USAID'S HEALTH EVALUATION AND APPLIED RESEARCH DEVELOPMENT (HEARD) PROJECT

Developing and Evaluating the Nurturing Families Intervention in Jordan: Brief Summary of Key Methods and Findings

BACKGROUND

Mental Health and Psychosocial Support (MHPSS) services aim at supporting individuals and families at different levels, from protecting or promoting well-being, to preventing or treating distress. Most research on psychological interventions comes from High Income Countries (HIC). Recently, an increasing number of studies suggest that these can be successfully adapted to different cultures and contexts, and can be delivered by non-specialists, for settings where there are few mental health professionals available. However, most of this research is conducted with adults, and much less is known about interventions to support children and adolescents. Additionally, most current interventions target individuals (adults or children) and very few focus on the family as a system. A nurturing family environment is essential for child and adolescent psychosocial wellbeing, and can buffer the effects of stressful events. Yet, there is a gap in documented programs addressing the whole family; particularly in humanitarian settings.

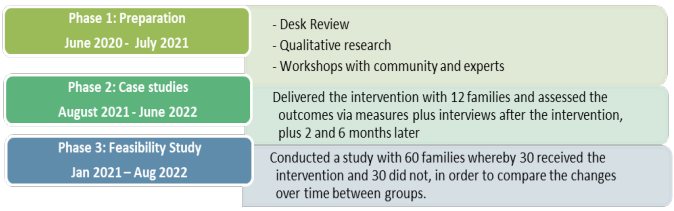
The German Federal Ministry for Economic Cooperation and Development through the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Regional Project "Psychosocial support for Syrian and Iraqi refugees and IDPs" commissioned War Child Holland to work with a community in Jordan to develop a whole-family MHPSS intervention and determine whether it works, and what factors increase or decrease the effectiveness.

War Child partnered with Collateral Repair Project (CRP), a local community-based organisation with strong links to the local communities in Hashmi. Two advisory boards ensured that the intervention and project was relevant to the community.

The main research question was "Does the MHPSS intervention enhance the well-being of persons affected by forced migration due to armed conflict?". Sub-questions were:

1. Active ingredients: What factors make the MHPSS intervention effective?
2. Enhancers of MHPSS effectiveness: Under which conditions can those factors best develop their full potential?
3. Inhibitors of MHPSS effectiveness: What barriers can limit the effectiveness of the MHPSS intervention and how can they be mitigated?

The study included Syrian, Iraqi, and Jordanian populations in East Amman (Hashmi al Shamali). Jordan has hosted many refugee populations, most recently from major conflicts in Syria and Iraq. Refugees in Jordan have been reported to have high levels of emotional distress, and face many stressors including lack of income and housing; child labour; limited access to education, health and other services; sexual harassment; and discrimination. Therefore, it is important that high quality services are available to support these families. The study had three main phases:



Phase 1: Intervention Design

First a desk review of parenting and family interventions in Jordan was conducted to determine existing evidence and learn from past experiences. Next, 20 families and 13 professionals in Hashmi were interviewed to explore challenges impacting families, and the best ways to support mental health and wellbeing. Four key challenges were identified: i) trauma and loss, ii) poverty and unmet needs, iii) social stress, iv) changes to identity and future uncertainty. Data revealed negative impacts of these stressors on the whole family system, family coping and resilience.

The intervention was developed through a series of workshops with the local study advisors and community advisory boards in Hashmi, the research team, and expert review. The Core Module draws from a 6-session intervention developed by War Child in Lebanon. It was adapted to Jordan, and child-focused sessions were added as well as an additional session for families to identify remaining needs and optional Advanced Modules.

Phase 2: Case studies

Method:

The intervention was piloted with 12 families to gather input for further improvement. Collateral Repair Project staff carried out recruitment, using an adapted tool, Reach Now from War Child. Families had to speak Arabic, have at least one child aged 10-17 years, and be experiencing multiple challenges, as by a social worker. Before the intervention, mid-way, immediately after the intervention, as well as 2 and 6 months after the end of sessions, the following outcomes were measured: parent distress, child distress, positive parenting, family relationships, parent ability to manage emotions, the impact of problems on the family, and child wellbeing.

Facilitators were four individuals from a Syrian or Iraqi background, living in Hashmi. They were supported by two co-facilitators. They received a total of 16 days of training, as well as weekly supervision from a local supervisor with an MHPSS background.

Results:

There was very high interest in the intervention from families, and good attendance, with only 1 family dropping out of the intervention due to illness. 60% of fathers attended at least some sessions, but common challenges for them to attend were work commitments, as well as stigma around MHPSS services. Feedback from facilitators and families was overall very positive, and they particularly liked the family format, the relationship with the facilitator, and found the improvements in family communication, strategies for managing emotions, and problem-solving skills to be powerful ingredients for the changes they saw. Facilitators found the content challenging at first, but with time they saw their skills and confidence grow.

The outcome measures showed improvements in: parent distress, parenting, family relationships, managing emotions, adolescent distress, adolescent wellbeing, and impact of problems. Two and six months later however, some scores worsened again. Looking at individual families, changes over time varied. Some families had significant additional stressors affecting them and reported that the intervention didn't sufficiently address their needs.

Several challenges were noted and addressed in future stages. It was not feasible to implement the separate caregiver and child/adolescent sessions at the same time, due to staffing and space requirements. Therefore for phase 3, only the caregiver check-in was included. Another major challenge was the ability to ensure referrals for families with urgent or intense needs.

We acknowledge support from the Health Evaluation and Applied Research Development Project funded by the United States Agency for International Development (USAID) under cooperative agreement AID-OAA-A-17-00002. The project team includes prime recipient University Research Co., LLC (URC) and sub-recipient organizations. The information provided is not official U.S. Government information and does not represent the views or positions of USAID or the U.S. Government. For more information, please visit iscollab.org.

