World Awareness for Children in Trauma programme

(WACIT: www.wacit.org): The Story so far

The WACIT programme was designed to address the UN's Sustainable Development Goals for Poverty, promoting health and wellbeing, and reducing inequalities, in addition to the overarching commitment to 'leave no-one behind'. WACIT contributes to organisational capacity-building, supporting in-country community partners to develop culturally appropriate, research-informed frameworks for service delivery that ensures traumatised children continue to benefit longer term.

The programme has the dual objective of enhancing *practice*, by integrating psychosocial skills in relation to professionals, community volunteers and agency roles; and to improve *service delivery* by re-focusing provision, and connecting agencies and communities to maximize their strengths and resources. These components were chosen to reflect international policy and direction, and following consultation with local stakeholders (see evidence below). Local co-production was ensured throughout the programme by a lead local agency engaging services, community and religious groups.

Since 2015, the programme has potentially benefitted over 44,000 children and young people in 14 countries who have experienced trauma—in refugee camps; care facilities; settlements; or through homelessness - by training approximately 1,200 professionals (from health, social care, education and non-statutory agencies) and community volunteers (paraprofessionals) with the skills to identify trauma and support them.

To date, we have completed the following sequential phases:

Phase 1

Established *readiness* and *barriers* of child and adolescent mental health service provision among drivers in LMIC disadvantaged communities (Getanda et al., 2017; Tamburrino et al., 2018).

Phase 2

Developed and implemented *practice-focused capacity building*. Stakeholders from six LMIC welcomed WACIT's interdisciplinary and scaled approach (Vostanis et al., 2019b).

Phase 3

Developed the *WACIT service transformation framework*, supporting training manual (Smit & Vostanis, 2018) and digital tools. This framework aims to improve services on six domains: safety, parent support, school and community, primary care, counselling, and mental health provision.

Phase 4
Captured *children's voices* in four LMIC (including SA) on improving *help-seeking* (Vostanis et al., 2020; Haffejee et al., in preparation).

Phase 5
Established *proof of concept* after delivering the WACIT framework in six LMIC (including SA) (Vostanis et al., 2019a and under review; Vostanis & Haffejee, under review).

Our current work focuses on the implementation and evaluation of the service transformation framework in different countries.

Beneficiary groups and testimonials of impact

Four primary groups across four continents have benefitted from the programme.

Professionals and community volunteers
Research findings and their applications were translated into capacity-building interventions, targeting agencies operating in disadvantage and post-conflict communities: teachers, health practitioners, social workers, and community volunteers (paraprofessionals). Since January 2015, the WACIT Programme (Professor Vostanis and local co-facilitators) conducted capacity-building interventions — involving 1-3 day training workshops with post-training booster psychoeducation and digital materials—in 11 LMIC: Pakistan (settlement areas and orphanages: three years), India (settlement areas and street children: two years), Bangladesh (settlement areas – two years), Turkey (street and refugee children: four years), Indonesia (orphanages: two years), Brazil (favelas: three years), Kenya (internally displaced and settlement areas: three years), Rwanda (disability care homes – one year), Uganda (refugee children and settlement areas: one year), Tanzania (street children: one year), and South Africa (care homes and settlement areas: three years). Also, vulnerable groups in high/middle-income countries: France (refugee: one year), Greece (care homes and refugee: four years years), and Qatar (orphanages: one year). Testimonials will be obtained/submitted from our key partners.

Each interdisciplinary workshop was attended by an average 25 professional participants (range 15-80, from health, social care, education, non-statutory, community and religious groups). In total, approximately 430 participants attended in Asia; 210 in Latin America; 460 in Africa: and 100 in other countries; or 1,200 staff and community volunteers overall. For an average caseload of 50 children annually, we reached at least 44,000, excluding those whom participants could additionally reach in the community, and children on their future caseload.

"It really gave me some impetus to be able to continue to do what I was doing, and I have come up with various strategic plans in the church that target young people…the children have increased, I have now almost 100 kids and almost 50 young men and young ladies who have come, and every week we hold training for them". - Pastor, Kenya.

"I think, one, it has, the relationship between me and the young people that I've engaged with so far, it has strengthened the relationship. So, it's no longer when I talk to them, now there's a relationship. And I've seen behaviour change…" - Care Home Manager, South Africa

Managers and policy makers

The previously described practice-focused and service transformation workshops were regularly attended by clinical and service managers, budget holders and policy makers, thus generated transportability and sustainability of impact. Stakeholders included CEOs, programme managers, council representatives, clinical directors, community and religious leads. This was translated at a range of positive impacts on the ground such as awareness campaigns, reduction of stigma, inclusion of life skills and mental health promotion in school curricula, and integration of child mental priorities in urban regeneration (Vostanis et al.; Haffejee and Vostanis, submitted).

"We are actively supporting 50-70 children and their families every year, for 20 years. We cared for approximately 400-450 children, and 150 of them were street children…We also improved our connection with other NGOs after this workshop. It was a great resource sharing, I remember how I enjoyed the workshop. We organised trainings for volunteers…And we collaborated with municipalities as well. So, parents, children, government and NGOs worked together". - NGO Manager, Turkey

"Making them feel that they have actually achieved something, because most of our carers have had absolutely no training whatsoever, many of them would struggle to write their own names themselves – they have lived very desperate lives…I think they just love the knowledge and that someone is actually taking notice of them and showing them respect and giving them the confidence that they lacked in what to do, wanting to take an interest in them, listening to them, asking them what problems they face and their issues - and no one has ever done that before". - NGO CEO of disability care homes, Rwanda

Children, young people, parents and caregivers

Vulnerable groups included disadvantaged, homeless, looked after and refugee children. Parents and caregivers (including orphanage staff) participated in and benefited from trauma-focused interventions by developing more adaptive parenting skills. Children benefited through a decrease of mental health symptoms and by developing resilience strategies. For example, a psychosocial intervention in Kenya settlements led to significant reduction of post-traumatic stress symptoms (effect size 0.79) and improvement in quality of life (effect size 0.52) (Getanda & Vostanis, in press); an attachment-focused intervention with refugee families in Turkey led to reduction in post-traumatic stress (effect size 0.59) and general mental health symptoms (effect size 0.62) and improvement in attachment relationships (effect size 0.40) (Eruyar & Vostanis, in press); and a trauma-focused creative intervention with refugee children in the UK led to reduction in post-traumatic and other emotional symptoms (Kocik and Vostanis, in preparation). Therapeutic interventions were linked to capacity-building events and organisational partnerships. Their impact has been sustained by enhancing staff and caregivers' competencies to provide ongoing trauma- and attachment-focused (nurturing) interventions.

"I feel this is the best way I could express how I feel than talking to anyone"; "*I feel like I have changed*"; *"now I am free".* - Children in Kenya slum area following psychosocial intervention.

"I am happy to confirm to you that I have seen some changes in my daughter". - Parent in Kenya slum area following psychosocial intervention.

"*All of them were useful for me*". - Refugee child in Turkey on therapeutic activities.

"He started to direct his excessive power to something positive and useful". - Parent after attachment-focused intervention with refugee children in Turkey.

A list of research publications is attached as a separate document. Information on the WACIT projects and training activities, as well as free to download psychoeducational resources, can be found on our website: www.wacit.org.