# Adolescents in Emergencies

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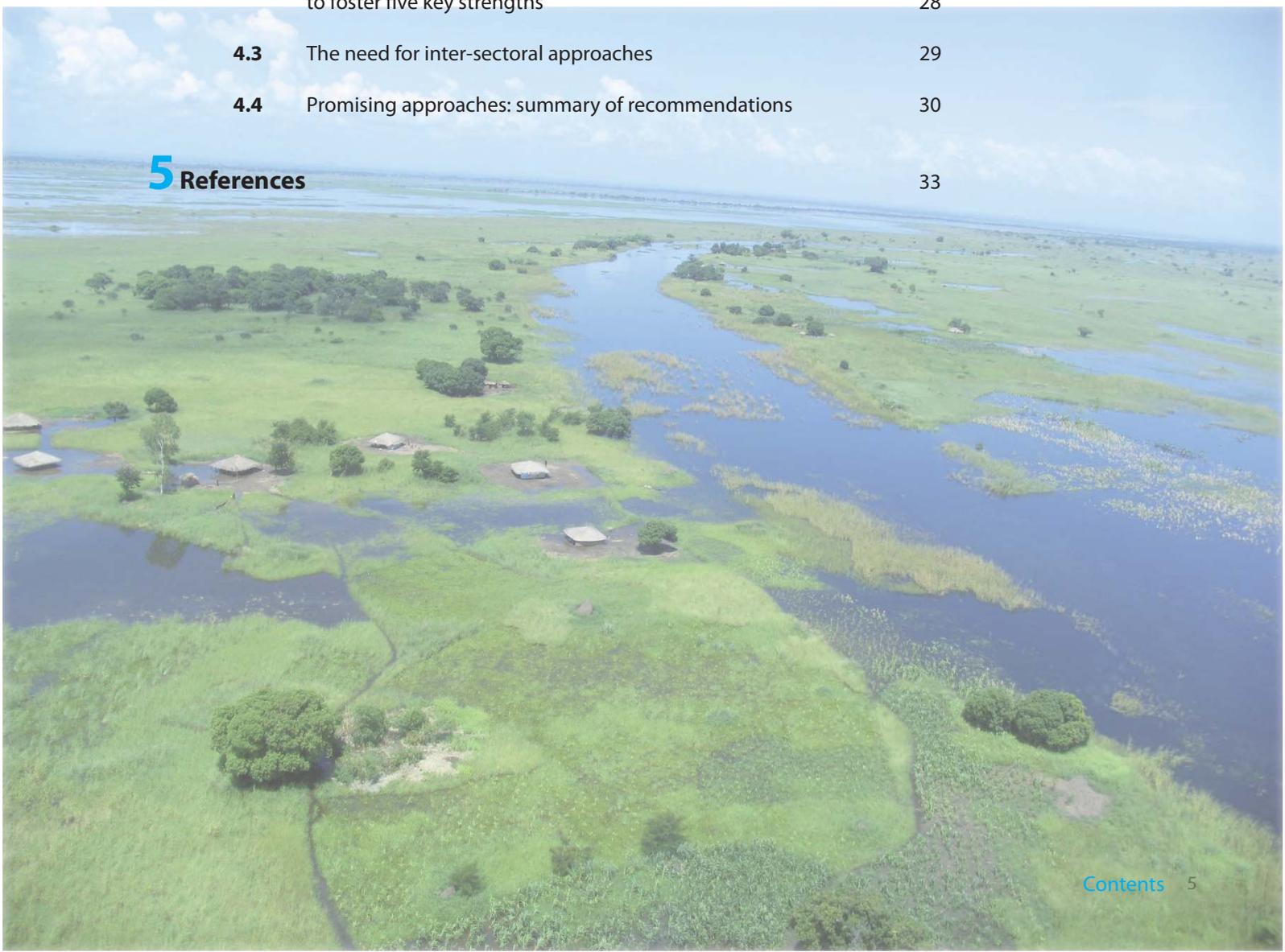h.cahill@unimelb.edu.au

# Adolescents in Emergencies

# Contents

# Section 1
# A Focus on Adolescents

## 1.1    What is an emergency?

Over recent decades, the number of natural disasters has steadily risen, both globally and within the Asia-Pacific region. This region is characterized by the highest incidence of both natural and man-made disasters. In 2009, 89 per cent of people who suffered from natural disasters lived in Asia (Vos et al. 2010). Whilst the severity of any disaster depends on both the country context within which the disaster occurs, and the nature and force of the onslaught, it is those who are least advantaged who usually come to greatest harm during or after a disaster. To date little specific focus has been given to the needs of adolescents during times of disaster and conflict. Caught between the status of child and adult, they can be easily overlooked in programming efforts. This paper seeks to redress this lack of specific focus by drawing together research which investigates both their specific vulnerabilities and the ways in which they can contribute during preparedness, response and recovery efforts.

An emergency is an extraordinary situation that puts the health and survival of a population at risk. Emergencies may be man-made or natural. They may be unpredicted, occur regularly, be short-term or long-running. They are characterised by turmoil, insecurity, poor sanitation, and short supplies of clean water, food, fuel, medical care and shelter. These conditions affect all age groups in the population.

Emergency programming efforts commonly take a three-phase focus, with emphasis on preparedness, response and recovery efforts. In the preparedness phase countries engage with inter-sectoral planning, capacity-mapping, needs analysis, stockpiling and focus on becoming equipped to deal with the possible onset of an emergency experience. It is in this phase that the greatest opportunity occurs for culturally informed attention to be given to programming for the needs and capacities of adolescents.

During the early response phases of an emergency, all those affected by the emergency need access to the basics which ensure survival. Initial efforts most importantly and urgently relate to the supply of water, food, shelter, clothing, sanitation and medical care. At this stage of response, adolescents can benefit from the same strategies as the rest of the population as they share the same needs for primary survival support. However, once initial life-saving efforts addressing survival are underway, attention of the humanitarian response expands to address recovery. In this phase, just as in the preparedness phase, there is a need to focus on catering for the particular and diverse needs of the population, including adolescents. It is increasingly recognised that in these efforts adolescents need to be viewed as a distinct group with distinct vulnerabilities and also great potential for contributing to the emergency response.

## 1.2    Lack of focus on adolescents

Adolescents tend either to be ignored as a target group during times of emergencies or to be conceptualised as passive victims or active security threats (Sommers, 2006). Caught between the perceptions that infants are the most vulnerable and adults the most capable, there can be a tendency to overlook their needs. This has led to a failure to focus on adolescents in disaster preparedness or recovery activity. In addition, programming efforts have been hampered by the lack of a strong theoretical base for understanding the needs of adolescents in emergencies and a sparse evidence base about 'what works' (Boyden, 2003).

## 1.3    Are adolescents a distinct group?

There are different ways to define who adolescents are. The World Health Organisation (WHO) defines adolescents as those aged 10-19 years (World Health Organisation, 2008). They (mostly) fit as a sub-group within the UN definition of 'child' as a person up to the age of 18 years. The United Nations Convention of the Rights of the Child (CRC) defines children as under 18. Hence adolescents may be included in the definition of 'children' in programming efforts.

The following definitions are used by the UN:

| Children | under the age of 18 years |
|---|---|
| Adolescents | aged from 10 to 19 years |
| Young people | aged from 10 to 24 years |
| Youth | aged from 15 to 24 years |

Whilst 'adolescence' is a term that is used to describe people of a particular age group, it is also a term that carries other associated meanings, and these meanings differ from culture to culture. In some cultures the meaning of 'adolescence' has also shifted (and continues to shift) over time. Before the era of industrialisation in the West children became adults as they assumed adult roles. The focus on adolescence as a distinct life phase emerged in the early 19th century and came to prominence post World War II with the growth of 'youth culture' and associated concerns about deviance and normal development (Lesko, 1996).

More recently in the West those working from a biomedical model define adolescence as a distinct life phase of transition from child to adult that commences at puberty, and encompasses physical, social and cognitive development. Those working from a more sociological tradition tend to critique this model (Wyn & White, 1997). They emphasise that the transitional phase of 'adolescence' is culturally defined and

likely to be understood differently from country to country. This leads to recommendations that adolescence be understood as a social and cultural construct. Within this argument it is noted that even within one culture 'adolescence' may be experienced differently by different sub-groups, and patterned along gender or class lines. Girls and boys may be expected to 'grow up' in different ways and at different speeds. In addition, disadvantaged or poor young people may be expected to 'grow up' earlier than their wealthy peers who may go through a prolonged period of 'adolescence' with extended time and energy invested into education as a preparation for their (withheld) adulthood (Lesko, 1996).

There are thus competing models for understanding 'adolescence'. One model assumes that the developmental transition is largely a natural and individual phenomenon occurring in a linear way with changes occurring at physical, psychological and cognitive levels. The other model assumes that the transition from child to adult is largely culturally constructed and may bear only limited connection to the process of physical and cognitive development. It is important to note and review the assumptions that are made about who adolescents 'are' when approaching the challenge of addressing the needs of adolescents within emergencies programming and response. The assumptions underpin and orient programming efforts.

## 1.4 The need for data

Along with attention to the underpinning assumptions that are made about who adolescents 'are', there is a need for good data through which to examine their vulnerabilities and contribution. Many countries are faced with a dearth of data about the situation of adolescents as often population data is not disaggregated by age. Thus adolescent outcomes tend to become buried within data about the adult or the early childhood population. This is a general problem with data collection and analysis that is heightened in the emergency situation.

Despite the lack of comprehensive research, there is enough data to indicate the need for an explicit focus on adolescents and to point to some patterns in the vulnerabilities that they experience.

This document draws on a range of literature sources to look at adolescent's unique experiences of emergencies and subsequent programming needs and guiding frameworks to inform future programming work.

**Section 2: Impacts and Vulnerabilities** provides a discussion of the impact of emergencies on adolescents. These include variables such as gender which often have a determinant effect of the problems and impact of problems experienced; as well as a discussion of key areas of impact identified in the literature, such as education, mental and physical health, child soldiers and trafficking.

**Section 3: Promising Approaches** draws on programming literature to outline recommendations for programming in specific areas including measures to ensure cultural sensitivity, gender sensitivity and participation, as well as good practice principles for programming in education, work, health provision and recreational activities. Where possible, we have provided case studies of promising programs.

**Section 4: Programming Frameworks** discusses the broad implications for future programming, presenting a model to inform future planning and response.

# Section 2
# Impacts and vulnerabilities

## 2.1 Types of losses for adolescents in emergencies

The most commonly reported causes of death of adolescents during or in the initial aftermath of emergencies include:

- diarrhoeal diseases;
- acute respiratory infections;
- measles;
- malaria; and
- severe malnutrition.

These conditions are also the major causes of death in developing countries with the highest child mortality rates. The increased occurrence of mortality due to these causes during emergency calls for rapid assessment and treatment of large numbers of children and adolescents (Moss et al., 2006).

For those who survive the emergency and initial aftermath, emergencies are characterised as a period of loss. Whilst adolescents share with other age groups the more generalised losses that arise from physical and social disruptions that occur, this disruption can play out in particular ways for young people. Research which captures the views of young people themselves highlights the pervasive sense of loss that they experience. Young people identify the following interconnected loss of opportunity, order, learning, loved ones and place, which in turn dislodge their sense of a predictable or promising future (Betancourt & Khan, 2008).

- Loss of the time for learning and opportunity to build a good future;
- Loss of place of home or places of belonging;
- Loss of family, friends and significant adult role models;
- Loss of order, routines and meaningful activities, and the onset of a time of waste and emptiness;
- Loss of health or capacity though injury, illness and poor; and
- Loss of trust in response to personal or witnessed experiences of harm or abuse.

This disruption occurs at a time of life which is normally set aside for learning and the development of livelihood skills. Young people are keenly aware of the possibility that this loss will never be recovered (Betancourt & Khan, 2008).

Specific impacts of emergencies relevant to adolescents are outlined below. These include cross-cutting variables such as gender which have a determinant effect on the incidence and impact of problems experienced; as well as a discussion of key areas of impact identified in the literature, including sexual and reproductive health, mental health, violence and trafficking.

## 2.2 Gender

Gender can be seen as a lens through which to consider vulnerability. Each of the domains of survival, education, health, protection and participation, employment and livelihoods has a gendered component. This is in part because disaster significantly exacerbates existing inequalities (Jean-Charles, 2010). Humanitarian emergencies have gender-specific results that disproportionately affect women and girls (IASC, 1999). Studies have demonstrated that women and girls are more likely to die during or within the aftermath of natural disasters and that the stronger the disaster the greater the gender gap (Neumayer & Plumper, 2007). This gender gap is weakened for women of higher socio-economic status, indicating that it is the socially constructed nature of gender roles rather than physiological differences that place females at greater risk.

This pattern may occur because girls are likely to get poorer access to resources and services than boys and to face additional burdens associated with sexual violence, exploitation and arduous carer work such as queuing for rations. Girls may be additionally burdened by norms which reduce their opportunities to learn to swim, climb, flee or resist assault, as well as by norms which permit the exclusion, abuse or exploitation of women (IASC, 1999). During emergencies they complete these gendered tasks in more arduous and dangerous settings and face additional risks of sexual assault as they move about without traditional forms of protective supervision.

In most developing countries, girls have lower levels of education and less access to education opportunities than boys. They have limited access to work and therefore less opportunity to earn an income. This increases their vulnerability before, during and after disasters (Sommers, 2006). Female adolescents have been shown to be more at risk for psychological problems than older youths and male survivors (Tuicomepee, 2008). Furthermore, women and girls are more likely to be seen as passive non-actors within communities and left out of participation programs (Sommers, 2006; UNDP, 2006).

Though girls carry the greater vulnerability, both boys and girls are vulnerable due to differing aspects of their gendered roles. Boys may be burdened by pressures to provide and protect, or to adopt the peer group rather than the family as a point of reference, with associated uptake of risky or violent behaviours. During emergencies boys become even more vulnerable to masculinised patterns of externalised or aggressive survival, are more likely to be pushed into militia, and are at risk of mental health problems associated with depression and drug use. They are also vulnerable to being pushed into physically risky work.

### 2.2.1　Gender-specific impacts:

### Understanding the needs of adolescent girls in a disaster context in Bangladesh

In 1998 severe floods covered one third of Bangladesh for nine weeks. Qualitative interviews conducted with Bangladeshi, adolescent girls aged between 15 and 19, revealed a number of gender-related cultural factors which increased their vulnerability during the time of the floods.

Interviews with the girls revealed that the floods removed their usual coping mechanisms for complying with cultural norms, such as the preservation of purity and cleanliness and the expectation that they remain covered and secluded, and appear moral at all times. The flood led to the girls sharing living spaces with unfamiliar, or unrelated, men. This created great anxiety as they felt physically exposed and ashamed when they had to perform routine tasks such as changing clothes, bathing and sleeping. Going to the toilet without necessary facilities led to girls holding on as long as possible, and even reducing their food intake.  In this way, their struggle to maintain honour had a flow-on negative effect to their health.

Menstruation was a great cause of anxiety during the floods as it is usually dealt with privately, with most girls not even telling their mother when they have their period. Menstruation is linked with dirtiness and pollution in Bangladesh and the inability to bathe regularly or to find a private space to change and wash their menstrual cloths greatly increased their distress.

