother told the doctors at the hospital that they had no home to return to. The doctor 'told us that we should go to the LNP Headquarters'. However, 'when we got there and explained what had happened to us, the people there started to drive us away and that there was a place at the Police Headquarters for us to stay'. But, the people 'at the Police Central drove us away'. 'Nobody could take us in'. In desperation, 'I told my mother that we should go back to New Kru Town at the Redemption Hospital'. But when they arrived 'the people there said they could not help us – they too chased us away'. With nowhere to go they returned to their quarantined house. Fortunately, a neighbour 'accepted that we should sleep on their porch'.

A week later, 'we were sleeping on the porch still' and 'my younger brother became ill'. 'The doctor said the boy had cold on his chest' and gave him some medicine. However, her mother was 'worrying too much' and 'did not hear what the doctor had told her' and accidently gave her brother too much medicine. He died. The next day her mother fell ill.

After Leymah and her younger sister took their mother to the hospital, 'we returned to the same porch'. Their aunt initially offered to take them in, but her neighbours 'threatened to call the police'. Then 'my grandfather too refused'. 'I decided that my sister and I would remain where our mother left us; we slept on the porch'. A week later, their mother died.

Now Leymah and her younger sister are living with their maternal uncle and his wife, who treat them well. Leymah wants to be a doctor and take care of the sick the way she wishes her family had been taken care of.

Generally, the distribution of health personnel per population in Gaza is reasonable. However, specialty and subspecialty areas, including in mental health, are greatly under-represented. There is a reasonable gender balance among health personnel, and women are more likely to participate in the health workforce in future as they are currently participating in training programmes in higher numbers than their male counterparts (WHO, 2010). However, there are issues surrounding the quality of care due to lack of appropriate standards and weak implementation of existing guidance. Perhaps most importantly for the purposes of our study on MHPSS, access to advanced services, however, remains a real challenge facing the health care system in Gaza. And indeed, for the poorest households, obtaining a medical report to get financial assistance from the Ministry of Social Affairs was often mentioned by health providers as a barrier to psychosocial and mental health service uptake, but interestingly this was not mentioned by service users or programme beneficiaries.

Moreover, our facility checklist identified that there were a number of shortcomings in terms of the quality of existing facilities and related equipment. In Gaza, MoH mental health facilities were reported to be less well-equipped and less spacious than facilities run by NGOs or UNRWA. Other constraints that were frequently mentioned by research participants include shortages of drugs and lack of modern equipment. The mental health hospital (and particularly its seclusion units) was described as a particularly outdated facility.

In terms of staff capacities, more efforts are needed to ensure that women are appointed to senior positions in the health system, including within the MHPSS sector. Moreover, findings reveal gaps in training for mental health personnel, including improving technical performance, developing skills in assessment and diagnosis, use of case management, therapeutic modalities, psychiatric emergencies and child/adolescent psychiatry. Other areas identified as priorities include psychotherapy, Cognitive Behavioural Therapy, family therapy, team case management, case management, managerial and leadership skills, supervision skills, occupational and rehabilitation approaches, substance abuse, forensic psychiatry, crisis intervention and community-based interventions.

In Liberia, service providers highlighted that resource shortages were a key concern, with a dearth of basic office supplies and a lack of budget for photocopying the necessary reporting forms. '*As for the police, if people commit crimes in the community and we call the police, they usually request that we fuel their vehicles; for ambulance, it has to be an extreme emergency but it is not readily available*' (adolescent boys' FGD, Bomi).

Moreover, there was overcrowding at the hospitals – where the existing MHPSS services are provided – where '*some people may go there [the hospital] during the morning and don't return until late evening; the place is usually crowded…it would be difficult for you to get attention and come home; it would be difficult even to get drugs*' (adolescent girl, 15, Bomi). In the same vein, even if survivors of sexual abuse are eventually referred to a safe house, their stay is limited to just two weeks before they are 'reunited with their families' but this often results in girls' being put at risk of abuse again or at the mercy of resource-strained extended family members.

> *One victim was 16 years old, she was raped by one boy in the same community and she told us that the perpetrator always threatened that if she tells the story to anyone she will be beaten badly by him. So we asked her where she wanted to go and she told us that she wanted to go to one of her aunties who lived in Monrovia and we called that aunt and explained the story to her and she agreed that the girl go to her – she even got pregnant from the rape … That is why we send the survivors to the safe home for two weeks and after the two weeks they come back in the community and reunite with their families; if after this they are not still feeling secure we will ask them for an alternative where they want to stay and they will tell us. Then we will talk to whomsoever for such purpose.* (Service provider, New Kru Town)

Furthermore, although there is a general discourse post-Ebola about 'building back better' resource constraints emerged as even more pressing for the service providers in our research sites, as this quote highlights:

> *Before Ebola we used to give them small token mainly for those that live far away for transportation (LRD 250) but since then, it has stopped … The partners (IRC and UNFPA) can provide scratch cards for communication but that is not sufficient because we need to go and see where the survivor lives and know their living conditions, then we know how to work around things. Sometimes some patients can come very hungry to the point where we can use our money to buy food. We told the partners since they are not providing food they could provide some small small food for such patients.* (Service provider, New Kru Town)

