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The Cost of Being Female: Mental Health and Psychosocial Support (MHPSS) of Displaced Female Youth in South Sudan and the Kurdistan Region of Iraq

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Overview

Globally, one in five girls marry under the age of 18.[2] However, rates of early marriage are believed to *increase* during conflict and humanitarian crises.[3] Early marriage may have devastating consequences for the child bride, including higher rates of child and maternal mortality, poor physical and mental health outcomes, loss of access to education, and increased exposure to violence and poverty.[4] While the problem is clear, the solution is less so. One barrier is the lack of empirical knowledge on early marriage in conflict settings. Research conducted to date is very limited; what does exist arises mostly from development settings, is anecdotal, or is based on one-time assessments.[5] Moreover, girls who are already married, married as children and then divorced or were widowed, or are living with disabilities are rarely included in studies on early marriage. To address some of these gaps, Save the Children Denmark and the Feinstein International Center (FIC) of the Friedman School of Nutrition Science and Policy at Tufts University created the Leave No One Behind (LNOB) research project in 2019 to study female youth and early marriage in displacement and conflict settings.

The LNOB project is currently conducting research in South Sudan and the Kurdistan Region of Iraq (KRI). South Sudan has experienced multiple decades of conflict, ongoing political insecurity, extreme environmental events, and regular economic crises, which has left more than two-thirds of the population in need of humanitarian assistance.[6] Approximately 2.3 million South Sudanese have become refugees in neighboring countries. An estimated 2 million more South Sudanese are internally displaced persons (IDPs), with humanitarian conditions reportedly worsening as of early 2022.[7] As of 2020, South Sudan's rate of child marriage was higher than the Sub-Saharan Africa average, with 52% of girls estimated to be married before the age of 18.[8]

The KRI has hosted Syrian refugees since the Syrian civil war began in 2011, with approximately 253,000 Syrian refugees and asylum seekers in the territory by early 2022.[9] The KRI also hosts about 600,000 IDPs, predominantly those from the Yazidi minority group, seeking refuge from internal conflicts, including the 2014 ISIS occupation of Sinjar and Mosul and subsequent military interventions.[10] Many of IDPs these populations live in substandard housing, are unable to access social safety nets, and have little opportunity to achieve durable solutions.[11] Rates of early marriage are lower within the KRI than in South Sudan, but these averages mask differences

[1] The research team firstly acknowledges the respondents for this study who discussed their lives, stories, and aspirations, often over many conversations. We greatly appreciate funding from Tufts University, Save the Children Denmark, DANIDA, and the European Union's Horizon 2020 Research and Innovation Programme under the Marie Sklodowska-Curie grant agreement No 786064 that made this work possible. We acknowledge the many colleagues at Save the Children Denmark, Save the Children South Sudan, Save the Children Iraq, and Tufts University who provided support to the team and the research. We thank George Neville for his research support, and graduate research assistants Gabriela Cipolla and Julie Salloum for their assistance with literature reviews. We are grateful to Ruby Gardner for her time, perspective and engagement in the analysis process.

[2] UNICEF, "Child Marriage," October 2021, https://data.unicef.org/topic/child-protection/child-marriage/.

[3] UNICEF, "A Study on Early Marriage in Jordan 2014" (UNICEF Jordan Country Office, 2014); Jennifer Schlecht, Elizabeth Rowley, and Juliet Babirye, "Early Relationships and Marriage in Conflict and Post-Conflict Settings: Vulnerability of Youth in Uganda," *Reproductive Health Matters* 21, no. 41 (2013): 234–42; UNICEF, "Falling through the Cracks; The Children of Yemen," 2016; Girls Not Brides, "Child Marriage in Humanitarian Contexts," Thematic Brief, August 2020.

[4] UNFPA and UNICEF, "Addressing Child Marriage in Humanitarian Settings," February 2021; E El Arab and M. Sagbakken, "Child Marriage of Female Syrian Refugees in Jordan and Lebanon: A Literature Review," Global Health Action 12 (2019): 1–12; Yvette Efevbera et al., "Girl Child Marriage, Socioeconomic Status, and Undernutrition: Evidence from 35 Countries in Sub-Saharan Africa," *BMC Medicine* 17, no. 55 (2019); Save the Children, "Too Young to Wed: The Growing Problem of Child Marriage among Syrian Girls in Jordan," 2014; World Bank Group, "Voice and Agency: Empowering Women and Girls for Shared Prosperity," 2014.

[5] Dyan Mazurana and Anastasia Marshak, "Addressing Data Gaps on Child, Early and Forced Marriage in Humanitarian Settings" (Save the Children and Tufts University, December 2019).

[6] United Nations Office for the Coordination of Humanitarian Affairs (OCHA), "South Sudan: Humanitarian Snapshot," February 2022, https://reliefweb.int/sites/reliefweb.int/files/resources/south_sudan_humanitarian_snapshot_february_0.pdf.

[7] United Nations Office for the Coordination of Humanitarian Affairs (OCHA).

[8] UNICEF, "Some Things Are Not Fit for Children-- Marriage Is One of Them," Press Release, October 2020, https://www.unicef.org/southsudan/press-releases/some-things-are-not-fit-for-children.