Overall, there was a strong sense of helplessness and shame among the girls during the floods, who found themselves subject to increased harassment by boys and men whilst simultaneously failing to conform to cultural expectations of purity and seclusion. This study highlights the need for a safe, private space for girls in a disaster situation (Rashid & Michaud, 2000).

## 2.3　Sexual violence in refugee camps

Refugees and displaced persons are more vulnerable to sexual violence, particularly when forced to live in camp settings either within their own country or in a foreign setting (Benjamin & Murchison, 2004). The vulnerability of women and children in these settings is worth particular attention, as they comprise 80% of refugee and displaced populations worldwide (Benjamin & Murchison, 2004; 7). Although they make up a majority, women often have more difficulty than men do in obtaining their entitlements in camp settings. Reasons for this include:

- Lack of awareness of their rights;
- Lack of information about benefits and resources available to them;
- Illiteracy; and
- Male control of resources in camps.

As a result of these barriers, women are more likely to resort to coping strategies such as exchanging sex for money, material goods or protection. This increases their vulnerability to additional forms of exploitation and abuse. Thus, while camp settings may provide a respite from armed violence, or safe shelters when regular arrangements are damaged, these settings are characterised by frequent reports of sexual violence The most vulnerable period for refugee and internally displaced women tends to be during the transition into camp settings and the period after they first arrive. Often they will have experienced significant trauma of some kind, be exhausted, without family members, money, food or clothing. In such conditions, they are extremely vulnerable to exploitation and attack (Benjamin & Murchison, 2004).

### 2.3.1　Sexual vulnerability of adolescent refugees:

### Liberia, Guinea and Sierra Leone

A 2001 assessment initiated by UNHCR in partnership with Save the Children-UK looked into the extent and nature of sexual violence and exploitation of refugee children Liberia, Sierra Leone and Guinea. A participatory approach was used, involving focus groups and interviews with different sections of the refugee community (including children and adolescents).

They found extensive sexual exploitation of refugee children across the three countries. Mostly, this took the form of 'casual informal encounters', however organised prostitution and trafficking were also uncovered as particularly affecting adolescent girls.

With a few exceptions, men are the principal sex exploiters. These were largely men with money and some kind of power within the community. This included men from local and international humanitarian agencies. Those sent to protect may also exploit and attack.

Girls aged between 13 and 18 years of age were the main targets of sexual exploitation. Boys were identified as the main victims of other forms of exploitation, in particular in the labour market. Especially vulnerable groups included girls from single parent households, separated and unaccompanied children, children from child-headed households, orphans, girls who were street traders, or girls whose mothers were street traders.

Poverty, including a desperate need for food, and other basic survival resources was frequently cited as the reason for entering exploitative relationships. The problem was exacerbated by the lack of viable employment opportunities. Families were often aware of the exploitation, but saw it as 'the only way to make ends meet' (UNHCR & Save the Children - UK, 2002; 11)

Sexual violence was also commonly reported (although less common than exploitation). Sexual violence reported included rape, the abduction and abuse of children by military forces, female genital mutilation, and rape as a weapon of war. Perpetrators were men including international and regional peacekeepers, fellow refugees, armed forces personnel,

government soldiers and men from the host community. Boys are also reported as perpetrators against girls of the same age.

Unsurprisingly, both exploitation and violence were associated with serious health problems, negative psychosocial outcomes, loss of developmental opportunities and damage to long-term prospects.

In terms of humanitarian programming, the following problems were highlighted:

- An absence of monitoring and retribution for staff who abuse their power;
- An absence of international staff located in camps giving male national staff power and control over camp life;
- A lack of pre-planning of aid programmes leading to poor camp design and cramped housing which does not allow for adequate security;
- A lack of female staff;
- A lack of adequate regulations governing camp life;
- Inadequate sexual and gender-based violence programs or programs that do not pay enough attention to sexual exploitation of children;
- Inadequate consultation and involvement of the refugee community (especially children and women) in decision-making;
- A growing tolerance of acts of sexual violence and exploitation; and
- The prevalence of drug and alcohol abuse.

(UNHCR & Save the Children - UK, 2002)

## 2.4    Mental health and mental illness

A dominant focus in research about the impact of disasters on adolescents has been on their mental health, with a comparatively little focus on the impacts on physical health or life trajectories. There has been significant concern about the potential for experiences of trauma to trigger the development of mental illnesses including the identification and treatment of posttraumatic stress disorder (PTSD) which may develop weeks, months or years after the experience of trauma (Boyden, 2003; Williams et al. 2008). The dominant focus tends to be on PTSD; however researchers have noted that other mental health problems known to be associated with the emergency experience include depression and anxiety. More recently, research has highlighted that conduct-related disorders such as poor impulse control and high levels of reactive aggression can also be seen as a response to the disaster experience (Marsee, 2008).

Post traumatic stress has been defined as the normal response to trauma whereby people experience the intrusion of distressing memories of the experience. This requires processing on their part over time. Post Traumatic Stress Disorder, however, is the term used when the reaction has become a severe anxiety disorder which may include re-experiencing the original trauma(s) through flashbacks or nightmares, avoidance of images, sounds or places associated with the trauma, increased arousal and hyper-vigilance, difficulty falling or staying asleep, anger, or numbing. These symptoms persist over time and are severe enough to cause significant impairment in social, occupational, or other important areas of functioning. Those with pre-existing mental health problems are also more likely to develop PTSD (Pfefferbaum et al., 2008).

It is unsurprising that the multiple losses and major disruption to life associated with experiences of emergencies can have a negative impact on mental health. Despite this, research indicates that most children recover within a year or more of traumatic events (La Greca & Silverman, 2009). On the other hand, some children and adolescents may still display chronic stress reactions or other mental health symptoms years beyond the initial event (Sagy & Braun-Lewensohn, 2009). Those who have experienced multiple losses and diminished support are more likely to be in this category.

## 2.5    Sexual and reproductive health

In many developing countries there are various barriers that even in non-emergency settings prevent adolescents from accessing sexual and reproductive health services. These include individual barriers (feelings of shame, fear and anxiety around areas of sex and reproduction), socio-cultural barriers (norms that determine behaviour, stigma, education levels) and structural barriers (actual existence of programs, location of programs, cost, accessibility).

In times of emergency, these barriers are exacerbated (UNFPA & Save the Children, 2009). Damage to infrastructure and/or increased pressures on existing service provider can leave adolescents without access to sexual and reproductive health information or services during a period when they are at heightened risk of sexual violence, unwanted pregnancy, unsafe abortion, STIs and HIV infection (UNFPA & Save the Children, 2009).

The following sub-groups of adolescents have been identified by UNFPA and Save the Children as being at particularly heightened risk during a crisis situation (2009; 7-8) :

- *Very young adolescents (10-14 years), especially girls:* due to their dependence, lack of life experience, lack of power and lack of participation in decision making.

- *Pregnant adolescent girls:* due to an increased risk of pregnancy complications and reduced availability of emergency obstetric care services in emergency settings.

- *Marginalised adolescents (e.g. HIV+, disability):* due to stigma, culture, mental or physical limitations.

- *Adolescents separated from their families (parents/ partner) and adolescent heads of household:* due to lack of protection, access to livelihood.

- *Adolescent survivors of sexual/gender based violence:* due to a risk of unwanted pregnancy, unsafe abortion, STIs, mental health problems and social stigmatisation.

- *Adolescent girls selling sex:* due to a risk of unwanted pregnancy, unsafe abortion, STIs, drug and alcohol problems and exploitation.

- *Children associated with armed forces:* usually sexually active at a younger age and risk of STIs and higher risk of HIV, sexual violence and abuse (especially for females), this leads to risk of unwanted pregnancy, unsafe abortion and STIs. Also more likely to have risk-taking attitudes.

Lack of adequate capacity to respond to the physical, sexual and reproductive health needs of adolescents during emergencies is integrally interconnected to their mental health status. Feelings of safety and security are diminished

when adequate food, water and medicine or health care is not available. Feelings of dignity and self-respect are further diminished when health services are withheld on moral grounds, or when they are provided in a judgemental or punitive fashion. Feelings of shame, stigma or neglect are associated with higher levels of despair, alienation, aggression and depression.

## 2.6     Trafficking

Trafficking problems are fuelled by deepening poverty, deteriorating living conditions, persistent unemployment, conflicts, human deprivation, and feelings of hopelessness (Laczko & Gozdziak, 2005; 80). Therefore it is unsurprising that trafficking problems are exacerbated in situations of conflict and emergency. Vulnerable, displaced populations are likely to be preyed on by traffickers, and in the absence of alternative opportunities, desperate people will resort to low-paid labour and exploitation. Those who are already vulnerable to trafficking prior to emergency (varies according to region), are most likely to fall victims.

Most trafficking follows predictable patterns based on the country's placement in regional trafficking patterns. During conflict, human trafficking is primarily related to the recruitment and use of child soldiers and women associated with fighting forces (WAFF). Trafficking of refugees and displaced persons, especially for sexual exploitation or labour is also common (Nelson, Guthrie, & Sumner Coffey, 2004).

A lack of law and order combined with large numbers of vulnerable populations (especially female refugees, separated children, and war widows), make emergency situations a good source for human trafficking for sexual exploitation or forced labour with major health and wellbeing risks for victims (Zimmerman et al., 2003).  In such a climate, women and girls suffer disproportionately from a lack of access to resources and education. On one hand, they are tempted towards opportunities to improve their social, economic, and political situations in more developed cities or countries, however, they usually lack comprehensive information or access to legitimate migration programs and are therefore vulnerable to trafficking for sexual exploitation or forced labour. This phenomenon occurs not only in the immediate post-conflict period, but often well after the conflict has subsided (Nelson et al., 2004).

Reports of child and adolescent exploitation are common in the aftermath of natural disasters. Poor rural families are often forced to send their children to cities to live with wealthier families and exchange work for food, shelter and education. This can leads to exploitation, physical and sexual abuse (CdeBaca, 2010).

## 2.7     Child soldiers

Child soldiers include children up to 18 years of age, who have either been abducted to fight, or signed up voluntarily. Some adolescents perceive that joining armed forces is the best way to ensure their own survival needs are met. Adolescents are also particularly vulnerable to ideological recruitment, and education or religious organisations as well as families can play a major role in socialising adolescents into pro-conflict beliefs.

Adolescents returning from soldier experiences face a number of challenges once back in the wider community. Many former soldiers suffer from Post Traumatic Stress Disorder (PTSD),

or from psychological symptoms such as stress, guilt and nightmares. Adolescents returning to the community often face persecution, threats to their life or stigmatisation due to the acts they have committed, regardless of whether they were forced to do them or not.  Former soldiers can also experience abuse and/or  resentment from grieving families of unreturned child soldiers (Blattman & Annan, 2008).

An additional burden is experienced as a result of inequality caused by the time spent fighting instead of gaining education and employment skills. In Uganda, a study found that former abductees were twice as likely to be illiterate, and half as likely to be engaged in skill or capital-intensive employment as non-soldiers. They were also found to have a third lower daily earnings (Blattman & Annan, 2008; 16). It is estimated that 60 percent of this gap in wages and productivity was due to the gap in education due to their time away from schooling. While it was found that the inequality gap decreased over time, it did not disappear entirely, with former soldiers continuing to be disadvantaged long after returning.

## 2.8     Loss of access to education

In post emergency situations, adolescents are much less able to attend any form of schooling or education than are younger children. This can be because they have economic and family responsibilities that prohibit them from attending. They may also lack opportunities and an appropriate learning environment targeted for their age and circumstances (Children, 2000). This lack of opportunity reflects programming and funding patterns that prioritise primary education over adolescent education. This may arise because of a tendency to view education for adolescents as a development, rather than a life saving measure to be prioritised in relief efforts (Children, 2000; Lowicki & Pillsbury, 2000). Hence funding and resources are not directed to providing opportunities for adolescents to engage in either formal or informal literacy, numeracy, life-skills or vocational education.

Despite that adolescents are often forced to take on adult roles and responsibilities during times of emergencies, including having to provide for themselves and others, most post-emergency livelihood initiatives tend to focus on adults.

Without skill-building opportunities, adolescents are particularly vulnerable to economic exploitation and may be subjected to unsafe working conditions, discrimination as workers and forced labour. Where alternatives are not available, some adolescents resort to harmful activities such as child soldiering or prostitution, in order to survive (Children, 2000; Lowicki & Pillsbury, 2000).

With lesser value being placed on girls' education in many communities, adolescent girls are more likely than adolescent boys to miss out on an education. This can also be due to a security concerns, family responsibilities, the unavailability of sanitary or hygiene facilities, pressure to marry, and perpetuation of family assumptions that boys must be catered for first (Children, 2000).

# Section 3
# Promising Approaches

Adolescents affected by emergencies and armed conflict have been largely absent from the agendas of donors and international humanitarian agencies. Increasingly though, some funding for, and implementation of, adolescent programs has taken place, albeit mostly on an ad hoc basis. Reports, case studies and evaluations of these programs have begun to generate better understandings of what is possible within an adolescent programming approach.

The following section presents case studies of promising programs and discussion of some emergent recommendations. The promising approaches included in this section have been selected on the basis that they:

- Relate realistically and responsively to the cultural, political, economic and social circumstances of the particular situation;
- Advance the rights of adolescents;
- Seek the active participation of adolescents (in needs analysis, planning, design, implementation or evaluation phases); and
- Promote protective factors associated with adolescent wellbeing and/or reduce risk factors associated with harmful outcomes for youth.

Whilst considering their vulnerabilities, these case studies also highlight the potential that adolescents have to contribute to their communities during times of emergency. During and post emergency, many adolescents spontaneously adopt significant or augmented helping roles. These may relate to rescue, care, labour and fulfilment of household leadership roles (Manyena et al., 2008; Penrose, 2006).

## 3.1.1  Adolescents as spontaneous active participants in early recovery phases: post-tsunami experiences in Indonesia, Sri Lanka and India

### Promising Program

In their post-tsunami development work Plan International consulted over 300 children and adolescents (7-17) in tsunami-affected communities in Indonesia, Sri Lanka and India about how they were involved in the disaster response. Many children played a role in the immediate post-emergency response, using their knowledge and skills to help save themselves and others. They helped younger and older people, administered first aid, took injured people to hospital and searched for family members. Despite this, their contribution was barely acknowledged.

They felt 'frustrated and disempowered' by the delays in rebuilding homes, schools and livelihoods. They longed for opportunities to play an active role in reconstruction, rather than being left on the sidelines feeling frustrated and dependent.

The results of this study indicate that children and adolescents do play an important role in the recovery process but that they may not be acknowledged for their role, nor given opportunities to contribute in later stages of reconstruction. Also significant is their strong desire to help and their belief that they would benefit from having an active role in rebuilding efforts (Penrose, 2006).

## 3.2  Cultural sensitivity in adolescent programming

To ensure both cultural appropriateness and sustainability, it is essential to elicit the participation of local people, including adolescents, in the planning, implementation, monitoring, and evaluation of emergency response programs (Duncan & Arntson, 2004).

To ensure that programs are effective, it is important to recognise that cultures differ. A child's social development occurs within the beliefs, practices, and values embedded in their culture (Duncan & Arntson, 2004). For example, agents of socialization, such as the family, vary in definition across cultures. In one cultural system, family may encompass only the immediate or nuclear family, in others, it may refer to the extended family or peer group. Similarly, while in some secularised contexts, spiritual development may be seen as peripheral, in many other cultures, spiritual development is understood to be central to individual and family life.