Respondents also noted that there are some targeting issues with support for the most vulnerable children following the Ebola epidemic. While there are some provisions for support for affected community members, some people are reportedly using fake death certificates to claim for support, to the detriment of those most in need, as this quote explains:

> *Some people whose children are not orphans; some say they are survivors. They impost [act as imposters] so that they can receive money and that is the reason why we don't receive the money. Recently I went to Duport Road Clinic: people took fake certificates claiming to be Ebola survivors. They used to do it every time. One day they were caught. They claimed they were Island Hospital Survivors. The people called us to verify those who were pretending to survivors; our leader said he didn't know them.* (Boys FGD, New Kru Town)

## 8.4 The role of community attitudes and gender norms in shaping service uptake

A consistent theme in our research was the negative role that community attitudes towards mental health service uptake in general and to the uptake of services by adolescent girls in particular. First, in terms of community attitudes vis-à-vis mental health, we found strong evidence that mental health problems and psychosocial ill-being are associated with high levels of stigma and discrimination. In the Gazan context, most study participants felt there is still stigma attached to psychosocial and mental ill health, although it is declining over time (this is truer for psychosocial than mental health services). Responses indicate that stigma is evident among the broader community, among general health service providers, mental health providers, and the media. One key informant from the MoH in Gaza for example admitted, '*The issue of stigma is severe in Gaza. We at the health system stigmatise mental illnesses and also the staff working on this field.*'

It is clear that conflict-related trauma, given the high level of need, has helped people (especially adolescent boys) to disclose and address their mental health issues. Multiple strategies developed by development agencies in coordination with the Ministry of Health have been formulated to reduce the stigma attached to mental health problems, including changing the names of health facilities (e.g. from 'mental health hospital' to 'community mental health rehabilitation centre') and integrating mental health with other health care services. But they have largely proved ineffective.

As a result, and exacerbated by the lack of proactive targeting by psychosocial and mental health service providers mentioned above, families themselves usually decide when and how to seek services after recognising that a family member has psychosocial problems. Typically, families only seek formal mental health services late on in the course of psychosocial or mental health episodes and after consulting traditional healers.

Second, in addition to the general stigmatisation of MHPSS conditions, adolescent girls faced additional barriers in receiving adequate care. Generally speaking, adolescent girls tend to have less access to mental health services because of prevailing psychological and social norms, which act as barriers to service uptake. The older the girl is, the

less likely she is to receive mental health services because the stigma that comes with doing so could affect her reputation and her chances of marrying. A girl's mental health issues are seen to affect the whole family and could be seen to 'infect' the family that she marries into. Accordingly, these cultural perceptions affect how people deal with seeking help for mental health needs. Typically, families would only seek formal mental health services late on and after consulting traditional healers. One expert explained:

> *It is a million times easier for families to take girls to traditional healers than mental health providers. This removes any blame from the family, which is perceived by the community as a victim of external evils who envy their daughter because she is pretty and wonderful. This perception is highly rewarding to the family, while on the contrary, when the girl receives specialist mental health care, then she has a problem. Her family may also have problems, so people tend to avoid them and will not consider them for engagement and marriage options.*

In this regard, fear of male partners' reactions was also mentioned frequently by mothers of adolescent girls as being a deterrent to service uptake. During the fieldwork for this study, for example, the mother of a 17-year-old adolescent girl was contacted to invite her daughter to participate in a focus group discussion. The mother was afraid of being beaten by her husband if she agreed to this request or allowed a researcher (even a female one) to visit their house. This is illustrative of the numerous obstacles preventing adolescent girls accessing psychosocial or mental health care.

In the Sri Lankan case, social norms also played an important role in hindering effective uptake of MHPSS by adolescent girls. The KIIs and FGDs in the second round of fieldwork underlined the tendency of service providers and child protection systems to criticise mothers who migrate and see it as the main reason for problems (e.g. school drop out, early marriage) related to adolescents. For instance, the principal of the school in the research location said that 84 out of the 428 students in the school had mothers abroad as migrant workers. According to him, not only were these children cared for less in terms of cleanliness, interest in their school attendance and performance, but that their mothers' absence underpinned adolescent problem behaviours. As a result of this 'blaming' attitude, there was less focus on how to better support children in the absence of their mothers.

Our primary research findings also highlighted that social and religious priorities can overshadow a girl's right to access appropriate support services. In the Muslim community, religious institutions play a crucial role in mediating in situations of sexual abuse and early pregnancy. The typical response is to instruct the man to marry the adolescent girl. Even in cases of abuse or rape, the *Ullama Sabhai* or the Mosque Sammelanam (the joint committee of all the mosques in the division) push for marriage as long as the girl has reached puberty at the time of the abuse. According to a Muslim religious leader, only in cases of incest would the police be informed, if at all. The *Ullama Sabhai* are consulted regarding the incidents of abuse of Muslim girls, even when these are reported to the police. Moreover, given that the health sector has mandatory reporting requirements of underage pregnancy and also of abortion to the police given the illegality of abortion in Sri Lanka, adolescents and their caregivers are often very nervous about availing themselves of needed services.