Phase 3: Feasibility Study

Method:

To further test the intervention with a larger number of participants, a feasibility Randomised Control Trial was conducted with a total of 60 families. This again showed high interest in the programme, and showed that the outreach team were able to use the tool to accurately identify families who would benefit from the intervention, without stigmatisation of these families. 30 families were randomised to receive the intervention (intervention group), and 30 were randomised to receive standard services at CRP, which included a financial literacy programme (control group). Measures were mostly the same as in Phase 2, but parents were asked to also report on adolescent distress, and asked adolescents to also report on family relationships.

Results:

- **High engagement and attendance.** There was high interest in the intervention from families, and good attendance, with 3 families not commencing the sessions, and 1 family dropping out of the intervention due to moving abroad. 50% of fathers attended at least some sessions.
- **Overall positive feedback.** Feedback from facilitators, families, and implementation staff was positive about the intervention's usefulness, relevance, and impact.
- **Signs of multiple improvements in families.** The 30 families in the intervention group showed significant improvements on most outcomes: caregiver distress, positive parenting, family relationships (reported by both adolescents and caregivers), caregiver ability to manage emotions, adolescent distress as reported by caregivers, and impact of problems. Adolescent distress and wellbeing as reported by adolescents themselves did not change significantly over time. The 30 families in the control group improved only on the impact of problems.
- **Suggestions for improvement.** Participants suggested ensuring that sessions are as engaging as possible for adolescents, and considering additional supports for them.

Reflections and Recommendations

Overall, the Nurturing Families intervention was well perceived by families, facilitators, and implementation staff and was feasible to deliver via non-specialist facilitators in Jordan. Our research showed that it has many positive effects on caregiver, adolescent, and family wellbeing. Partnering with a community-based organization (CRP) and also the LSA and CAB ensured that the intervention and the study were acceptable, relevant and feasible for families living in Hashmi.

What are the active ingredients leading to the intervention's effect?

1. **Whole-family approach.** One of the most important elements was bringing the family together for the sessions, enabling them to share, discuss, learn and practice together. This is among the first application of a whole-family approach for families experiencing multiple problems, living in humanitarian settings, and our findings strongly support the value.
2. **Active skills building in sessions:** Conducting activities to directly focus on family dynamics live in sessions seemed to be a very powerful component. Changes within sessions translated to improvements in family relationships outside of sessions as well.
3. **Strategies to improve communication:** Participants reported that strengthening communication skills was impactful for many individual and family outcomes.
4. **Managing Emotions:** The supportive and safe space created in the sessions was reported to lead to a sense of relief and unburdening. Additionally, specific strategies for managing emotions were found to be very helpful and used regularly by caregivers and adolescents.
5. **Managing Problems, together:** The problem management strategy for working together as a family to solve problems was reported to be impactful for families for various problems.
6. **Supporting parents:** Caregivers liked the opportunity to discuss parenting, particularly as children move into adolescence, and reported remaining calmer, being more engaged with their children, and using less harsh punishment.
7. **Promoting positive family relationships:** Families reported significant improvements in family relationships, including less conflict between family members, more communication, increased positive time together, and more parent involvement in the home (especially from fathers), which was reported to lead to better wellbeing in adolescents and caregivers.

What factors make the intervention more effective?

1. **Content was practical, memorable, and related to families' realities:** This was ensured via practical exercises, with easy-to-remember titles and acronyms, engaging metaphors, the inclusion of sayings and proverbs throughout, and relatable example vignettes and illustrations throughout.
2. **Flexibility and responsiveness to individual needs:** Having the optional advanced modules, allowed families to tailor the intervention to their needs.
3. **Facilitator competency:** Many family members expressed feeling comfortable with the facilitators and cherishing the opportunity to share their concerns, being listened to and supported with processing their past and present challenges as well as learning techniques to apply for present and future problem solving.
4. **Promoting use of strategies outside of the sessions:** Having structured home practice with worksheets and audio reminders sent via Whatsapp was found to be helpful in cementing learning from sessions, and maintaining motivation within families.
5. **Trust and approachability of centre:** Conducting outreach and holding the sessions in an accessible and trusted local community centre, and having facilitators from the same community was perceived to promote trust and engagement with the intervention.

What factors make the intervention less effective?

1. **Challenges with more urgent needs.** When families had significant additional stressors or unmet needs (ex. economic, education, or health), this impacted effects of the intervention.
2. **Poor father engagement.** Major barriers to fathers attending were competing work demands, and lack of interest, sometimes due to stigma. Flexible scheduling and male-friendly outreach methods were recommended to improve attendance.
3. **Barriers and stress related to attending:** Frequent rescheduling of sessions because of other commitments such as school, work, or immigration appointments, were noted.

Recommendations for future intervention development

1. Incorporate extensive community consultation and co-design to ensure that the intervention is relevant, feasible, and acceptable. Find the right balance between scientifically demonstrated and community-developed approaches.
2. When working with the family system, ensure that adolescents have adequate individualised support for their own emotions. This could either be via separate sessions, or via referrals to adolescent-specific interventions.
3. Ensure that facilitators receive adequate training, supervision, and support for their own wellbeing. Focus on building and monitoring skills needed for working with whole families.
4. Develop outreach methods that are simple, do not create stigma, and reach fathers. Make sure that outreach targets all families who might benefit, from any nationality.
5. Make sure that adequate referral options are in place to meet families' additional needs, including referrals to specialist mental health care, for those with higher needs.

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This study was commissioned by the German Federal Ministry for Economic Cooperation and Development through the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) Regional Project "Psychosocial Support for Syrian/Iraqi Refugees and IDPs"