To design culturally appropriate interventions, it is important to understand and respect beliefs and practices in the local setting. Given that humanitarian aid workers are often not members of the local culture, this is not an easy ask. Duncan and Arntson (2004) suggest that these 'outsiders' should acknowledge that their own assumptions and practices may not apply to other cultures: 'A value or belief from one culture – for example, the importance of building a strong sense of individuality – should not be imposed on another culture as truth. Rather, it should be a basis for discussion and seeking cross-cultural understanding' (Duncan & Arntson, 2004; 9). They should seek to learn from those they aim to serve by consulting and involving the target group in the design and implementation of the intervention.

In the chaos that arises in emergencies, aid workers face the challenge of trying to forward plan while at the same time dealing with the immediate needs of communities (ESCAP, 2008). Not only is it important to work with key stakeholders to ensure cultural sensitivity, but this is also the best way to incorporate cultural patterns, local traditions and customs as assets within programs (Children, 2000) (see for example Section 3.4 Using traditional approaches in mental health interventions). Those programs which have an indigenous support structure are more likely to be sustained with beneficial results for the target community (Saltzman et al., 2003).

### 3.2.1 Lessons learned: cultural sensitivity in programming in Albania

In 1999, hundreds of thousands of Kosovars were forced to leave their country for mass refugee camps in Albania. Many humanitarian organizations gave food to Kosovars. In one camp, the elders said they felt demeaned by being fed Albanian food and treated as if their own culture did not matter. Although it was not the intention, the food handouts were having a negative impact.

NGOs asked for a list of the ingredients they wanted. A group of refugees took over the building of a kitchen and began cooking and serving their own meals and working 12 hours each day. Youth in the camp helped to organise people in shifts in order to avoid long lines.

Both the cooks and the recipients reported positive results. The change of food made them feel more in control over their circumstances, and they experienced pride in what they had accomplished. Through their demand for more control over their circumstances, what had been a straightforward food distribution project evolved to encompass positive psychosocial outcomes (Duncan & Arntson, 2004).

## 3.3 The active participation of young people

Ensuring children and adolescents' meaningful participation can be difficult at the best of times. Adults often do not recognise the value of their views and they sometimes have restricted access to information and opportunities to participate. In times of emergency, practicing participatory approaches can be moved even further down the priority list, despite evidence of its positive impact on communities. Most accounts of programs speak of children's and adolescents' exclusion from the emergency response phase due to dominant norms, cultural values and a tradition of fast moving, non-participatory practices that undermine the community's (let alone young people's) ability to respond (see for example Manyena et al., 2008; Penrose, 2006; Sommers, 2006).

While on one hand it is important to emphasise the vulnerability of children and adolescents and the requirement for protection and assistance, it is equally important to recognise their ability to form and express opinions, participate in decision-making processes and influence solutions (Nikku, Sah et al., 2006; Penrose, 2006). Participation is one of four overarching pillars of the CRC. The principle of participation affirms that children have the right to express their views in all matters affecting them (UNICEF, 2008). The active involvement of young people is central to their protection and wellbeing (UNICEF, 2008). It is also central to overcoming the deep pain and humiliation of traumatic experiences. This means that time must be taken to ensure real participation (Duncan & Arntson, 2004).

Thus the case for greater participation in development work is not simply a moral but also a practical one. Involvement of people in projects has consistently led to better programming results, particularly around the sustainability of interventions and the avoidance of excessive dependency that can arise if participation is minimised (ESCAP, 2008; McIvor & Myllenen, 2005). Participation with young people recognises their potential to enrich decision-making processes, share perspectives and be part of restorative processes. Furthermore, a lack of engagement can lead to a culture of dependency, which will be difficult to reverse when the supported intervention phase is over (McIvor & Myllenen, 2005). It also reinforces power relations between the 'expert' aid worker and the 'needy' recipient. This simply increases the vulnerability of the population being assisted.

Case studies demonstrate that programs can fail to cater for the needs of adolescents when they are ill-informed about the nature of the constraints that young people face. Sports programs that do not account for gendered requirements about dress have failed to serve the needs of girls (Henley, 2005). Education programs that do not account for the fact that many girls must provide childcare for siblings, and thus do not provide childcare support at school, find that adolescent girl's attendance rates are low. Peace education programs that focus on ethnicity but not on gender as a basis for discrimination can fail to serve the needs of girls (Sommers, 2006). Food distribution programs that do not include adolescent perspectives fail to learn about patterns of child abuse or inequities within families associated with getting access to food (Manyena et al., 2008; McIvor & Myllenen, 2005). To include young people's input is therefore a pragmatic strategy rather than just an ideological strategy within a rights-based model.

Exactly how young people are given opportunities to get involved is context-specific. Youth leadership and engagement can be more readily fostered when collaborative spaces are provided for their participation and contribution. Recommendations for good practice are summarised below:

- Involve adolescents in all stages of program needs analysis, development, operation, monitoring and evaluation (Etaba et al., 2005).

- Include children and adolescents from various backgroundssuch as age, caste, class, religion, ethnicity, [dis]ability) and give them equal possibility to have their voices heard (Nikku et al., 2006).

- Encourage the wider community to unpack their assumptions about young people and acknowledge the benefits of child and adolescent participation (Manyena et al., 2008; McIvor & Myllenen, 2005).

- Be aware that while participatory processes can empower young people, they can also further manipulate them, depending on the level of consultation and the opportunity they are given to make choices. Full participation goes beyond consultation and should include opportunities for leadership and decision making (Lowicki & Pillsbury, 2004; UNDP, 2006).

- Where young people are involved in consultation, it is imperative that they see the results of their participation.

- Participation is not a quick fix. It requires long-term commitment to develop the capacities of young people to achieve realistic goals (UNICEF, 2004).

## 3.4 Physical health

Health has been described as the most developed and coordinated sector of international response to adolescents affected by armed conflict (Children, 2000). However, in humanitarian responses, health care is often delivered by multiple organizations, with health workers with different levels of qualifications and experience, using diverse guidelines and training materials, and sometimes operating with a different set of understandings about the services that adolescents should be provided with. Ensuring comprehensive, coordinated, and appropriate care is difficult in such situations; however, coordinated interventions are critical for relief efforts to be successful (Lane, 2008; Moss et al., 2006).

As well as organisational coordination, health-care response needs to incorporate:

- Evidence-based, locally adapted guidelines for the care of adolescents (as differentiated from children) in complex emergencies;
- Properly trained and supervised health-care workers;
- Adequate and appropriate drug and contraception supplies;
- Knowledge of local epidemiology;
- Appropriate methods to encourage help-seeking behaviour, particularly as related to adolescents;
- Accessible health-care facilities; and
- Functioning referral systems.

The health needs of adolescents depend on the type of emergency. Armed conflict, famines and natural disasters all carry specific health risks and responses should account for these differences (Moss et al., 2006). It is important to note however, that much of the burden of disease in these situations is caused by malnutrition and a range of infectious diseases that are common to young people in many non-emergency settings and for which there exist evidence-based guidelines for prevention and treatment. This evidence should direct attention to the health needs of adolescents in complex emergencies (Moss et al., 2006; 62).

### 3.4.1 Reproductive health

All adolescents, but particularly those from higher-risk sub-groups require particular attention and targeted interventions to ensure that their sexual and reproductive health needs are met in emergency situations (UNFPA & Save the Children, 2009; United Nations, 2009).

While there are few field-tested models for such interventions in emergency situations, existing models used in non-emergency contexts in the developing world can be adapted to emergency contexts (UNFPA & Save the Children, 2009).

The following recommendations are drawn from the literature.

- Use creative and innovative approaches to ensure services or programs are acceptable, accessible and appropriate for adolescents. Consider the need for 24 hour access, peer referral, privacy and gender-specific services.
- Take culturally-informed approach to program design
- Involve adolescents in needs analysis, monitoring and feedback.
- Use peer-educators are well-placed to assist peers to seek services.
- Negotiate for community and parental acceptance of prevention programs
- Include a gender rights perspective within sexual and reproductive health prevention programs
- Include services to support those who are victims of sexual assault or rape within the health care package.
- Include education about reproductive health within school-based life-skills and peer outreach programs.

and teaching, as well as reproductive health issues. The program was split into three age-specific groups with 7-10 year olds learning primarily about bodily changes and anatomy; girls aged 11-14 learning about sexually transmitted diseases, and girls aged 15 and over focusing on healthy pregnancies and safe practices when caring for a baby. Additional topics included nutrition and relationships.

The aim of the program was the transfer of knowledge throughout the community. In order to receive their merit badge, girls had to complete a number of tasks including reaching 25 girls and women in the community with the information they learned, keeping journals and developing illustrations relating to anatomy, puberty and child birth. Girls were also able to receive gold, silver and bronze medals if they participated in additional activities such as preparing a healthy meal or performing a drama based on health themes.

The greatest benefits of the program were found to be improved self-esteem among the trained girls and greater use of health services. Other positive aspects of the program included the creation of a safe learning environment for women and girls, opportunities for creativity and fun and interaction of between women and girls which allowed for knowledge sharing (Barnett, 2000).

## 3.5    Psychosocial health and mental health interventions

Disaster preparedness and recovery plans should include strategies to address the psychosocial needs of adolescents (Betancourt, 2005; Betancourt & Khan, 2008; Children, 2000). Research indicates that during the aftermath of the disaster young people draw their sense of safety from adults, predictable routines and consistent support systems (Children, 2000). Family support is especially important. For example, research demonstrates that those with strong relationships with their mother are more likely to recover whereas those whose mothers are themselves suffering from mental health problems are less likely to recover early (Wickrama & Kaspar, 2007). Other research conducted with adolescents one year after the 2004 Indian Ocean Tsunami showed that educational opportunities and support from family, peers, and other social networks was associated with better recovery from the trauma (Tuicomepee, 2008).

Therapy should not be the first line of response in the immediate aftermath of a disaster. There is little evidence that early provision of critical incident stress debriefing (CISD) (i.e. asking the child to revisit their experience) is of any benefit in the short term. In fact, there is some concern that this may be unhelpful or even harmful. Individualistic therapeutic models are also impractical during emergencies as they rely on high ratios of highly trained staff (Belfer, 2006).

There is considerable consensus that approaches which are more in the style of psychological first aid (PFA) are more appropriate during the aftermath of emergencies. In PFA approaches, efforts are made to engage in promoting safety, calming, connectedness and hope along with provision of opportunities for self and community care which promote a sense of control and efficacy (La Greca & Silverman, 2009).

In the most immediate aftermath of the response phase, best practices in psychosocial support response include those which:
 • Reassure;
 • Address fears and worries about safety and security;
 • Allow (but do not force) expression of feeling;
 • Provide information; and
 • Normalise disaster reactions

More general recommendations to assist with promoting psychosocial health in the recovery phase include:

 • Integrating responses to the psychosocial needs of children and adolescents into general disaster preparedness and recovery plans;
 • Working with families rather than individual children to address their needs;
 • Providing safe spaces as well as some form of education including age-appropriate life and livelihood education;
 • Involving young people in disaster relief or community care activities in order to strengthen psychosocial health via enhancing protective factors of social connection, self-esteem, sense of agency and control, and sense of hope and purpose;
 • Employing culturally appropriate methods of care for those with higher levels of psychological distress in the (likely) absence of specialist mental health care for those most seriously affected; and
 • Equipping staff in schools and community facilities with the capacity to recognise and respond to children's common reactions to trauma (Sagy & Braun-Lewensohn, 2009; Williams et al., 2008).

### Supporting Families, Supporting Adolescents:

### A Sri Lankan Study

A quantitative study carried out in Sri Lanka after the 2004 Tsunami found a number of links between family support (specifically from the mother) and the mental health of adolescents.

This study found that the quality of the mother-child relationship corresponded with lower levels of depressive and post-traumatic stress disorder (PTSD) in tsunami-affected adolescents. When mothers were experiencing their own depressive or PTSD symptoms, the detrimental influence of psychosocial losses from the tsunami increased. Increased family conflicts and mothers' impaired mental health also increased or prolonged adolescent mental health problems.

These findings hold useful insights, and suggest that parent-child relationships, family conflict and mothers' mental health can be used as indicators of mental health problems in disaster-affected adolescents. Family-focused or family specific therapy/programs are potentially needed in post-disaster situations to assist adolescents. Families and mothers in particular are a key resource and protective factor for young people, with a mothers' wellbeing found to be a buffer to disaster exposure. Most importantly, the link between family and mental health of adolescents shows that dealing with the mental health problems of parents can have a positive flow-on effect for adolescents in their care  (Wickrama & Kaspar, 2007).

### 3.5.1 Psychosocial support within life-skills education

Subsequent to the initial response, psycho-educational activities may be delivered within formal or informal life skills programs. These programs should be evidence-based and include teaching people about grief reactions. This assists to normalise the grief process and diminish the possibility that young people are distressed about the meaning of reactions, which may include shame, guilt, regression and inordinate fear of places or sounds that remind them of the trauma. There is no indicated need for immediate delivery of such education and it can occur after the first impact of the emergency and once additional support structures are operative.

Those taking a resilience or strength-based approach recommend an ecological approach to promoting the psychosocial health of adolescent (Betancourt, 2005; Betancourt & Khan, 2008; Boyden, 2003; Ronan et al., 2008; Ronan & Johnston, 2005; Weems, 2008). An ecological approach directs attention to the environments, relationships and activities that the young person will engage in, rather than a sole focus on treating the individual. Thus those working within the resilience, strength-based or ecological tradition research the use of education, life skills, livelihood skills, sports programs, arts programs, or safe space initiatives as the means through which to provide the psychosocial support that is associated with a return to wellbeing. This research, though patchy and limited due to the challenges associated with conducting research in emergency settings, has demonstrated that these ecological interventions are associated with substantial improvement in mental health outcomes. As a result of this research it becomes clear that education initiatives have a major role to play post-emergency, both as a way to improve both mental health outcomes and as a way to increase skills and knowledge that will equip adolescents for employment during reintegration and restoration phases post-emergency. Education sites can also function to provide learning as locations in which to detect and seek additional help for those most affected by trauma (Madfis et al., 2010).

### 3.5.2 Cultural appropriateness of therapeutic responses

For those who do not recover well from the trauma, additional support is needed. Some children may still display chronic stress reactions or other mental health symptoms years beyond the initial event (Sagy & Braun-Lewensohn, 2009). Ideally such support is provided by trained staff who are culturally attuned. There is controversy about the focus on providing treatment for PTSD and on assumptions that Western models of individual therapeutic talking treatments are the best way to deal with trauma in different cultural contexts.

Within the discussion about therapeutic treatment it is also noted that there are cultural differences in the ways that different populations understand mental health. Distress can be manifested and expressed physically, somatically and psychologically in different ways. For example, mental health distress may be manifested and communicated as set of physical sensations or as a concerns that parts of the body are not functioning, rather than via a narrative style as a concern about a pattern of distressing thoughts (Hinton & Lewis-

Ferna´ndez, 2010; Hinton, Pich, Marques, Nickerson, & Pollack, 2010; Kohrt & Hruschka, 2010). Thus a therapist from outside the culture may not pick up on the indicators of distress that are of relevance to the young person and thus fail to reassure them or to convince them to persist with their helping encounter in the face of perceived irrelevance.