> *In most of the abuse cases, the perpetrators are men they know, such as akka's (sister's) husband, sitappa (father's brother), or mama (mother's brother), and when this happens, families don't like to expose the pregnancy or take legal action. They prefer to make the girl have an abortion or deliver the baby in another area and give the baby up for adoption. If they come to the hospital we have to report it to the police, probation, or the GBV desk.* (Valaichenai Hospital FGD)

So although health care is available, it is not particularly sensitive to the fears of adolescent girls or their families, nor does it provide a sense of confidentiality or support for them to choose options in their own time. Similarly,

**Box 12: Psychosocial support in the context of Ebola**

*'Me and my sister, the time they took me from the ETU that day Auntie Mettie (the mental health clinician in Bomi) carried me home. Me and her took pictures everything. Aunty Mettie can counsel us so we can go for counselling class.'* When asked about how she knows Aunty Mettie and the relationship she says, *'only during the Ebola crisis we know Aunty Mettie but she acts like our Ma. She can behave just like our Ma because anything we lack of, we explain it to her and she can help us...when something (is) bothering us we explain it to her, she can find the solution to it. Sometimes I sit down and I can just cry. But at least I (am) moving on small, small because I can go for counselling session and they (are) teaching (me) how to cope with my situation, so I just have to accept it, the way it is. [Before the counselling] I was looking just like a crazy woman. I was getting crazy. I was getting crazy, thats how Auntie Mettie say just be going for counselling session.'*

there perceptions are reinforced by a strong focus on an individual's symptomatology and specific mental health conditions, rather than including other aspects of wellbeing. This discourages some families from accessing services to ensure the health and safety of the pregnant teenagers. This also highlighted the challenges in responding to these situations through a legal/rights framework that gives adolescent girls little space to decide on options when in situations that are not acceptable in the socio-cultural context.

In Liberia, despite the training of mental health clinicians in child and adolescent services, their practices have largely focused on adults and those with serious mental illness. There were some positive stories of psychosocial support, especially during Ebola and its aftermath (see Box 12). However, what the case study below emphasises is the high levels of stigmatisation surrounding mental health issues.

### 8.5 Sectoral silos and limited coordination within the MHPSS sector

Although our discussion on adolescent girls' psychosocial wellbeing highlighted that this is a complex multi-dimensional phenomenon cutting across the mandates of multiple sectors, in practice the provisioning of relevant services remains siloed sectorally and even within the MHPSS sector itself. In Gaza, our findings indicate that there is limited coordination (and therefore unnecessary duplication) among psychosocial and mental health programmes. This could be because the government does not play a sufficient coordination role with the various service providers, as reflected also in the fact that while referral forms are usually available at service sites, these are not appropriately managed or utilised. Most organisations involved in this study reported referring service users to other institutions, but most referrals originate from NGOs who point those in need in the direction of specialist services. There are few referrals in the opposite direction, which raises important questions about continuity of care. Moreover, systematic follow-up of referrals, feedback and exchange of information is rare. An important exception, however, is the finding that teachers gave numerous reasons for referring adolescents to school counsellors, including poor academic performance, behavioural problems (including violence and aggression), family problems, engaging in culturally unacceptable behaviours, and mixing with members of the opposite sex.

In Sri Lanka, in terms of formal policy and institutional mechanisms there is a reasonable degree of vertical integration between the health, education and child protection sectors from community-based services to DS division, district and national level mechanisms, with children's and adolescent girls' protection and medical requirements given particular consideration. However, in practice, KIIs and FGDs with service providers highlighted that the priority given to cross-sectoral collaboration is generally low. While school authorities accommodate awareness programmes by Child Rights Promotion Officers (CRPOs) and Probation Officers (POs), incidents of child abuse, especially sexual abuse, occurring in school are often not reported to child protection mechanisms. CRPOs and POs claim that school authorities try to resolve these issues within schools to avoid reputational damage. Such concealment reduces POs' and CRPOs' ability to be alert to child protection risks and to ensure support for the affected children. School authorities in turn raised concerns about the failure of POs/CRPOs to inform schools when case conferences are conducted about child abuse occurring outside school. They point out that given the amount of time children spend in schools, teachers are able to provide insight into children's behaviours and issues, but POs generally consult schools only if school personnel are alleged to be perpetrators or the abuse has happened within the school premises. Such compartmentalised service provision presents challenges in responding to the complex nature of problems experienced by adolescents living in adverse conditions.