Some projects have demonstrated success in achieving good recovery rates from PTSD through use of traditional calming, cleansing or meditation techniques involving arts, meditation, prayer, song, play or rituals (Baráth, 2003; Betancourt & Khan, 2008; Catani et al., 2009). Other research has demonstrated that when adolescents perceive they are receiving a high level of support during the emergency response phase they are less likely to develop mental health problems (Pina & Villalta, 2008).

### 3.5.3 Meditation-Relaxation Therapy for traumatised children: Sri Lanka

A psychiatric study was conducted in Sri Lanka with Tamil children in the aftermath of the 2004 Indian Ocean tsunami. Children (aged 8-14 years) who showed strong diagnostic signs of posttraumatic stress disorder (PTSD) were randomly assigned to two different therapy methods for treatment. The first method is known as Narrative Exposure Therapy for children (KIDNET), which focuses on reliving the traumatic experience, and the second method is Meditation-Relaxation, which uses a number of breathing and relaxation techniques.

The children completed six sessions each, lasting between 60 and 90 minutes, over a two-week period. Each Meditation-Relaxation therapy session started and finished with a 15 minute breathing exercise, and the remaining part of the session consisted of a number of exercises including 'inner peace meditation', 'uchchadana mantra chanting' and 'progressive muscle relaxation'. Facilitators were provided with a manual for these exercises which detailed the exact way these exercises were to be carried out.

Pre-therapy evaluations of the children were compared with evaluations carried out one month after the treatment and again six months after. The results showed no significant difference in the effectiveness of the two different techniques. This was a positive finding as the use of the meditation/relaxation techniques required little training for those administering them. In addition the techniques were culturally appropriate to Tamil culture, developed by local counsellors, and the children were familiar with these meditation and relaxation techniques as they are commonly used in formal schooling.

This study highlights the usefulness of locally-developed therapies for children following traumatic experiences, such as war or natural disaster (Catani et al. 2009).

## 3.6    Education for adolescents

Education is widely accepted as an integral part of humanitarian response in emergencies. Education is seen as central to: restoring a feeling of normalcy; protecting the most vulnerable populations; providing care; promoting tolerance/ unifying divided communities; and assisting the process of peace building and reconstruction (Johnson & van Kalmthout, 2006). It is also a primary means to ensure skills-building, training for livelihoods, peace-making, community-building, social reintegration, good health practices and protection (Lowicki & Pillsbury, 2000).

Education specifically for adolescents should also be fully integrated into education programming at all stages of emergencies (Lowicki & Pillsbury, 2000). It should include and emphasis on the provision of training in life skills and vocational opportunity, particularly for those who have missed out on access to education due to dislocation or lack of provision (Machel, 1996, 2001).

During the immediate aftermath and initial response phases, the provision of purposeful educative activity in supervised spaces generates social interaction, relational support and a sense of hope and purpose (Madfis et al., 2010). As well as enhancing skills or capacities, education interventions can work to strengthen a set of protective factors which in themselves function to support recovery or prevent the onset of mental illness. Education sites can also function as locations in which to detect problems and seek additional help for those most affected by trauma (Madfis et al., 2010). Efforts to address the psychosocial needs of children and adolescents can be integrated within an education response and thus serve multiple protective objectives (Children, 2000).

### 3.6.1    'Youth Education Program': literacy, life-skills and vocational training: Timor-Leste

Timor-Leste is the fifth country to have the 'Youth Education Program' (YEP) implemented by the Norwegian Refugee Council globally. The non-formal education program runs for one year, and is unique in that it combines literacy, life skills and vocational training in an attempt to engage out-of-school youth who have low levels of education.

Components of the program include ensuring class sizes do not exceed 25 students, maintaining an equal gender balance (through prioritising acceptance of single mothers and female-headed families), enabling youth to decide some topics of interest, providing each class with two teachers, (preferably one male and one female) and ensuring vocational skills training is based on local needs.

The program started in 2008 in Timor-Leste and has been deemed highly successful. Approximately 40 per cent of graduates have secured jobs and those who have not have moved on to further education, returned to assist their families in agriculture, and overall have remained engaged and active in their communities.

Evaluation two years on from the first YEP initiative in Sierra Leone found that the vocational skills component of the course had proved the most useful, while the literacy component had been perceived as too academic and therefore irrelevant to many of the participants. This highlights the need to constantly evaluate these programs to ensure they are consistently relevant to the students (Midttun & Skjetne, 2004; Naletto, 2010).

## 3.7    Livelihoods education

While education should be prioritised, the reality is that with increased family responsibilities and sometimes in the absence of parents, adolescents need access to resources and training in a viable skill to promote their livelihoods (Lowicki & Pillsbury, 2000). Work is connected to personal empowerment and self esteem (Sommers, 2006) and without opportunities, adolescents are more vulnerable to exploitation, abuse, depression and hopelessness and will lack a sense of self-worth.

Livelihood programs have typically focused on adults. For example, microfinance programs typically serve adults or at the very least, young people who have had some kind of previous business experience. For those without experience, entrepreneurial skills training is necessary (USAID, 2005).

Livelihoods education depends on opportunities and spaces for young people to find paid work. In this way, vocational training should never be a stand-alone policy, but should be linked with job creation and employment opportunities. One way of linking the two is by creating a micro-credit or apprenticeship component that follows on from vocational training.

Some effective job creation programs have existed in Angola, where "Quick Impact Project" funds provided by the UNHCR, allowed former child soldiers, along with their families, to rehabilitate small businesses, such as bakeries, through micro-credit loans. Another program provided support (such as favourable rental terms on sewing machines) for small businesses or labourers on the condition that they accept an apprentice. It was found that these programs were more useful than vocational training alone because they provided more rapid acquisition of skills and income for young people (Verhey, 2005).

The following recommendations pertain to provision of livelihood education opportunities:

- In the planning phase, needs assessments should be situation-based, age-specific and participatory, and should consider the resourcefulness of adolescents (Children, 2000);
- Use surveys to determine short and long-term labour and skill needs and share results with youth education planning and livelihood programs;
- Take account of the needs of disabled adolescents, former child soldiers, adolescent girls and adolescent heads of household need special attention (Children, 2000); and
- Improve access for adolescents to income generation and micro-credit opportunities (Children, 2000);
- Do some 'capacity mapping', that is, identify and encourage economic activities and skills which are sustainable at a time of crisis and beyond (ILO, 2005);
- Create a variety of training and employment opportunities so the market is not flooded in only a couple of sectors;
- Attempt to take advantage of any skills learnt during conflict/ war (especially for former child soldiers);
- Be flexible (move with the market, be adaptable to new local opportunities/ needs);
- Invest in the provision of training for guidance counsellors to ensure they are providing accurate, up-to-date information and are helping to address stereotypes about certain careers (Mac-Ikemenjima, 2008); and
- Ensure program frameworks incorporate family livelihood needs (Verhey, 2005).

### 3.7.1 Vocational training for adolescent refugees: Syria

UNICEF, the Syrian Arab Red Crescent (SARC) and the French Institute Européen de Coopération et de Dévelopment (IECD) launched a vocational training centre for the most vulnerable adolescent refugees in Syria. This was largely targeted at adolescents from Iraqi refugee families, many of whom were dependent on humanitarian aid and deprived of any regular income.

The centre's mission was to increase professional opportunities for adolescents upon their return to Iraq or resettlement in a third country.

As well as providing a unique opportunity to enhance adolescents' skills and employability, the program gives young people a safe space to spend time with their peers and provides them with leadership opportunities.

The centre involves Palestinian adolescents in running its life-skills training sessions and provides a space for other youth-led initiatives. Among other things, the students have produced short documentaries and perform rap songs about the challenges of adolescent life and their goals for the future (Krzysiek, 2010).

## 3.8 Disaster preparedness and survival skills education

Some programs favour the use of survival skills training as a component of disaster preparedness and as a strategy for increasing psychological support for those young people already affected by emergencies (Ronan & Johnston, 2005). Despite concerns that disaster preparedness education programs might heighten children's fears and anxieties, research demonstrates that the opposite is true. When young people are more able to appraise risk and understand what they can do to reduce risk or to cope with adversity, they are less likely to worry (Morris & Edwards, 2008; Peek, 2008; Ronan & Johnston, 2005).

Research indicates that school-based disaster preparedness training can:

- Help to alleviate fears of vulnerability during recurring attacks or recurring weather or geophysical events;
- Reduce physical risks of disaster by aiding participants with the information to recognise the signs of dangers and take appropriate action;
- Lead to better decision-making under duress;
- Lead to the adoption of hazard minimisation strategies at home; and
- Promote a sense of control in a disaster situation by improving coping mechanisms.

Disaster education program components can include:

- Practising disaster drills;
- Risk mapping;
- Evacuation planning and rehearsal;
- Home hazard adjustments tasks;
- Search, rescue and first aid training;
- Risk communication exercises; and
- Competitions and 'survival games' (Morris & Edwards, 2008; Ronan et al., 2008; Ronan & Johnston, 2005).

Disaster preparedness education activities have been found to be more effective when:

- They are a regular occurrence (children were found to be more prepared for disaster when they had only recently completed classes/ activities, or if they had participated in multiple education programs);
- Interaction is encouraged between the children and parents, for example, by setting homework discussion tasks (irrational fear and inaccurate knowledge about hazards is more likely in children whose parents are ill-equipped); and
- The curriculum has a specific and practical emergency focus, with associated participatory skills exercises and activities (rather than just providing classroom lessons about natural disasters in general) (Ronan et al., 2008; Ronan & Johnston, 2005).

### 3.8.1 Disaster Preparedness in Jamaica

The Office of Disaster Preparedness and Emergency Management (ODPEM), run by the Jamaican government has been perfecting their disaster preparedness strategies for a number of years. Children have, over time, become central to disaster management, and this has been achieved through the integration of disaster preparedness strategies into the school curriculum and getting children involved in developing their own strategies for risk reduction in a disaster. There is a focus on creating awareness of local risks, and programs attempt to be age-specific, with the understanding that children of different ages have different needs and face different risks.

Jamaica dedicates specific days, weeks and months to focus on disaster preparedness including 'Hazard Awareness Days', 'Disaster Preparedness Month' and 'Earthquake Awareness Week'. There are a number of activities that are now routinely done during these times. For example, during 'Disaster Preparedness Month', every year, the ODPEM holds a culinary competition. This is targeted at the adolescent age group with 10-13 year olds and 14-18 year old competing separately. The aim of the competition is to prepare dishes using only non-perishable foods, or foods that would typically be accumulated if a disaster was imminent. This is an extremely practical program which allows young people to use their own creativity in developing useful skills for an emergency situation.

Other typical activities include encouraging children to develop songs, poetry and skits that relate to disaster management ideas, and which also express some of their perceived vulnerabilities.

On top of these significant days and events, disaster risk management has been incorporated into the school curriculum with regular lessons relating to natural disasters. Drills and disaster simulation exercises are also common. Lastly, a child-friendly website has been developed which attempts to familiarise children with disaster situations through interactive games, problem-solving and information. All of these programs recognise the importance of children in disaster risk reduction and allow them to move from passive victims of disaster to creative beings capable of developing their own strategies (Morris & Edwards, 2008).

## 3.9 Peace education for and by young people

Education has a key role to play in preventing conflict in the future and building lasting peace and stability (World Education Forum, 2000). Much literature talks about the potential of education as a prevention mechanism and there is increasing effort to educate children in conflict resolution skills throughout the world (see for example http://www.peace-ed.org/). However, a major review of peace education in 2001 found that peace education programs were most often provided to young people who were already peaceful. Those young people who are not in school and who are highly vulnerable to being victimised and involved in violence are the least likely to gain access to peace education initiatives (Sommers, 2001).

### 3.9.1 Peace Education Programs in refugee camps: Kenya

In 2000 the UNHCR attempted peace education programs in Kenyan refugee camps. While the program was titled 'Peace Education', the focus was on empowerment, teaching self-sufficiency through life skills training, tolerance and empathy. Conflict resolution was a component of the program; however, overall the central goal was conflict prevention. The UNHCR developed two peace education guides, one, which was implemented in primary school-aged children and focused on cyclical education (repeatedly teaching the same concepts over a long period of time so the children develop an understanding of the concepts for themselves), and the other being for a community workshop where adults, and youth, were taught more complex ideas, such as theories of peace and conflict resolution.

Refugee youth face serious risks including prostitution, indoctrination, criminality and military recruitment. In Kenya, the Peace Education Program appeared to have a number of promising benefits. Firstly, there was widespread support for the program among the refugee population to the extent that even at times when funding was unavailable from the UNHCR the community continued, and in some cases even expanded, the program without it. Secondly, its popularity was also explained by the perception that techniques for conflict resolution were an extension or complementary to existing, traditional methods. Thirdly, limited evaluation methods showed that the program appeared to bridge cultural gaps within the refugee camps, although the details of this finding were not made clear. Fourth, graduates and facilitators of the program came to be known in the refugee community as 'peacemakers' and were regularly sought out to resolve conflicts within the camp. Lastly, teaching methods focusing on open-ended questions, discussion and reflective writing allowed the young people's voices to be heard, and recorded, which could be useful for future policy makers and for the continual improvement of the program.

It is important to note here that the program faced a number of significant challenges and limitations. The program generally attracted those in the camps who were already participating in the community, and were largely peaceful. It did not reach the most marginalised and violent in the community. In addition, only a small number of females participated in the program and despite reports of high rates of sexual violence in the camp, the course focused on tolerance for people of different cultures and ethnicities and not on gender equality (Sommers, 2001).

## 3.10 Safe Spaces

Humanitarian organisations often seek to establish 'Safe Spaces' as part of disaster response. The idea is to provide a place s where groups of children can gather or be sent for supervision and support. Safe Spaces have primarily been used for younger children, rather than adolescents.

Safe Spaces programs commonly set out to provide for the physical protection of children. Some also seek to provide specific psychosocial support, and others also provide for the education of children during the period in which regular schools are not operating. However, that due to there being little consensus about the Safe Spaces concept, different institutions and organisations do things differently, with some centres focusing on recreation, rather than on learning. This is more likely to be so in those instances when the spaces are specifically for adolescents.

### 3.10.1 Safe Spaces Project: Solomon Islands

In the aftermath of a tsunami in the Solomon Islands in 2007 that displaced 10,000 people, Save the Children implemented a Safe Spaces program based on the B-SAFE model of Save the Children USA. The model focuses the following points:

**B** uilding relationships, respect and coordination among peers;
**S** creening for high-risk children;
**A** ctive, structured learning and life-saving information;
**F** acilitating children's natural resilience and a return to normalcy; and
**E** stablishing a sense of security and self-esteem.

The B-SAFE program was implemented 22 days after the tsunami in 89 places throughout a number of tent cities that had developed in the weeks after the disaster. Over 4 months approximately 4957 children were served by the program.

The limited evaluation methods, including the use of basic questionnaires administered periodically over the four months, found that children reported significant, positive changes in four key areas, including perceptions of safety, self-esteem, friendship and learning.

The second significant outcome of the B-SAFE model in the Solomon Islands was the assisted hand-over of Safe Spaces by Save the Children to local schools and communities. In total, 36 Safe Spaces were handed over to schools, and 45 to communities to conduct formal education. This case study highlights an important role for the Safe Spaces model in encouraging participating children to return to formal education, in assisting with the transition from crisis to formal education, and also in creating a framework for an education program where schools do not exist (Madfis et al., 2010).

## 3.11    Adolescent-specific gender-sensitive programming

In post-disaster situations women usually face greater risks than men. With a breakdown in social order, women become vulnerable to sexual and physical abuse. They are also less likely to receive compensation, especially if they have lost their identity papers in the disaster or have lost their husband. Women are also usually the most economically vulnerable in a time of crisis (Chew & Ramdas, 2005).

Well-documented field practice has shown that gender-sensitive humanitarian assistance can help in mitigating the different and negative effects of complex emergencies and natural disasters on men and women (IASC, 1999). The literature suggests that while gender is usually acknowledged as a vulnerability, this concern has not been recognised in programming. Given the differential impact of emergencies on females, it is crucial and that gender-sensitive approach be adopted when planning, implementing and evaluating policies and programs (UNDP, 2006). Addressing the specific needs of each sex/age may best be done by taking 'targeted action' (IASC, 1999).

While women face greater risks in a post-disaster situation, disasters can also provide opportunities for women to step into informal leadership, assistance roles, as disasters literally push women out of their homes and communities (Yonder et al., 2005). Creating a physical, female-only space allows for physical protection from abuse and the possibility of receiving psychological support. Safe spaces can also create an opportunity to enhance women's roles in society by facilitating their mobilisation in the community. Safe spaces for women can be used as a site to provide essential life skills (including vocational training, and health education) to address pre-existing inequalities in the society

While little evidence can be located about adolescent-specific gender-based programs, the following guidelines are summarised from the literature on good practice:

- Consider gender-based needs during planning and response phase as the priorities and vulnerabilities of males and females can differ considerably (Sommers, 2006)

- Acknowledge the need for childcare when programming to include young women as many will already be mothers or have duties caring for younger family members (Sesnan et al., 2004; Sommers, 2006);

- Use the United Nations Convention on the Elimination of All Forms of Discrimination against Women as a guiding tool;

- Create a widely publicised female-only 'safe space' accessible to adolescent girls. Aim to have this open 24 hours to provide protection.

- Ensure that the Minimum Initial Service Package of reproductive health care (see http://misp.rhrc.org/) is part of the health services provided through relief agencies, and make them available to adolescent girls, regardless of marital status;

- Involve girls and young women in helping to identify and solve the community's problems, particularly those related to safety, planning, construction, food and water distribution, health care, child care and education (Levine, 2010);

- Lessen dangers that adolescent girls face as they are sent to collect fuel, food or water. Construct footpaths, and temporary streetlights to ensure that the routes are not isolated and assist girls to travel in groups to complete these tasks; and

- Provide specific programs to empower and educate women and girls.

### 3.11.1  Safe Spaces as skill development sites for women and girls: Turkey

Following the 1999 Marmara Earthquake in Turkey, women were largely untargeted in government programs. As a result Foundation for the Support of Women's Work (KEDV) initiated a 'safe spaces for women and children' program. Centres established in the disaster zone provided safe, communal living rooms for women. They also functioned as community information centres and spaces for training. Childcare was provided so that the women were free to participate in training. As Yonder (2007) points out, 'the centres became a visible presence in the community and gave women a group identity' (p. 27).

Importantly, the strategy included capacity building with women offered a variety of skills training programs. As many of the participants had never worked before, this was their first opportunity to earn a decent wage.

Finally, the program set up communication between women and government agencies. While the women said that alone, government officials did not take any notice of them, presenting in groups from the centres gave them a lot more credibility and finally their opinions were heard.

Over three years, the program reached over 10,000 women and each of the centres became independent women's production co-operatives, with attached childcare centres. Gender stereotypes in the communities were challenged.

This program highlights several lessons regarding gender-specific programming that can be transferred when working with adolescent girls:

- Creating safe physical spaces assists women to support each other and organise;

- Providing women with training and educational opportunities is highly empowering, especially when this leads to them gaining employment;

- Taking a participatory approach empowers women to adopt leadership roles which in turn can challenge gender stereotypes within the community; and

- Programs will be more successful if they employ a long-term perspective and are funded to straddle the recovery, reintegration and restoration phases (Yonder et al., 2005)

## 3.12    Reintegrating child soldiers

Demobilised adolescent soldiers are in particular need of assistance with livelihood development. They need job-related skill to assist with their potentially difficult reintegration and to prevent re-recruitment as a response to financial need (Lowicki & Pillsbury, 2000).

In a study of child soldiers and their long term mental health outcomes in northern Uganda, Annan and Blattman (2006) found evidence of the important role of family in their reintegration and their long-term mental health outcomes. Those who had high family connectedness and social support were more likely to have lower levels of emotional distress and better social functioning.

The three greatest needs of former child soldiers for reintegration are said to be family reunification, psychosocial support (including education), and economic opportunities (Verhey, 2001). A number of points can be made regarding the development of effective programs for reintegration:

- There must be a balance between work initiatives and access to education in programming, ensuring program developers do not forget about the importance of education once work is found.

- Reintegration strategies must include programs specifically designed for young girls.

- Programs should include a focus on drug education and sexual health education.

- Programs must support participation in cultural/religious cleansing, and other ceremonies, as they can be important for feelings of acceptance and forgiveness.

- Programs should be sustainable - resources for the reintegration of child soldiers should last for at least three to five years.

- Family reunification strategies and community-based programs have been found to be more effective than reception centres and should be used whenever possible.

- Psychosocial approaches have been found to be more effective for assisting former child soldiers than Western trauma assistance models.

- Micro-enterprise support and apprenticeships have been found to be more effective for providing former child soldiers with an income than vocational training.

- Advance planning for reintegration programs is needed, including the preparation of adequate, trained staff.

- All actors need to be working together including agencies, NGOs and government.

### 3.12.1  Sports programs for re-integration of former child soldiers: Uganda

One study looked at the benefits of sport in the reintegration of former child combatants in Uganda.  Three accommodation centres for former young soldiers agreed to organise a sports component to their schedules, and qualitative semi-structured interviews were held with the three staff members in charge. At one of the centres, a group discussion was held at the end of each sport session where the participants could talk about the influence of sport on their reintegration process.

The children and reception staff highlighted a number of specific benefits brought about by these sporting sessions. Firstly, 100 per cent of the children (48 in total) playing sport during the session stated that they had played sport before being abducted or drafted for conflict. Therefore, sport was a powerful tool for bringing about a feeling of normalcy and was associated with happier times in the past, playing with family and friends. Secondly, participation appeared to be beneficial for the children socially, with improvements in problem solving and non-violent conflict resolution skills. It also acted as a connector by creating a neutral conversation topic, and brought about equality, as players developed greater respect for each other and a sense of team with their fellow participants. Lastly, sport helped the former soldiers in terms of their psychosocial wellbeing. Participants reported that after playing sport they 'had a relaxed mind', could sleep better, and were able to keep their mind off the past.

Using sport as a social connector could also have potential as a way of reconnecting with the wider community, combating the stigmatisation former child soldiers encounter upon their return (Ravizza, 2008).

## 3.13    Arts and leisure activities

While there are patterns in adolescents' experiences of emergencies, there is also great diversity in their experiences (Lowicki & Pillsbury, 2004). This calls both for imitative and creative approaches to meeting their needs and supporting their rights. Arts, communications, sports and leisure programs can provide young people with a voice and an outlet. They can also provide opportunity for adolescents to provide leadership and service as they assist to deliver or contribute within such programs, designed either for peers, community members or for younger children.

Arts activities should not be confused with therapy. Rather, they are most effectively used as part of broader education and psychosocial endeavours and as tools to encourage adolescents to engage in critical thinking about their worlds. A number of researchers suggest that an undue focus on re-telling the disaster story may be unhelpful and that this can best be left to more therapeutic endeavours. Rather, metaphors, analogies, traditional songs, dances, myths and stories can be used to provide a form of protective distancing and function as motifs through which to explore concepts of resilience and integrity in the face of adversity (Cahill, 2006, 2008; Chinyowa, 2007; Kershaw, 1998; Krusic, 1996).

Whilst some arts activities take on an educative or developmental function, there is also a role for arts activities which are engaged in just for fun, to build a sense of community or connection with others, to provide distraction and humour, or to celebrate survival or accomplishment.

### 3.13.1  Youth engagement through the arts and communications: television broadcasting in Albania

UNICEF initiated a program in Albania, affected by poverty and inequality after an unstable government and conflict in surrounding countries.

After assisting with the establishment of a Youth Club dedicated to social change, UNICEF approached an Albanian television network to look for ways to involve adolescents in the media. Young people became involved in the creation of a news program that allowed them to discuss issues that were important to them.

Participants were provided skills training and worked closely with UNICEF and the television network to produce the show. While there was some resistance from adult staff, this was soon overcome when they saw the quality of the program.

The program became successful and sustainable with 80 young people participating in 11 regions across the country. The young people chose story ideas, report, prepare scripts and did voiceovers, sending the finished element to a producer in the head office for compilation. Their involvement brought them into contact with their community and the presence of adolescents on television helped build their credibility as an age group in the community. The young reporters are 'proud that their programme is helping build a new and better Albania'.

This is an example of a program that created a framework within which adolescents could participate. Whilst adult roles were important, the process was largely led by young people, with positive results, both for the young people themselves and their broader communities (UNICEF, 2004).

## 3.14    Sports activities

Sport and play have been found to be crucial to the learning, development and optimal growth of children from early childhood to adolescence. Sport can assist in the development of social skills, such as empathy, problem-solving, conflict resolution, power dynamics and sharing.

Sports activities are increasingly used in post-disaster situations as a non-medicalised, psychosocial method for dealing with traumatised individuals. According to experts in the field, psychosocial programs in emergencies should be based on eight key principles including:

- Contingency planning prior to disaster;
- Assessment of the sociocultural context (including local perceptions of illness and ways of coping);
- Long-term planning (including plans for a future hand-over to the community to operate independently);
- Strong collaboration with other agencies to ensure no wastage of resources;
- Access to facilities for all, but no physical space set up for specific, disadvantaged groups (stigma);
- Continued staff monitoring and training; and
- Continued evaluation and monitoring of projects (Van Ommeren, 2005).

Through sports activities, stress and trauma can be addressed both individually and as a community. It also presents a gentle, non-confrontational and non-verbal approach to healing. Lastly, while trauma in young children will often manifest in behavioural difficulties, trauma in adolescents is often manifested socially. Sport, then, is particularly relevant to dealing with adolescent trauma as it provides a neutral, safe and socially beneficial environment.

In addition to the above principles, the literature suggests that various good practice principles for sports programs include:

- Ensuring appropriate timing for the initiation of the program (Henley suggests a time frame of no earlier than approximately the third or fourth month, and no more than two years, after the disaster);

- The creation of programs that are very situation-specific;

- Recognition of the important role of coaches, including addressing possible trauma they themselves are experiencing and ensuring they possess strong interpersonal skills and an understanding of trauma-related emotions/ behaviour; and

- An emphasis on coordination and recreation, rather than winning and losing (Henley, 2005).

## 3.15    Research, monitoring & evaluation

Common in much of the literature about adolescents and emergency is concern about the scarcity of evidence for 'good practice' in the area (Children, 2000; Sommers, 2006).  While many NGOs provide guidelines or conceptual frameworks for working with children or adolescents, there is a call for people to share information about their actual experiences in youth programming.

Part of the process of writing this document was to look for accounts of good practice in evaluation of adolescent-specific programming. We find that with some promising exceptions, many NGOs do not have the time or resources to share their experiences. Furthermore, while more exists on child-specific programming, the need for adolescent-specific programming has only recently been recognised and prioritised and therefore this is still very much an emerging field. There is still a lot to be learned, changed, implemented and evaluated. As such, this should be considered a work in progress. Through dissemination of this document, colleagues, field-based managers, and coordinators of emergency programs can continue to provide critical review and further input from a variety of disciplines, cultural settings and regional perspectives. Ensuring resources and time for documentation and dissemination of what works (and equally important, what doesn't work) based on lessons from the field is critical to continue to inform policy and the design of future intervention strategies.

While large scale quantitative data collection ensures a broader reach and can yield useful information, it is equally important to collect qualitative data which will provide a greater depth of information about people's experiences (see Tuicomepee 2008 for a good example of a mixed methods approach.)

Participatory methods in research and evaluation are increasingly recognised as good practice. This ensures that research addresses specific issues identified by local people, and that results are directly applied to the problems at hand, with local involvement.



### 3.15.1  Assessing the long term impacts of the 2004 Tsunami on Thai adolescents: a mixed methods approach

One study focusing on Thai, adolescent, tsunami survivors a year after the 2004 Indian Ocean tsunami has identified a number of long-term impacts young people experience following a traumatic event. Results deriving from both quantitative and qualitative research found that one year after the disaster adolescents continued to experience psychological effects, including concentration problems, obsessive thoughts, nightmares, confusion, loneliness and a fear of the sea, and physical effects including headaches and tiredness.

The study has found that certain factors influence the prevalence of psychological problems in survivors. A number of risk factors were identified, that is, factors that were positively correlated with behavioural problems. These included gender, with female adolescents being at greater risk, age, though the results were unable to conclude exactly which age groups were most vulnerable, and disaster experience, especially the loss of immediate family members. The greatest protective factor that this study found was effective family functioning, with a strong negative correlation between family support and behavioural problems. Similarly, family could act as a risk factor when there was family conflict or financial insecurity. The qualitative data, though not backed by the quantitative results, suggested that community programs, peer support and school connectedness were important factors in alleviating stress; and religious and educational aspirations functioned to counteract young adolescents' feeling of loss.

This study is a good example of the usefulness of a mixed methods approach, with the quantitative analysis useful in measuring the events experienced by the adolescents during the natural disaster and some of the long-term effects of the trauma. Conducting qualitative interviews on top of this allows for a more nuanced understanding of the youths' post-natural disaster experience, their coping strategies and their on-going needs. This research also highlights the importance of youth voices for effective policy making in the aftermath of a disaster (Tuicomepee, 2008).

# Section 4
# Programming Frameworks

## 4.1 Frameworks to guide planning for the needs of adolescents in emergencies

During the initial response to emergencies, adolescents need access to food, water, sanitation, shelter, clothing, protection and social support. In this sense, they have the same needs as the rest of the population. Once systems are set up to deal with these immediate survival and safety needs, attention should focus on their particular needs and on their capacities to contribute.

Given that adolescents are not commonly programmed for in disaster preparedness and response, it is important to have a conceptual framework to guide attention to this area.

A framework for understanding adolescent development is proposed here. It utilises a modified version of Bronfenbrenner's (1979) ecological model for understanding child development. This, together with a model which synthesises research on strength-based approaches to enhancing resilience in children and adolescents, is proposed as a schema around which to engage in advocacy (to attract donor and ministry support), needs analysis, capacity mapping, priority setting and program design. The models are discussed and illustrated and examples given of how they might inform a programming approach.

As discussed in section 1, much adolescent literature discusses adolescence from a health or biomedical perspective. This tends to direct attention to the problems and not the capacities of youth. It also directs attention to the young person as an individual rather than as also a member of groups (families, schools, communities, churches, workplaces). This can lead to a focus on targeting the individual rather than on the groups where they have membership.