In terms of horizontal linkages, there is considerable variation. Some NGO and bilateral agency or state programmes are of relatively long-term duration. The training of counsellor teachers by GIZ, for instance, demonstrates consistent collaboration and long-term financial and technical support. Successful interventions such as the GBV desk of the Batticaloa and Valaichenai hospitals (see Box 7) also display sustained state-NGO collaboration through continued support by a succession of NGOs: GBV desks have been financially supported by Care Sri Lanka, WIN, Neelan Thiruchelvam Trust through Eastern Social Development Foundation (ESDF) and New Arow (local NGOs). Most NGO-state collaboration, however, is of short duration. Frequent and effective collaboration between state and NGO agencies is visible mainly in the sharing of resource personnel across programmes: non-state resource persons are active in promoting awareness on child protection and children's agency, while state employees participate as resource persons or medical professionals in NGO programmes on health and wellbeing. For instance, ESCO's project on promotion of child mental wellbeing, implemented in collaboration with BasicNeeds, has intermittently conducted medical screening camps for children in the project locations. The medical screening is done by MOHs where available, and the Medical Officer (Psychiatry) and Medical Officers of Mental Health also participate.

Collaboration or inter-sectoral linkages among NGOs working in different sectors in Sri Lanka, such as livelihood support and child protection seem to be relatively weak. Most organisations work independently at ground level, despite networking at district and national levels. This situation is exacerbated by donor requirements for visibility and clear ownership of the projects they fund. For instance, they request original attendee lists

for programmes, which can hinder efforts by NGOs to organise events collaboratively as each strives to have activities counted as part of their own programme. Collaboration requires resources and ownership to be shared, but if donors require resources and materials to be labelled as belonging to projects funded by them, it challenges the willingness to share ownership.

The collaborative linkages that do exist are related to child protection, legal services, safe-house accommodation, providing limited economic support to families in need and sharing resource persons for training programmes. Such support is often ad hoc or reactive, responding to situations after a crisis or incident. The lack of consistent, proactive and holistic measures to prevent incidents of self-harm, abuse and neglect among adolescents, particularly girls, was highlighted in KIIs with several service providers. Weak integration is evident in the absence of collaborative inter-sectoral NGO planning to realise common long-term goals to address recurrent issues faced by adolescents.

In Liberia, synergies across sectors remain largely elusive. Key informants and adolescent survivors repeatedly highlighted problems with reporting of abuse, community elder intervention on behalf of male perpetrators and lengthy delays in processing cases especially in order to reach prosecution stage. This means that for girls at the centre of such cases, they are typically exposed to ongoing stigmatisation and familial pressure to 'hide' the case. The following quote from a service provider in New Kru Town captures some of the system challenges:

> *If someone complain of a rape case, maybe round 9:00pm in the night as we are working or sometimes in the day time, where you meet our office packed, and we need privacy, we may not interview you in the present of the people and we may not have chance, we give them referral to first go to the hospital and from the hospital, they come back to us then we start from that background … We have problems with the social workers at the Ministry of Health whom we always give our information to and whenever they write and win project with the information we give to them, they don't send any support to our office but rather are enjoying the money by driving luxurious cars around – and without us they can't do any work. All this material and office furniture you see here are been provided by ourselves, we furnish our own office without support from no one. At times most of the children messed up themselves and the entire office can be polluted with tainted odour which causes lots of disturbances for our work.* (Female service provider, New Kru Town)

# 9 Conclusions and policy and programming implications

## 9.1 Conclusions

Overall our research findings confirm that the prevailing combination of chronic economic, political, cultural and social vulnerabilities facing many adolescent girls in our three case study countries and the inability of health and social services to respond adequately has exacerbated the already high levels of psychosocial ill-being in these fragile state contexts. Although adolescents did report mostly positive or constructive coping strategies to deal with psychosocial and mental health stresses besides turning to family members, the approaches were generally very individual in nature. Compared to the diversity of economic survival or livelihood strategies that people resort to in times of crisis, the coping repertoires that adolescent girls, family members and service providers described, were decidedly more limited in scope. Further, we found that severe and far-reaching psychological and social stressors arising from conflict can result in reduced resilience in the face of adversity, even when symptoms of specific mental illness are not diagnosed (Bragin, 2014; Ward, 2006, Wessells, 2008). It is also worth noting that even in the case of heritable mental illnesses these can be exacerbated by social and economic stresses, including social exclusion, and in contrast may be minimised through positive social circumstances. They require medical treatment first of all, and then enlightened community-based care. WHO argues against segregating out this group as medications only work accompanied by social supports and wherever possible, inclusion. Therefore this underscores the need for a blend of informal and more formal proactive support mechanisms in order to enhance psychosocial resilience.

While the psychosocial service environment in Gaza and Sri Lanka is relatively well developed, attitudes to service delivery and in particular access in Gaza, reflect the social norms and values of the study communities, often hindering adolescent girls' access to appropriate support. Moreover, many of the services do not specifically target adolescents and do not adequately tackle the complex issues that they face in a fragile context. The same social norm challenges exist in Liberia, but they are compounded by a very low baseline of service provision as well as extremely high levels of sexual violence which has become normalised, especially among adolescents and increasingly even younger girls.