In contrast, an ecological approach is useful because it:

  a.  Emphasises investing in settings, systems and services that work to support young people's development;
  b.  Focuses on the importance of including young people's contribution and participation;
  c.  Directs attention to the importance of investing in young people's capacity to be strong civic contributors in the present as well as the future;
  d.  Engages with both the physical and social context of people's lives;
  e.  Engages with the way in various ecosystems interact and the effects that these interactions have;
  f.  Accounts for the interactive and multidirectional nature of influences within and between these systems;
  g.  Supports approaches which are inclusive of the adult and child community; and
  h.  Is inclusive of a rights-based approach.
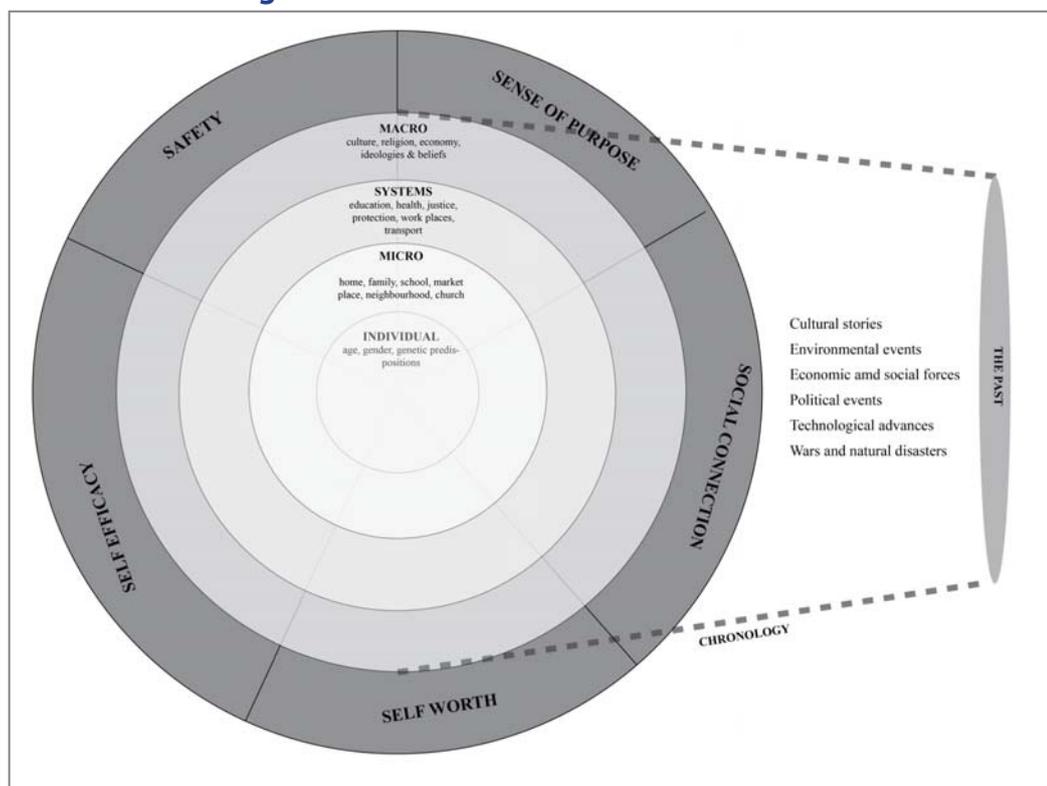
### 4.1.1 The ecological model



Figure 1: Ecological model for understanding adolescent development (adapted from Bronfenbrenner, 1979)

The ecological model emphasises interconnection between influences at the Individual level; the Micro level (home, school, neighbourhood, church ), the Systems level (education, heath, justice, protection systems and labour market), the Macro-level (culture, religion, the economy, ideologies and beliefs); and the Chronological level (influence of time, age and historical events).

Bronfenbrenner's ecological model looks at child and adolescent development within the context of the system of relationships that form their environment. It allows us to consider the role or status of children in their ecological context to assess opportunities and limitations inherent in working on their behalf.

Bronfenbrenner's theory defines complex layers of the developmental context (outlined in detail below). Bronfenbrenner's theory extends attention beyond individual factors in child development to the multiple, interrelated contexts of child development and the interactions that occur between them. The interaction between these layers is important; changes or conflict in any one layer will ripple throughout other layers.

*The Individual level*

• The individual is influenced by, and in turn influences the micro level of their world.

*The Micro level*

• Includes the settings in which the individual is actually present (home, family, school, neighbourhood, market place, church, clinic, workplaces, recreation);
• Experiences at the micro level are influenced by, and in turn exert influence on systems operative at the Exo-level[1]

*The Institutional level*

• Includes the structures and systems which influence the young person's experience of life in the micro settings. This happens via the allocation of resources, provision of infrastructure, application of policy and laws, and provision of services.
• Examples of 'institutions' operating at an exo or skeletal level in the society include the education, heath, justice and protection systems as well as adult workplaces.
• The activity and priorities at the institutional level are in turn influenced by the state of the nation at the macro-level.

*The Macro-level*

• Includes the big shaping forces of culture, religion, the economy, ideologies and beliefs. The macro level has a direct influence on Individuals as well as an indirect influence through transmission via activity at the micro and exo levels.
• All levels are affected by historical events and the passage of time. Individuals are also affected by the passage of time in their own life (and by the life phase they occupy).

*The Chronological level*

• Accounts for the influence of time and the impact of historical events.
• This includes economic and political changes, technological advances, environmental incidents, natural disasters, war, and conflict as well as the evolution in the history of ideas such as those that pertain to rights.

### 4.1.2 Using the ecological model to inform: implications for emergency preparedness and response

Emergency situations potentially disrupt the social ecology of adolescent development at all levels. As such the ecological model provides a valuable framework for analysing the interrelated contexts that shape the social and emotional adjustment of children and adolescents affected, and tailoring the response accordingly. It allows us to extend the focus of response beyond the individual to family to peer, school and community settings as well as cultural and political belief systems. Considerations at each level are identified below.

*Micro level*

During emergencies micro level attention is directed at:

• **Family: a key protective factor for young people**

--> Maintaining connection with family through housing families together, tracing and reunification of families, assisting adolescents to remain with families or extended family, restoration of or return to homes, minimizing need for displacement, providing family support so as parents remain well and effective and can provide for their children.

• **Schools: provide for protection and social connection as well as an educative function**

--> Re-establish schools or interim safe spaces within which to conduct educative activities (informal and/or formal);

--> Provide psychosocial support associated within school-based activities;

--> Provide life-skills or livelihood activities within the school-based site;

--> Co-locate child care or infant schools with adolescent education initiatives so adolescents who are carers can also participate in the youth program;

--> Include young people as assistants in education, arts, life skills, peer education and leisure activities;

--> Use the school as the site to convey health messages and information and to conduct screening;

--> Provide catch-up schooling with an age-appropriate curriculum for those adolescents who have lost or missed basic literacy and numeracy skills;

--> Provide adolescent specific classes for those who need the catch up curriculum;

--> Re-establish the routine of the formal curriculum when interim response phase has passed; and

--> Include young people as active participants in identifying needs, shaping and delivering service and providing evaluative feedback.

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[1] Bronfenbrenner uses the term meso-system to describe the interaction between various immediate influences from the micro level such as home and school where the child is actually present and the term exosystem to define the interplay between the settings where the child is actually present, such as home, school or community and the settings in which they are not present such as parental workplace and larger institutions.

- **Neighbourhood**

--> Provide monitoring and protective supervision especially for adolescent girls queuing for food distribution or moving between shelter and services;

--> Provide girls only latrine areas;

-->Establish well marked, lit and supervised pathways for girls to get between food services, latrines and sleeping areas;

--> Provide female Safe Spaces (inclusive of women and young children); and

--> Include young people as active participants in identifying needs, shaping and delivering service and providing evaluative feedback.

- **Community**

--> Involve young people in disaster relief or community care activities;

--> Include young people as active participants in identifying needs, shaping and delivering service and providing evaluative feedback;

--> Involve young people in community consultations about needs and efficacy of programs; and

--> Position young people as leaders, staff or contributors to community activity.

- **Clinic**

--> Provide youth inclusive approaches in Health services providing reproductive health ('youth-friendly' and non-judgmental in their orientation, particularly in relation to provision of sexual and reproductive health services, giving adolescents the same entitlement to contraception or reproductive health care as that given to adults);

--> Include young people as assistants in disseminating health information; and

--> Include young people as active participants in identifying needs, shaping and delivering service and providing evaluative feedback.

### Institutional level

The way in which young people are reached directly is through the micro level. However, it is during times of emergency that institutions as well as micro systems are most disrupted. Strong use of the cluster approach to emergency planning and response is the best mechanism to ensure that interim systems are in place. Young people will be best served if adolescent programming is included at the cluster level rather than left to a chance matching with the priorities of independent humanitarian actors.

### Macro-level

Cultural, ideological and religious beliefs can lead to practices that discriminate against particular groups. During emergencies discriminatory practices tend to be heightened due to the competition for scarce resources. Adolescent girls are particularly vulnerable. In extreme forms this leads to rape, violence and killing. It can also lead to inequitable distribution of food (where, again, girls are vulnerable) and to over-allocation of chores to girls thus precluding their participation in emergency efforts.

Activity at this area is directed through the micro level. However, a 'radar of concern' informed by knowledge of the cultural, ideological and religious beliefs and practices should alert the need for system level design of protective or moderating influences.

These can include activities or structures to ensure rectification of any likely inbalance in the provision of services such as:

- Safe gathering, schooling and hygiene spaces for girls;
- Supervision of food allocation; and
- Patrolling for protection of girls at risk of sexual assault or trafficking.

### Chronological level

Of immediate interest here is the impact of the emergency experience. Adolescents may be particularly vulnerable if a time of change and transition in their own lives overlaps with a period of civic disruption or turmoil. This can disrupt their transition to a healthy adulthood, affecting future generations.

The chronological level also refers to historical time and the way in which events affect groups and populations in particular ways at particular times. Young people are affected by economic, environmental, technological and political shifts that precede and surround them. Those who are born into or are affected by conflict and war or by natural disasters are particularly affected by events that are time-related.

When positive role models are lost, and when systems of healthy socialization are in disarray, then adolescents must

cobble together the sense of who and how they ought to be without some of the supportive guides that are normally available. Responsibility and moral concern may be heightened by shared experiences of loss and the requirement that one become a key contributor. However, the transmission of moral codes may also break down it times of break down in the social order, in response to and in turn contributing to patterns of violent or predatory behaviour.

***Looking at the inter-play between various influences***

For good adolescent programming it is important to look at the interplay between the different components of the micro level. Adolescents, as not-quite-adults and no-longer-children are vulnerable to the mismatch in expectations and role requirements that can be exerted on them as they move between (or within) family, school, community, church and clinic. Not only do they fall between the cracks, they sometimes get squeezed whilst between them.

Sometimes there can be conflict between roles young people are required to play in key settings such as school and family and community, with negative effects for the adolescent. During emergencies these can be heightened. Girls can be propelled into more extensive or more arduous carer duties (home), forced to engage in commercial sex to gain a livelihood (community), but simultaneously find they cannot access reproductive health services (clinic) because they are considered to be still a child. Boys might experience tension between (family) expectations that they become providers and protectors and expectations (school and community) that they prioritise learning. They experience a clash as they move in and out of adult and child roles.

As families are the context in which adolescents are often pushed to assume adult roles, and as schools and clinics are those settings in which adolescents are least likely to be positioned into 'adult' roles, then a conflict at the micro level will create tension for the young person between their family and their other sites of belonging. This is one way in which adolescents experience a tension which is more extreme than that of younger children (less is expected of them) and adults (it is assumed they are a responsible and 'entitled' agent).

Though family is the key protective factor for adolescents, families are also complicit (and can be the cause) of adolescent exploitation. This will be augmented in emergencies as poverty, food insecurity and crowding, illness, injury and loss of adult family members and carers create the pre-conditions which propel parents to place these burdens on their older children. Therefore a key protective measure for adolescents operative at the Institutional level is to provide protective and preventative support via family and school. This can include:

- Ensuring adequate, reliable and predicable food supply;

- Setting up supervised safe spaces for young children, so as to release adolescents from these duties;

- Providing livelihoods training for parents;

- Providing livelihoods and literacy training for those already in adult roles;

- Training teachers or interim teacher assistants to fulfil these roles;

- Training medical staff in non-judgmental youth friendly practices;

- Setting up schools which have flexible attendance routines and timetables so as to allow adolescents to attend when released from other duties, or allowing them to attend in 'part-time' modes;

- Providing school attendance kits to families so as they do not have to fund resources needed for school such as books, pens and uniforms;

- Setting up attendance remittance schemes;

- Provide meals at school to encourage families to send their children; and

- Extending micro credit schemes to providers.

At the System level, children are influenced by what happens to their parents in their workplace and to other members of their community.
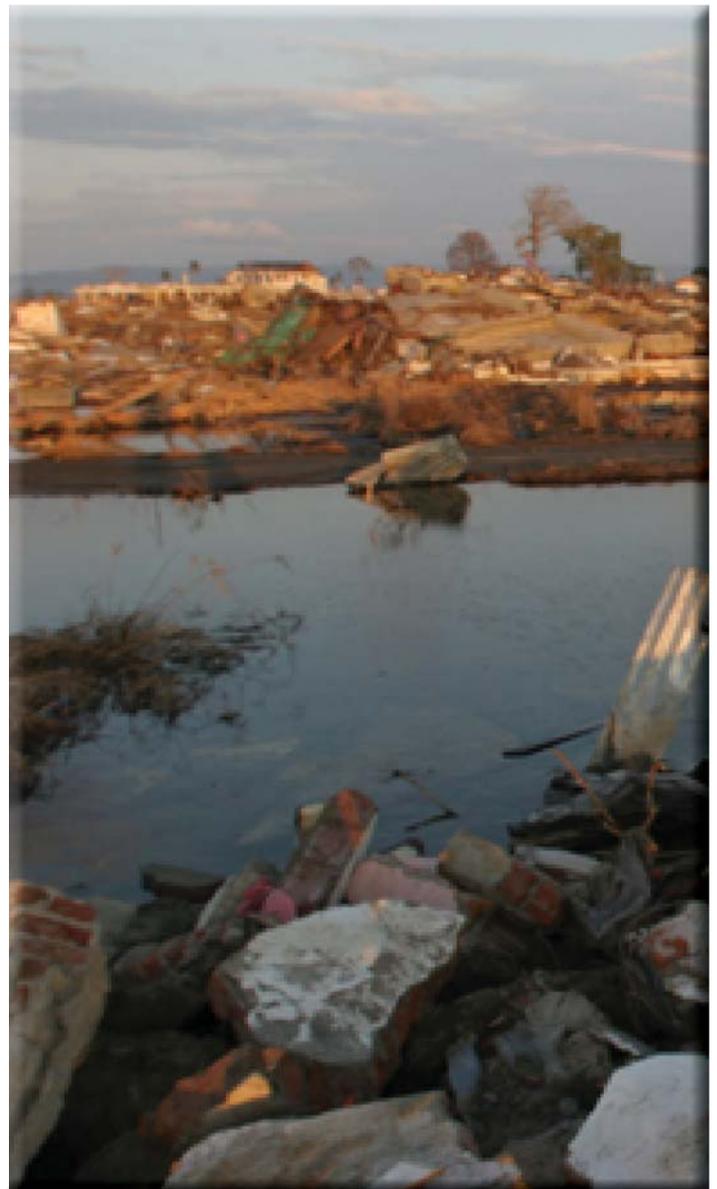
## 4.2 Individual protective factors: design policies and programs to foster five key strengths

Resilience research indicates a number of key protective factors which assist young people to deal with the impact of adversity (Benard, 2004; Betancourt, 2005; Betancourt & Khan, 2008; Masten, 2001; Ronan & Johnston, 2005; Sandler, 2001; Williams et al., 2008). The presence of these factors is associated with lower levels of psychosocial and mental health problems, and/or a more rapid recovery from trauma. Adolescent programming will be more effective if it plans to enhance these protective factors.

A strengths-based model is proposed which groups the spectrum of protective factors into five key 'strengths', encompassing a sense of safety and security; a sense of self-worth; experiences of social connection; a sense of self-efficacy and agency; and sense of hope, meaning or purpose. Ideally policy and programming efforts will address these as objectives.
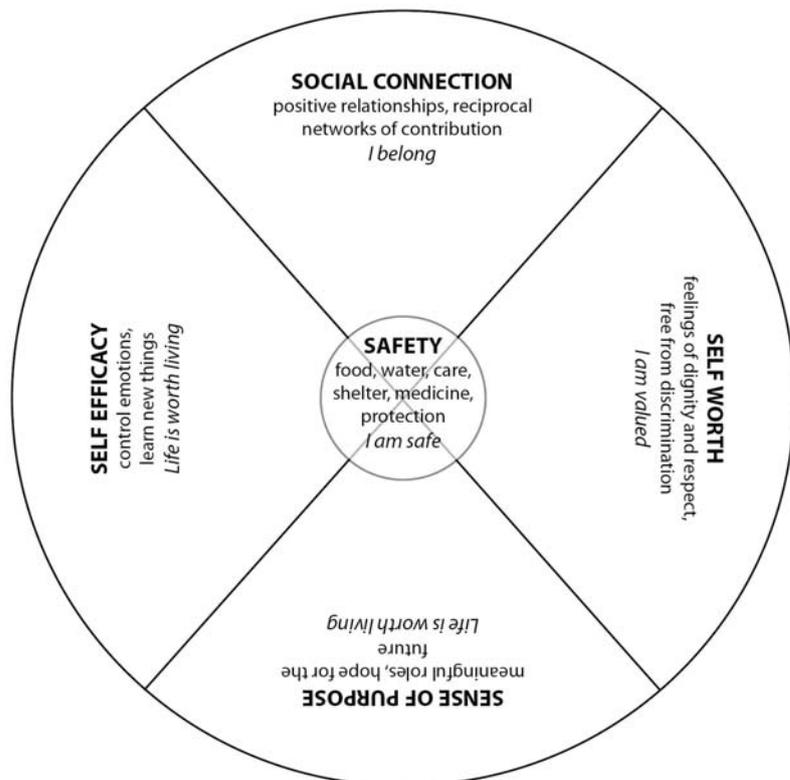
Figure 2. Key protective factors for adolescents

| Key protective factors for adolescent development and wellbeing | Enhance protective factors by ensuring: |
|---|---|
| 1. **Sense of safety and security** – food, water, shelter, medicine and protection from pain or harm. *I am safe.* | • Systems in place to ensure adequate food, water, shelter, hygiene and protection;<br>• Family care and protection<br>• Rights respected and protected. |
| 2. **Self-worth** – feelings of dignity and respect, freedom from stigma or discrimination, engagement in meaningful activity. *I am respected and valued.* | • Equitable treatment regardless of gender, ethnicity, religion, ideology;<br>• Rights respected and protected. |
| 3. **Social connection** – feelings of belonging and acceptance from a social group, positive relationships with key adults, family and peers. *I am wanted and needed. I can contribute and be contributed to. I can listen and be heard.* | • Schools / safe spaces for education available to all young people;<br>• Opportunities to participate. |
| 4. **Self-efficacy** – feelings of control and agency and autonomy; capacity to learn, to manage and shape aspects of their environment, to manage and moderate the expression of their own emotions, to take look after themselves. *I can do things to look after myself and others. I can learn. I can control the way I behave. I can influence my environment.* | • Life skills education;<br>• Peer education;<br>• Vocational skills;<br>• Opportunities to participate; Contribution to care of family and community;<br>• Education is a right. |
| 5. **Sense of purpose, hope or meaning** – belief in a possible future, hope for future prospects and a capacity to de-personalise the experience of extreme adversity. *Life is worth living. The future is worth striving for. I am not to blame for the things I cannot change in the world around me.* | • Education;<br>• Participation in community and family activity. |

## 4.3　The need for inter-sectoral approaches

A holistic approach to adolescent needs post-emergency requires collaboration between local and international agencies. Responses to humanitarian crises must cut across mandates and agendas that cannot be addressed by a single agency or organisation (UNDP, 2006). Cross-sectoral collaboration is highlighted as particularly important for adolescent programming (Office of Conflict Management and Mitigation, 2005; Sommers, 2006), reflecting their diverse needs.

Cross-sectoral programming for adolescent health and development is a challenge in normal circumstances. It is acknowledged that the urgent nature of post-emergency response and reconstruction makes cross-sectoral collaboration an even greater challenge, especially when wide-spread suffering calls for rapid responses.

The "cluster" approach to emergency preparedness and management where by UN agencies, NGOs and National Ministries work closely together has been established to deal with this challenge. The cluster approach operates at two levels. At the global level it strengthens system-wide preparedness and technical capacity to respond to humanitarian emergencies. It designates leadership and accountability to assist with this. The cluster approach also operates at a country level. Here the aim is to ensure effective and integrated response in a strategic manner. The country cluster brings together all key sectors, agencies and humanitarian partners. It also designates leadership of key areas of activity.

For adequate attention to be paid to the experiences, needs and capacities of adolescents in emergencies, it is important that both global and country level clusters incorporate a framework which is robust enough to ensure that adolescents do not get neglected in disaster preparedness programming or in the delivery of programs during recovery or rehabilitation phases.

Additionally, cluster groups fulfil an influential role, and can potentially advance the awareness of donor groups of the need to invest in serving the needs of adolescents.

Caught between the status of child and adult, it is important that adolescents are neither left to carry the burden of both roles, nor left without the entitlements or protections of either role. They should neither slip through the cracks nor be squeezed between them.

## 4.4    Promising approaches: summary of recommendations

| Theme | Vulnerabilities of adolescents | Recommended approaches |
|---|---|---|
| **Gender** | Adolescent girls are more vulnerable than adolescent boys in emergency situations. They are:<br><br>• less likely to attend schooling;<br>• more likely to have child-care and other domestic responsibilities;<br>• more vulnerable to trafficking for sexual exploitation;<br>• more likely to be have pressures to conform to religious or cultural norms (e.g. purity);<br>• less likely to have skills or opportunity to flee/ fight danger;<br>• at greater risk of psychological disorders in post-disaster situations;<br>• more economically vulnerable; and<br>• at a greater risk of encountering sexual violence.<br><br>Adolescent boys are more vulnerable to:<br><br>• trafficking for militia or labour;<br>• uptake of aggressive behaviours; and<br>• risky drug use. | • Use gender-specific targeted adolescent programming for health, education and protection.<br>• Encourage gender-balanced classrooms by getting girls attending schooling in equal numbers with boys.<br>• Ensure childcare is included in programs which adolescent girls attend.<br>• Prioritise development of 24-hour safe spaces for adolescent girls where they can perform routine activities privately.<br>• Ensure women and children are aware of their rights.<br>• Include gender-based violence and sexual exploitation programming at all stages or emergency response, including for staff and officials.<br>• Consult adolescent girls and boys about their specific needs.<br>• Use the United Nations Convention on the Elimination of All Forms of Violence as a guiding tool to ensure gender-sensitive approaches.<br>• Involve girls in vocational and life-skills education.<br>• Involve girls in peer education to support other girls.<br>• Provide health care responsive to needs of adolescent girls, including care for sexual assault and rape, contraception, testing, abortion, pregnancy support and maternal support for those who are mothers. |
| **Education/livelihood** | • Schooling commonly provided only for young children and not adolescents;<br>• Economic and family responsibilities often prevent children from attending school;<br>• Without education and skill building opportunities, adolescents are vulnerable to economic exploitation;<br>• Adolescent girls are more likely to miss out on education than adolescent boys;<br>• Post-conflict situations, some children will fall behind in education and therefore need special attention (e.g. child soldiers) and assistance to return to school;<br>• Education environments can be unwelcoming and unsupportive of certain groups;<br>• There may be a lack of qualified teaching staff;<br>• Adolescents may be expected/required to generate income for their families; and<br>• Safe labour market opportunities may not be available | • Provide specific education programs for adolescent girls and boys.<br>• Ensure education responds to adolescents' interests and the range of employment opportunities available.<br>• Provide age-appropriate life skills and vocational education.<br>• Move towards accredited education as soon as possible.<br>• (In conflict situations) relate education to peace-building initiatives, reconciliation and psychosocial healing.<br>• Recognise that informal education may be better suited to some adolescents, particularly those that are older and have been out of schooling or failed to attain literacy.<br>• Prioritise training of appropriate teaching staff.<br>• Encourage peer-education initiatives.<br>• Create jobs for young people that contribute to the creation of just and sustainable communities and reinforce the self-esteem and self-worth of young people.<br>• Consider adolescent-specific education and livelihood needs in disaster preparedness and recovery plans. |

| Theme | Vulnerabilities of adolescents | Recommended approaches |
|---|---|---|
| **Mental and psychosocial health** | • Experiences of trauma or chronic and enduring threat can negatively affect mental health;<br>• Protective factors ensuring adolescents' wellbeing may be minimised or taken away in a disaster situation, leaving young people without their usually coping mechanisms;<br>• Some young people experience ongoing or severe stress reactions which may include depression, anxiety, PTSD and behaviour disorders;<br>• Those who suffer multiple losses are more likely to take longer to recover or to develop a mental health problem;<br>• Those who receive additional psychosocial support are more likely to be resilient;<br>• Girls may be more vulnerable than boys in some societies; and<br>• Young people are vulnerable to boredom in a disaster situation with a lack of stimulation previously supplied by education and employment. | • Use education programs as the main platform for psychosocial support.<br>• Provide informal adolescent-specific educative activities in safe spaces in early phase of response (including life skills; sports, arts and leisure activities) which foster social connectedness and develop/strengthen social skills such as empathy and conflict resolution.<br>• Reinstate schools to provide a structure, routine and safe space for adolescents.<br>• Provide relevant livelihoods skills and vocational training, plus age-appropriate literacy and numeracy work).<br>• Avoid therapy as first response to trauma.<br>• Avoid therapy by non-trained.<br>• Do not force young people to re-examine the disaster story.<br>• Provide opportunity for self-directed self expression through play and talk, giving adolescents a voice and an outlet.<br>• Use school as site for screening and delivery of additional support interventions for those most affected by trauma.<br>• Allow adolescents to contribute to psychosocial or community programs through leadership/ assistance roles (for example, encouraging mentoring programs).<br>• Strongly consider psychosocial programs for former child soldiers as these have been found to be more useful than Western trauma therapies. Consider adolescents' specific psychosocial needs in disaster preparedness and recovery plans. |
| **Physical health** | The most likely causes of deaths for young people during emergencies continue to be as the result of:<br><br>• diarrheal diseases;<br>• acute respiratory infections;<br>• measles;<br>• malaria; and<br>• severe malnutrition | • Adolescents need access to food, shelter, clean water, good hygiene routines and medicines.<br>• Every attempt should be made to involve the beneficiary population in program planning, implementation and monitoring.<br>• Prepare medical response programs which allow for the rapid assessment and treatment of children and adolescents.<br>• Ensure medical treatment is non-judgmental and available to all. |
| **Reproductive health** | • During emergencies adolescents face greater risks related to sexual and reproductive health and services (if they exist) are under increased pressure.<br>• Some groups of adolescents are particularly at risk including: very young adolescents (10-14 years); pregnant adolescent girls; marginalised adolescents, adolescents separated from their families (parents/partner) and adolescent heads of household; adolescent survivors of sexual/gender-based violence; adolescent girls selling sex; and children associated with armed forces. | • Use creative and innovative approaches to reproductive health programs to ensure they are: acceptable, accessible and appropriate for adolescents.<br>• Always take cultural sensitivity and diversity into consideration.<br>• Involve adolescents in the design, implementation and monitoring of program activities, so that they are more likely to respond to their needs and to ensure they are acceptable.<br>• Gender specific training may be necessary. While girls are identified as more vulnerable than boys, boys' programs are also important (Barnett, 2000).<br>• Ensure community and parental acceptance and involvement in programs. Programs specifically for parents may be worth investing in.<br>• Sexual and reproductive health programs should include a gender rights element.<br>• Consider adolescents' reproductive and health needs in disaster preparedness and recovery plans. |

| Theme | Vulnerabilities of adolescents | Recommended approaches |
|---|---|---|
| **Participation** | • Children and adolescents may be uninformed and unprepared for a disaster.<br>• Children and adolescents are often assumed to be 'passive victims' not active contributors.<br>• Girls are less likely to participate in political and economic areas than boys | • Recognise children and adolescents potential to contribute in the preparedness, response and recovery stages.<br>• Ensure disaster preparedness education is integrated into the school curriculum in areas prone to natural disaster.<br>• Involve adolescents as active participants in the design, implementation, monitoring and evaluation of initiatives.<br>• Involve a diversity of adolescents in terms of gender, age, ethnicity, background etc.<br>• Use education programs that encourage creativity and individual development of strategies.<br>• Consult with young people about their needs but also include them in the processes that meet their needs.<br>• Make sure young people see the results of their participation.<br>• Encourage the wider community to recognise the value of young people's participation. |
| **Protection** | • Themes outlined above are all central to young people's protection, therefore implications and recommendations are transferrable. Girls are especially vulnerable to sexual and physical assault (boys to a lesser extent).<br>• Young boys are vulnerable to recruitment by armed forces. | • Ensure safe spaces for girls.<br>• Organise girls in groups for fetching water, firewood etc.<br>• Promote alternative political participation means for young people to limit   the temptation of joining armed forces or being re-recruited. |

Annan, J., & Blattman, C. (2006). Psychological Resilience of Youth in Northern Uganda: Survey of War Effected Youth, *www.sway-uganda.org/SWAY.RB2.pdf*

Baráth, Á. (2003). Cultural Art Therapy in the Treatment of War Trauma in Children and Youth: Projects in the Former Yugoslavia. In S. Kripper & T. M. McIntyre (Eds.), *The Psychological Impact of War Trauma on Civilians.* Westport CT: Praeger Publishers.

Barnett, B. (2000). Programs for Adolescents: Reproductive Health Merit Badge for Scouts. *Network, 20*(3).

Belfer, M. L. (2006). Caring for children and adolescents in the aftermath of natural disasters. *International Review of Psychiatry, 18*(6), 523-528.