A number of cross-cutting themes emerged from our case studies sites, some of which are more or less prevalent in the different settings:

- Key vulnerabilities that put adolescent girls at risk of psychosocial ill-being and that need to be addressed in policy and programming efforts include the following:
  - Gender and sexual-based violence and abuse, including also abandonment and unsuitable marriages after brief intimate relationships, and incest in the case of Sri Lanka and Liberia, high levels of physical abuse at home, in school and in communities, particularly in Liberia
  - Breakdown of family relations, including domestic violence, ill-treatment by relatives and lack of family support, particularly in Sri Lanka
  - Experiencing and witnessing physical injury, violence and death, including of loved ones, particularly in Gaza and Liberia – less so for Sri Lanka though they were exposed to other forms of violence, and displacement
  - Economic hardship, poverty or loss, including death of family breadwinner, loss of homes or family livelihoods and living in temporary collective shelters in the case of Gaza
  - Restrictive social norms for girls, including emphasis on early marriage, lack of voice in decision-making despite increased responsibilities in adolescence, limited access to or dropping out of education, mobility and ability to build wider social networks and connections
  - Lack of spaces for adolescents to have voice and a role in decision-making, as well as to have a safe environment in which to discuss sensitive issues in privacy

- Limited support from the school environment to address the specific needs of adolescent girls, leading to them drop out of school
- Community stigma, especially for girls who do not conform to dominant social norms (in the case of Sri Lanka)
- Community stigma for those who seek psychosocial services, which, in the case of Gaza are sought largely by girls.

- Coping strategies that adolescents, their families and communities rely on in the face of psychosocial vulnerability and stress include:
  - Being able to rely on a supportive family or extended family member, especially parents
  - Performing religious practices and seeking alternative healing (e.g. traditional or religious healers)
  - Turning to daydreaming, drawing, writing, investing in education and using social media in the case of girls – in contrast to their male counterparts, who often resort to violence, drugs, painkillers and alcohol
  - Being able to rely on supportive teachers and the broader school environment
  - Having access to inspiring local role models.

- The service environment in all three countries share some key characteristics:
  - Inadequate tailoring of services to meet the specific needs of adolescents and particularly adolescent girls
  - Adolescents, despite often taking on extra burdens and responsibilities usually related to domestic work for girls, are either ignored as a specific category or are treated as children – more broadly there is inadequate attention to differences and fact that it is a transitional stage in life
  - Adolescents are subject to conflicting priorities and messages, particularly in Sri Lanka where marriage confers respectability which unmarried girls do not get; at the same time, however, married girls cannot continue with education which is key for future life opportunities
  - Particularly in Sri Lanka, service providers' attitudes tend to be moralistic, controlling and punitive, not supportive and sensitive to priorities and concerns of adolescents.
  - Lack of awareness of SRHR and negative views of contraception are a barrier that is not addressed adequately by service providers, particularly in Sri Lanka
  - Lack of support particularly for adolescent girls who deviate from norms
  - Little space to discuss and explore self-esteem, skills, talents – NGOs have clubs but often not adolescent clubs (mobility restrictions in mixing with non-family male, self-regulation by girls)
  - Community-based mechanisms are focused on children, not adolescents
  - Mental health and psychosocial services in general are of poor quality, lack standardised management guidelines, interventions are generic and not individually tailored to specific cases and there is weak assessment of outcomes and fragmentation of services
  - Lack of universal, promotive, protective factors that support resilience, e.g. the development platforms of sanitation, school, community trust and social cohesion, security and adequate housing are missing for the most part even in rural areas.

## 9.2 Recommendations

Although our case studies concluded with context-specific recommendations, below we highlight four broad areas for action that are cross-cutting yet can be adapted to country realities, including the levels of fragility, political economy dynamics and environmental hazards that shape possible policy and practice entry points:

- Actions that need to be taken to address psychosocial vulnerabilities facing adolescent girls and to enhance their existing coping repertories and mitigate against negative coping responses
  - Enhance proactive identification of vulnerable groups, including adolescent girls, and tailor activities to meet their needs
  - Design programmes for conflict-affected families and those who have experienced gender-based violence
  - Train adolescents and their caregivers on basic coping strategies such as mind-body techniques, stress-reduction methods, seeking family/friends' support, critical thinking skills, building competencies and on the characteristics of the adolescent stage in the life-cycle
  - Provide low-resource psycho-social interventions for adolescents and their parents that address their socio-emotional health that promote connections, self and community efficacy, hopefulness and the capacity to use available resources
  - Encourage the use of social networks, including family and friend networks
  - Proactively monitor and target vulnerable groups at risk of developing negative coping strategies
  - Support initiatives to promote self-confidence, self-esteem and self-efficacy, key builders of resilience
  - Build on the role of supportive teachers and more generally invest in education as a means to develop self-esteem and self-efficacy
  - Address negative coping strategies through awareness raising, child protection networks, policy

setting and more generally initiative that promote self-esteem, life skills and positive coping
    - Encourage caregivers to support their adolescent girls to take up services and programmes to address their psychosocial vulnerabilities
    - Address issues of stigma that hinder access to psychosocial services through integration of services, media and education outreach and community mobilisation
    - Develop and finance an inter-sectoral national agenda for adolescent well-being that guides policy and programming
    - Conduct an education campaign to educate families and the public of the role of adolescence in development.

- Actions that need to be taken in order to strengthen the service environment
    - Strengthen service provider capacities, including vis-à-vis the following:
        - early detection of psychosocial ill-being and mental health illness disorders
        - treatment of mental health disorders, distinguishing them from suffering related to adversity
        - the importance of constructive dialogue with adolescents that helps them explore this transitional life stage – the psychosocial vulnerabilities as people go through the life cycle
        - addressing gender-based violence
        - providing services and supports to prevent substance use disorders
        - providing services and supports to treat addiction (alcohol and drugs especially)
        - implementing effective case management
    - Provide on-the-job training in order to link with formal training to ensure that it is applied at facility level and that appropriate benchmarks can be developed
    - Services should include a broad spectrum of activities, including those that promote productive engagement in social activities, space for creative expression and safe recreational activities to underpin adolescent girls' resilience
    - More investment is required to ensure proactive, integrated services (spanning education, health, justice, employment, social protection, sports, media, social work sectors). For instance,
        - in education, strengthen the quality of school psychosocial support and counselling services and protocols for responding to vulnerabilities and common life-challenges faced by adolescents
        - in the justice sector, ensure that police are adequately training on gender-based violence and how to support survivors in the health sector;
        - ensure availability of trained mental health and psychosocial workforce to work with adolescents; and maintain an adequate supply of common psychiatric drugs in places where stock-outs are an issue (e.g. Liberia)
        - in employment/labour provide opportunities to youths to make them employment ready and to support their skills' development
        - in social protection, prevention strategies to protect adolescents from abuse and promote their resilience.

- Actions required to enhance policy strategies, regulation and coordination
    - Strengthen coordination, regulation and integration of mental health and psychosocial services
    - Reinforce coordination among actors and programmes at community and sub-national level, including regarding referral processes and systems
    - Promote exchange of information among service providers and actors and consider developing networks of stakeholders to develop tailored solutions
    - Strengthen the role of national institutions and ministries (e.g. the ministries of health, of social protection and/or social welfare, of women and children) as the legitimate regulator of psychosocial services, including improved licensing and accreditation processes for mental health and psychosocial service providers and quality assurance standards
    - Build the capacity of the relevant national institutions/government agencies to monitor trends and statistics in service provision to respond accordingly
    - Promote greater evidence-informed programming including more robust data collection on adolescents' lives – e.g. dropouts, suicides
    - Develop, cost and implement a national strategy for adolescent well-being focused on resilience
    - Include a mapping process for psychosocial and mental health services and resources to better inform planning processes, including for better continuity of care
    - Strengthen managerial capacities and functions of mental health care providers, including training courses on management approaches, staff motivation and performance, improving supervision and strengthening case management approaches
    - Move away from the short-term time horizons and invest in robust management systems, including monitoring and evaluation mechanisms and feedback loops
    - Encourage external (especially funding) organisations (in particular WHO and UNICEF) to ensure that adolescents remain a target group in their programming and funding, particularly in contexts of fragility.

- Actions needed in terms of broader engagement with peace processes and conflict prevention
  - Take measures to address gender and sexual violence through broader community education programmes that address the stigma that surrounds sexual violence and the hyper-masculinities that leaves women and girls vulnerable
    - Link survivors to programmes that provide integrated justice, health and sexual violence support programmes
    - Develop better legal systems that tackle reporting and prosecution of gender and sexual violence
    - Fast-track initiatives that provide justice for children and adolescents and mandate appropriate programming for survivors and perpetrators
  - Raise the awareness of citizens and service providers about provisioning under UN Security Resolution 1325 especially vis-à-vis young people and extend these provisions to fragile state contexts
  - Engage with peace, reconciliation and transitional justice processes to ensure that the specific needs of adolescents and especially adolescent girls are supported and that they in turn are supported to participate in these processes, in order to strengthen efforts to build back better.

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# Annex 1: Service mapping

**Table 1: Outline of main services relevant to adolescent girls' wellbeing and protection (as mentioned by interviewees) in Sri Lanka**

| | Community level (mainly focusing on the community of Kadalkiramam) | DS/Zonal level – Valaichenai/ Oddamavadi / Kadalkiramam | District level – Services located in Batticaloa town | National level |
|---|---|---|---|---|
| **Health** | **State sector:**<br>Primary health services through Family Health Workers (FHWs). Mainly pre- and post-natal care of mother and child. Proactive in preventing teenage pregnancies | Medical Officer of Health (MOH) clinics – FHWs are attached<br><br>Valaichenai hospital – mental health unit, maternity ward and emergency treatment unit were highlighted in relation to adolescents<br>Counsellor at DS office | Batticaloa Hospital – especially mental health unit and emergency treatment unit highlighted in relation to adolescents | Ministry of Health – policy, planning and resource allocation<br><br>Directorate of Mental Health<br><br>National Institute of Mental Health |
| | **NGOs:**<br>Child Psychosocial and MH wellbeing promotion programmes – ESCO | Child Psychosocial and MH wellbeing promotion programmes – ESCO<br><br>Counselling services by NGOs | Family Planning Association (FPA) outreach services | SRH hotline operated by FPA<br><br>SRH related services through FPA |
| | **Community:**<br>Traditional healers | - | - | - |
| | **Private sector:**<br>Private dispensaries | Private medical centres and laboratories | Private hospital in Batticaloa | - |
| | **Collaborations:**<br>MOH/NGO awareness programmes in schools & community | GBV Desk at Valaichenai Hospital and supported by NGOs | GBV desk – Batticaloa Hospital, supported by NGOs | - |