Benard, B. (2004). *Resiliency: What We Have Learned.* San Francisco: WestEd.

Benjamin, J. A., & Murchison, L. (2004). *Gender-Based Violence: Care & Protection of Children in Emergencies. A Field Guide,* Westport, CT Save the Children Federation, Inc.

Betancourt, T.S. (2005). Stressors, supports and the social ecology of displacement: psychosocial dimensions of an emergency education program for Chechen adolescents displaced in Ingushetia, Russia. *Culture, Medicine and Psychiatry*, *29*(3), 309-340.

Betancourt, T. S., & Khan, K. T. (2008). The mental health of children affected by armed conflict: Protective processes and pathways to resilience. *International Review of Psychiatry, 20*(3), 317-328.

Blattman, C., & Annan, J. (2008). Child combatants in northern Uganda: Reintegration myths and realities In R. Muggah (Ed.), *Security and Post-Conflict Reconstruction: Dealing with Fighters in the Aftermath of War* (pp. 103-126): Routledge.

Boyden, J. (2003). Children under Fire: Challenging Assumptions about Children's Resilience. *Children, Youth and Environments*, *13*(1).

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge MA: Harvard University Press.

Cahill, H. (2006). Sensitive Issues: Supportive Structures. *Drama Australia Journal (NJ)*, *30*(1), 7-22.

Cahill, H. (2008). Resisting Risk And Rescue as the Raison D'Etre of Arts Interventions. In A. O'Brien & K. Donelan (Eds.), *The Arts and Youth At Risk: Global and Local Challenges* (pp. 12-31). Newcastle upon Tyne, U.K: Cambridge Scholars Publishing.

Catani, C., Kohiladevy, M., Ruf, M., Schauer, E., Elbert, T., & Neuner, F. (2009). Treating children traumatized by war and Tsunami: A comparison between exposure therapy and meditation-relaxation in North-East Sri Lanka. *BMC Psychiatry*, *9*(22), http://www.biomedcentral.com/1471-1244X/1479/1422

CdeBaca, L. (2010). *Best Practices: Human Trafficking in Disaster Zones*. Paper presented at the Harvard Kennedy School's Ash Center for Democratic Governance and Innovation. from http://www.state.gov/g/tip/rls/rm/2010/142160.htm

Chew, L., & Ramdas, K. N. (2005). *Caught in the Stom: The Impact of Natural Disasters on Women*. The Global Fund for Women.

Chinyowa, K. C. (2007). Frames of Metacommunication: Examples from African Theatre for Development. *Drama Australia Journal (NJ), 31*(1), 33-44.

Duncan, J., & Arntson, L. (2004). *Children in Crisis: Good practives in evaluating psychosocial programming*. Westport, CT Save the Children Federation, Inc.

ESCAP. (2008). *Enhancing Community Resilience to Natural Disasters: Lives of children and youth in Aceh.* Bangkok: United Nations Economic and Social Commission for Asia and the Pacifico.

Etaba, M., Izzi, V., Lendon, A., Ngjela, E., Sampson, P., & Lowicki-Zucca, J. (2005). *Youth and Violent Conflict: Society and Development in Crisis. A Strategic Review with a Special Focus on West Africa*. New York: Bureau for Crisis Prevention, UNDP.

Henley, R. (2005). *Helping Children Overcome Disaster Trauma Through Post-Emergency Psychosocial Sports Programs: A working paper.* Bienne: Swiss Achademy for Development.

Hinton, D. E., & Lewis-Fernandez, R. (2010). Idioms of Distress Among Trauma Survivors: Subtypes and Clinical Utility. *Culture Medicine and Psychiatry*, *34*, 209-218.

Hinton, D. E., Pich, V., Marques, L., Nickerson, A., & Pollack, M. H. (2010). Khyaˆl Attacks: A Key Idiom of Distress Among Traumatized Cambodia Refuges. *Culture Medicine and Psychiatry, 34*, 244-278.

IASC. (1999). *Policy Statement for the Integration of a Gender Perspective in Humanitarian Assiatance*, Inter-Agency Standing Committeeo.

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Jean-Charles, R. M. (2010). *Cracks of Gender Inequality: Haitian Women After the Earthquake.* Retrieved 8 July, 2010, from http://www.ssrc.org/features/pages/haiti-now-and-next/1338/1428/

Johnson, D., & van Kalmthout, E. (2006). Editorial. *Forced Migration Review*, 2006 (May).

Kershaw, B. (1998). Pathologies of Hope in Drama and Theatre in Research in Drama Education, *Research In Drama Education*, *3*(1).

Kohrt, B. A., & Hruschka, D. J. (2010). Nepali Concepts of Psychological Trauma: The Role of Idioms of Distress, Ethnopsychology and Ethnophysiology in Alleviating Suffering and Preventing, *Culture Medicine and Psychiatry*, *34,* 322–352.

Krusic, V. (1996). Escapism? Why Not! In J. O'Toole & K. Donelan (Eds.), *Drama, Culture and Empowerment: The IDEA Dialogues*. Brisbane: IDEA Publications.

Krzysiek, P. (2010). UNICEF Syria supports vocational training centre for adolescent refugees at risk. Retrieved 8 July, 2010, from http://www.unicef.org/infobycountry/syria_54044.html

La Greca, A. M., & Silverman, W. K. (2009). Treatment and Prevention of Posttraumatic Stress Reactions in Children and Adolescents Exposed to Disasters and Terrorism: What Is the Evidence? *Child Development Perspectives*, *3*(1), 4-10.

Laczko, F., & Gozdziak, E. (2005). *Data and research on human trafficking: A global survey.* Geneva: International Organization for Migration.

Lane, C. (2008). *Adolescent Refugees and Migrants: A Reproductive Health Emergency*. Watertown, MA: Pathfinder International.

Lesko, N. (1996). Past, present, and future conceptions of adolescence. *Educational Theory, 46*(4), 453-473.

Levine, R. (2010). Mind the Girls: How to Take Care of the Adolescent Girls in Haiti during the Resettlement. Retrieved 8 July, 2010, from http://blogs.cgdev.org/globaldevelopment/2010/01/mind-the-girls-how-to-take-care-of-the-adolescent-girls-in-haiti-during-the-resettlement.php

Lowicki, J., & Pillsbury, A. (2000). Recognizing War-affected Adolescents: Frameworks for action. *Development*, *43*(1), 73-82.

Lowicki, J., & Pillsbury, A. (2004). Supporting Young Refugees' Participation in their own Protection and Recovery: Lessons Learned. *Refugee Survey Quarterly*, *23*(2), 72-88.

Machel, G. (1996). *The Impact of armed conflict on children*. Geneva: United Nations

Machel, G. (2001). *The impact of war on children: a review of progress since the 1996 United Nations Report on the Impact of Armed Conflict on Children*. London: Hurst & Co.

Madfis, J., Martyris, D., & Triplehorn, C. (2010). Emergency Safe Spaces in Haiti and the Solomon Islands. *Disasters*, *34*(3), 845- 864.

Manyena, S. B., Fordham, M., Centre, D. a. D., & Collins, C. (2008). Disaster Resilience and Children: Managing Food Security in Zimbabwe's Binga District, *Children, Youth and Environments, 18*(1), 303-331.

Marsee, M. A. (2008). Reactive Aggression and Posttraumatic Stress in Adolescents Affected by Hurricane Katrina. *Journal of Clinical Child & Adolescent Psychology*, *37*(3), 519–529, 2008.

Masten, A. S. (2001). Ordinary Magic: resilience processes in development. *American Psychologist*, 227-238.

McIvor, C., & Myllenen, K. (2005). *Children's Feedback Committees in Zimbabwe: An Experiment in Humanitarian Accountability*. Harare: Save the Children

Midttun, E. K., & Skjetne, T. (2004). Youth Education Pack: An Investment in the Future. *Forced Migration Review*, *20*, 50.

Morris, K. N., & Edwards, M. T. (2008). Disaster Risk Reduction and Vulnerable Populations in Jamaica: Protecting Children within the Comprehensive Disaster Management Framework. *Children, Youth and Environments, 18*(1), 389-407.

Moss, W.J., Ramakrishnan, M., Storms, D., Henderson Siegle, A. Weiss, W.M., Lejnev, I. & Muhe, L. (2006). Child health in complex emergencies. *Bulletin of the World Health Organization*, *84*.

Naletto, A. (2010). Empowering Conflict-Affected Youth: Norwegian Refugee Council.

Nelson, S., Guthrie, J., & Sumner Coffey, P. (2004). *Literature Review and Analysis Related to Human Trafficking in Post-Conflict Situations. Washington DC: USAID.*

Neumayer, E., & Plumper, T. (2007). The Gendered nature of Natural Disasters: The Impact of Catastopphic Events on the Gender Gap in Life Expectancy. *Annals of the Association of American Geographers*, *97*(3), 551-566.

Nikku, B. R., Sah, N., Karkara, R., & Ahmed, S. (2006). *Child Rights Perspective in Response to Natural Disasters in South Asia*. Kathmandu: Save the Children, Sweden.

Office of Conflict Management and Mitigation. (2005). *Youth and Conflict: A toolkit for Intervention*. Washington DC: Office of Conflict Management and Mitigation (USAID).

Peek, L. (2008). Children and Disasters: Understanding Vulnerability, Developing Capacities, and Promoting Resilience – An Introduction. *Children, Youth and Environments, 18*(1), 1-29.

Penrose, A. (2006). Children's rights in emergencies and disasters. *The Lancet*, *367*, 698-699.

Pfefferbaum, B., Houston, B., North, C. S., & Regens, J.L, (2008). Youth's Reactions to Disasters and the Factors That Influence Their Response. *Prev Res.*, *15*(3), 3-6.

Pina, A. A., & Villalta, I. K. (2008). Social Support, Discrimination, and Coping as Predictors of Posttraumatic Stress Reactions in Youth Survivors of Hurricane Katrina. *Journal of Clinical Child & Adolescent Psychology*, *37*(3), 564-574.

Rashid, S. F., & Michaud, S. (2000). Female Adolescents and Their Sexuality: Notions of Honour, Shame, Purity and Pollution during the Floods, *Disasters*, *24*(1), 54-70.

Ravizza, D. M. (2008). *At Play in the Fields of Young Soldiers in Northern Uganda*, Washington Network on Children and Armed Conflict/ USAID.

Ronan, K. R., Crellin, K., Johnston, D. M., Finnis, K., Paton, D., & Becker, J. (2008). Promoting Child and Family Resilience to Disasters: Effects, Interventions, and Prevention Effectiveness. *Children, Youth and Environments*, *18*(1), 332-353.

Ronan, K. R., & Johnston, D. M. (2005). *Promoting community resilience in disasters: the role for schools, youth, and families*. New York: Springer Science and Business Media Inc.

Sagy, S., & Braun-Lewensohn, O. (2009). Adolescents under rocket fire: when are coping resources significant in reducing emotional distress? *Global Health Promotion*, *16*(4), 5-15.

Saltzman, W. R., Layne, C. M., Steinberg, A. M., Arslanagic, B., & Pynoos, R. S. (2003). Developing a Culturally-Ecologically Sound Intervention Program for Youth Exposed to War and Terrorism. *Child and Adolescent Psychiatric Clinics of North America*, *12*(2), 171-388.

Sandler, I. (2001). Quality and Ecology of Adversity as Common Mechanisms of Risk. *American Journal of Community Psychology*, *29*(1), 19-61.

Sesnan, B., Wood, G., Marina, M. L., & Avery, A. (2004). Skills Training for Youth. *Forced Migration Review*, *20*, 33-35.

Sommers, M. (2001). *Peace education and refugee youth*. Paper presented at the UNHCR workshop on Refugee Education in Developing Countries: Policy and Practice.

Sommers, M. (2006). *Youth and Conflict: A Brief Review of Available Literature*, USAID and EQUIP.

Tuicomepee, A. (2008). Thai Adolescent Survivors 1 Year After the 2004 Tsunami: A Mixed Methods Study. *Journal of Counselling Psychology*, *55*(3), 308-320.

UNDP. (2006). *Youth and Violent Conflict: A society in crisis?* New York: United Nations Development Programme.

UNFPA, & Save the Children. (2009). *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings,* New York, USA.

UNHCR, & Save the Children - UK. (2002). *Sexual Violence and Exploitation: The experience of refugee children in Liberia, Guinea and Sierra Leone. Report of assessment mission carried out from October to November 2001*. Geneva: United Nations High Commissioner for Refugees, Save the Children - UK.

UNICEF. (2004). *Adolescent Programming Experiences During Conflict and Post-Conflict*. New York: UNICEF.

UNICEF. (2008). Participation rights: having an active voice. Retrieved 22 March, 2010, from http://www.unicef.org/crc/files/Participation.pdf

United Nations. (2009). The UN Worldwide Campaign on Climate Change. Retrieved 15 March, 2010, from http://www.sealthedeal2009.org/

USAID. (2005). *Youth and Conflict: A toolkit for intervention*. Washington: U.S. Agency for International Development.

Van Ommeren, M. (2005). Mental and social health during and after acute emergencies: emerging consensus? *Bulletin of the World Health Organization*, *83*(1), 71-76.

Verhey, B. (2001). Child Soldiers: Preventing, Demobilizing and Reintegrating. *Africa Region Working Paper* (23).

Vos , F., Rodriguez, J., Below, R., & Gua-Sapir, D. (2010). *Annual Disaster Statistical Review 2009: The numbers and trends.* Brussels: Centre for Research on the Epidemiology of Disasters

Weems, C. F. (2008). Child and Adolescent Mental Health Research in the Context of Hurricane Katrina: An Ecological Needs-Based Perspective and Introduction to the Special Section. *Journal of Clinical Child & Adolescent Psychology*, *37*(3), 487-494.

Wickrama, K. A. S., & Kaspar, V. (2007). Family context of mental health risk in Tsunami-exposed adolescents: Findings from a pilot study in Sri Lanka. *Social Science & Medicine*, *64*, 713-723.

Williams, R., Alexander, D. A., Bolsover, D., & Bakke, F. K. (2008). Children, resilience and disasters: recent evidence that should influence a model of psychosocial care. *Current Opinion in Psychiatry*, *21*, 388-344.

Women's Commission for Refugee Women & Children (2000). *Untapped Potential: Adolescents affected by armed conflict. A reveiw of programs and policies*. New York: Women's Commission for Refugee Women and Children

World Education Forum. (2000). *Education For All: Meeting Our Collective Commitments (Text adopted by the World Education Forum, 26-28 April 2000)* Dakar: UNESCO

World Health Organisation. (2008). 10 facts on adolescent health. Retrieved 21 July, 2010, from http://www.who.int/features/factfiles/adolescent_health/en/index.html

Wyn, J., & White, R. (1997). *Rethinking Youth*. Sydney: Allen & Unwin.

Yonder, A. (2007). Grassroots Women's Participation in the Recovery Process. *Women's Rights Law Reporter*, *27*, 25-28.

Yonder, A., Akcar, S., & Gopalan, P. (2005). *Women's Participation  in Disaster Relief and Recovery*. New York: Population Council.

Zimmerman, C., Yun, K., Shvab, I., Watts, C., Trappolin, L., Treppete, M., et al. (2003). *The health risks and consequences of trafficking in women and adolescents. Findings from a European Study*. London: London School of Hygiene and Tropical Medicine.