| Education | Community level (mainly focusing on the community of Kadalkiramam) | DS/Zonal level – Valaichenai/ Oddamavadi / Kadalkiramam | District level – Services located in Batticaloa town | National level (if mentioned by respondents) |
|---|---|---|---|---|
| | **State sector:**<br>Village/village cluster-based state schools<br><br>School based counselling and career guidance awareness | Zonal education offices – support to schools<br><br>These are placed under the purview of the Provincial Ministry of Education | | Ministry of Education – policy making and generalised standards stipulation. Conduction of public examinations at grade 5 (scholarship exam and GCE O/L & A/L)<br><br>National Institute of Education (NIE) – develops school curriculum, textbooks and organises teacher training |
| | **NGOs:**<br>NGO interventions operate through schools in collaboration with the state school education mechanism | | | |
| | **Community:**<br>Free tuition classes, where these exist, are organised by community/ religious institutions in the community or through school development societies)<br><br>Some community leaders are members of school attendance committees | - | - | - |
| | **Private sector:**<br>Fee levying tuition classes for school children by individuals | Fee levying tuition classes<br><br>Fee levying schools e.g. Fee levying religious private school in Kattankudi | Fee levying tuition classes<br><br>Fee levying schools (some of these are semi government schools partly supported by the state) | |
| | **Collaborations:**<br>NGO support to train counsellor teachers/teachers of local schools – ESCO<br><br>NGO Support to conduct awareness raising programmes on counselling/ career guidance | NGO support to conduct psychosocial training to counsellor teachers/teachers of state schools – GIZ | | NIE-GIZ counsellor teacher training (though collaboration with GIZ) |

| Protection | Community level (mainly focusing on the community of Kadalkiramam) | DS/Zonal level – Valaichenai/ Oddamavadi / Kadalkiramam | District level – Services located in Batticaloa town | National level (if mentioned by respondents) |
|---|---|---|---|---|
| | **State sector:**<br>CRPO<br><br>Community Women and Child Desk Taskforce (Social Service Officer, Village Child Rights Monitoring Committee (VCRMC) led mechanism working on child protection)<br><br>PO working on reported cases of child abuse/risk of abuse and providing awareness raising<br><br>PO and Child Rights Promotion Officer (CRPO) awareness programmes in schools | POs and Zonal Department of Probation and Child Care (DPCC) offices<br><br>Children's welfare homes<br><br>Legal Aid Commission<br><br>Mediation board for issues such as petty thefts<br><br>Women and Child Desk at police stations | Probation Officer In Charge and DPCC district office<br><br>Snehadeepam – state safe house for children<br><br>Human Rights Commission<br><br>Police hotline 119<br><br>District Committee on Protection of Children | Hotlines :<br>•1929 (National Child Protection Authority)<br>•Ministry of Women's Affairs hotline<br><br>DPCC<br><br>National Child Protection Authority |
| | **NGOs:**<br>NGO Support to develop capacities of VCRMC members – ESCO former programme<br><br>Child rights and protection related awareness by NGOs – ESCO, the Eastern Social Development Foundation (ESDF), Plan Sri Lanka, World Vision etc. | Support to develop capacities of VCRMC members – ESCO former programme<br><br>Child rights and protection related awareness by NGOs – ESCO, Plan Sri Lanka, World Vision etc. | Koinoniya (NGO) safe house for women & children<br><br>Women In Need (WIN) outreach services<br><br>District based NGOs – Suriya and HHR (Home for Human Rights) | WIN hotline<br><br>Safe houses, counselling, legal support by WIN |
| | **Community:**<br>VCRMC – organised through the state (CRPOs) has membership of community leaders | Mosque and Qazi courts and Madrasa (for Muslim community) | | |
| | **Collaborations**<br>NGO support to conduct awareness raising programmes in schools | NGO support to conduct awareness raising programmes in schools<br><br>Some NGOs conduct training programmes for POs/CRPOs | Some NGOs conduct training programmes for POs/CRPOs | |

| Promoting participation and agency | Community level (mainly focusing on the community of Kadalkiramam) | DS/Zonal level – Valaichenai/ Oddamavadi/ Kadalkiramam | District level – Services located in Batticaloa town | National level (if mentioned by respondents) |
|---|---|---|---|---|
| | **State sector:**<br>POs facilitate registration of children's clubs [39] | POs facilitate registration of children's clubs | POs facilitate registration of children's clubs | Registration of all children's clubs under the DPCC (through district DPCC offices) |
| | **NGOs:**<br>Children's and Youth clubs and resource centres, children's libraries etc supported by NGOs – e.g. ESCO, Plan Sri Lanka, World Vision<br><br>Youth empowerment projects: ESCO's DEALS project | Children and Youth clubs operated by NGOs<br><br>Training programmes on soft skills – through NGOs | District level committees linking community children's / youth clubs (ESCO) | - |
| | **Community:**<br>Community leaders/ members voluntary support to children's clubs. This may also be facilitated through CBOs | - | - | - |
| | **Private sector:**<br>Donations by local traders for events (sports meets, new year celebrations & religious programmes etc.) organised through children's/youth clubs | - | - | - |
| | **Collaborations:**<br>POs / CRPOs engage with local children's [40] clubs (supported by NGOs) & monitors their activities<br><br>CRPOs/POs conduct training programmes for children's clubs | CRPOs/POs conduct training programmes for children's clubs | Probation Officer In Charge / POs participate in NGO facilitated planning/review meetings of NGO programmes to promote children's wellbeing, protection etc. | |

39 All children's clubs are required to be registered under the DPCC.

40 Children's clubs membership includes children up to 18 years. Many of those in GCE A/L classes are 18 but are still considered as children as they are still in school.

| Economic and social service support[41] | Community level (mainly focusing on the community of Kadalkiramam) | DS/Zonal level – Valaichenai/ Oddamavadi/ Kadalkiramam | District level – Services located in Batticaloa town | National level (if mentioned by respondents) |
|---|---|---|---|---|
| | **State sector:**<br>Grama Sevaka and Social Service Officer facilitates allowance for disabled persons/ children<br><br>Samurdhi – state poverty alleviation programme | State vocational training – National Vocational Qualification certificates through the Vocational Training Authority and the National Apprentice and Industrial Training Authority | Classes for National Vocational Qualification higher levels are conducted at in the main towns of the districts | Vocational Training Authority, National Apprentice and Industrial Training Authority<br><br>Non-formal education unit of the Ministry of Education<br><br>Samurdhi programme managed by the Samurdhi Authority at national level |
| | **NGOs:**<br>NGO supported economic support to selected families e.g. by ESDF<br><br>Programmes to support for migrant workers' families – ESCO | NGO supported Vocational training facility in Pudukuduirruppu & by the Church of American Ceylon Mission, etc. | Vocational training centre by Sarvodaya | |
| | **Community:**<br>CBO self-help groups/micro credit for livelihood activities | - | - | - |

41 Note that in this report vocational training is listed under economic services.

**Table 2: Service mapping of mental health/psychosocial services in Shajaia area/Gaza City**

| Programme name | Objectives | Implementation | Implementing agency | Geographic coverage | Service uptake | Approach | Implementation strategy | Target group | Programme orientation | Staffing level | Linkages | Results |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Structured sessions with caregivers** | To enhance children's resilience | Jan-Dec 2014<br>Sep 2014-Feb 2015 | Local NGO: Palestinian Center for Democracy and Conflict Resolution | Al Shajaia | Target: 90 parents | Level one strengthening resilience and stress management | Stand-alone interventions | Parents | Child focused activity but the target is parents | Information not available (N/A) | N/A | N/A |
| **Community-based session for children** | Support sessions for caregivers | Sep 2014<br>Oct 2014 | International NGO: Qattan Center for the Child | Al Shajaia | 1,845 children | Strengthen community and family support | The center offers education and recreation services to children | Children | Not clear if target is adolescents or children in general | Organisation has good capacities | N/A | N/A |
| **Responding to mental disorders** | Psychosocial first aid and detection of cases | Aug-Dec 2014 | National NGO: Gaza CMHP | Al Shajaia | 118 | (Person-focused) Psychological first aid | Stand-alone interventions from a specialist center | Children and adults | Not purposive intended targeting for adolescents | High | Yes | Not systematic |
| **Provision of specialist mental health services** | Specialist mental health services | 2005 to date | Government: Sorani PHC centre | Al Shajaia | 1,516 cases (Dec 2014) | Clinical management of mental disorders | Physically integrated within PHC centre Functionally stand-alone | No data on number of children in adolescence age | Not purposive intended targeting for adolescents | At least 8 staff, not all of them adequately trained | Referral exists but not organised | Not systematically available |
| **Psychosocial services at NECC** | Provision of PSS services through group activities and individual counselling | 2009 to date | International NGO: NECC | Al Shajaia | 800 children (Sep- Dec 2014) | Strengthen community and family support (group activities) | Integrated services in PHC centre | General population with focus on children and adolescents | Most group activities and recreational services are designed for adolescents | Only one counsellor | Not systematic. Referral | Not standardised |
| **CMHP at UNRWA clinics** | Provision of mental health/ psychosocial services through individual and group activities | 2005 to date | UNRWA | Al Shajaia | N/A | Awareness, individual and group sessions and debriefing | Integrated services in PHC centre | General population 222 persons/ 3 months | No adolescent intended targeting or tailored activities | 2 full-time counsellors and 1 part-time counsellor | Referral is available | Some application of post-test and pre-test but not for all cases |
| **Mental health services at a hospital** | Provide advanced mental health care | 1982 to date | MoH | All of Gaza Strip | Around 2,163 every year No info on number of adolescents | Clinical management of mental disorders | Stand-alone service | General population | No tailored services to adolescents | 70 staff, not all of them trained | Referral available | No impact measurement based on national indicators |

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