[9] UNHCR, "UNHCR Syria and Iraq Situations: 2022 Response Overview," 2022, https://reporting.unhcr.org/document/1799.

[10] United Nations Office for the Coordination of Humanitarian Affairs (OHCA), "Iraq: Humanitarian Dashboard for KRI (January to December 2019)," 2020, https://reliefweb.int/sites/reliefweb.int/files/resources/iraq_humanitarian_dashboard_2019_summary_for_kri.pdf.

[11] United Nations Office for the Coordination of Humanitarian Affairs (OHCA).

in early marriage rates among refugees, hosts, and IDPs. In a representative study conducted by the Women's Refugee Commission, IDPs showed the highest rate of early marriage among the three groups, with 13% of those currently aged 20–24 having married as minors.[12] This study also showed a potential increase in the rates of early marriage for refugees after displacement.[13]

The Project

This briefing paper is one in a series of outputs arising from the LNOB research.[14] LNOB relies on longitudinal, participatory research methodologies to understand the wide range of experiences, difficulties, opportunities, and constraints faced by female youth who have been displaced by or have experienced conflict. While the project's focus is holistic and multisectoral, particular attention is paid to the practice and experience of early marriage. The project examines multiple displaced and conflict-affected populations. These include internally displaced South Sudanese living in formal and informal camps,[15] and Syrian refugees and displaced Yazidi and Arab Iraqis located in camp and non-camp settings in the KRI. Four local researchers from affected communities (two from each case country) were central to the design of the study, participant interviews, and analysis of data.

LNOB's main source of data comes from a cohort of female youth, predominantly between the ages of 14 and 23,[16] who were regularly interviewed in 2020 and 2021 using surveys, semi-structured interviews, and participatory methods that include drawings and photographs. Members of the cohort are unmarried, married as minors, divorced, or widowed. The cohort also includes female youth who became pregnant under the age 18, and female youth living with physical, emotional, or intellectual disabilities, regardless of marital status. Family members of participants were interviewed when possible. LNOB also interviewed key informants, which included representatives from government entities, the United Nations, international and local non-governmental organizations (NGOs), camp managers, teachers, health workers, and community and religious leaders. At the time of this brief (April 2022), 600 interviews have been conducted. One hundred and thirty-nine female youth have been interviewed as part of the cohort. Each participant was interviewed an average of four times (range: 1–13 interviews). In addition, 87 key informants were interviewed, as well as 17 family members of female youth. LNOB is currently seeking funding to continue following the cohort into the future and to expand the number of country cases, methodologies, and sample size.

[12] K Hunnerson et al., "Child Marriage in Humanitarian Settings in the Arab States Region: Study Results from Djibouti, Egypt, Kurdistan Region of Iraq and Yemen" (Women's Refugee Commission, 2020). For this same age group the rates of early marriage were 3.4% for Syrian refugees and 4% for the host community. However, for girls aged 10-19 at the time of the study, 1 in 8 IDPs were married and 1 in 10 host and refugee communities were married.
[13] Hunnerson et al.
[14] See additional briefing papers on the project website: https://fic.tufts/edu/research-item/child-marriage-in-humanitarian-settings/
[15] Formal displacement camps had been administered by the United Nations Mission in South Sudan (UNMISS) and referred to as "Protection of Civilian" (POC) sites until 2020/2021. Since that time, UNMISS has handed over the administration of these camps to the South Sudanese government. We use the term POC throughout the paper in line with the nomenclature at the time of data collection.
[16] Our sample included female youth with disabilities. Only one of these respondents was married. Hence this briefing paper does not include a specific discussion on life after marriage for female youth with disabilities.

1. Introduction

Over the course of regular interviews with the cohort of participants in the KRI and South Sudan, the research team was struck by how central mental health—in particular poor mental health and psychosocial functioning—was to the lives of the displaced female youth in our sample.[17] In both countries, participants described deep sadness, worry, anxiety, insomnia, and suicidal ideation and attempts, as well as flashbacks, numbing, fear, and depressive symptoms, among others. Female youth also described loneliness, social isolation, hopelessness, and a range of physical symptoms and illnesses, which they attributed to their mental health.

Participants linked these difficulties to their experiences of war and displacement and ongoing threats of political insecurity. They described their poor mental health as a consequence of harassment and violence coming from the community, abuse by family members (husband, natal family, and in-laws), lack of access to school and livelihoods, curtailed freedom of movement, and uncertainty related to living in protracted displacement. Relatedly, female youth also described suffering from patriarchal systems and gender inequalities that either caused or exacerbated their poor psychosocial status. This was particularly seen in girls who were forcibly married, or those who married as minors and were later divorced or widowed. The mental health of some participants was so poor that it interfered with their ability to function normally—to socialize, attend school, work, or form relationships with others. Rarely were focused or specialized MHPSS services available in the locations where the study took place.[18] And yet, participants were vocal and eloquent about the need for a range of MHPSS services—including focused and specialized care—to support female youth in displacement. Moreover, many participants in both countries displayed incredible strength and resilience[19] despite their traumatic experiences and poor mental health and psychosocial functioning. Participants described that their own well-being[20] was often buttressed by positive relationships with friends and family, spirituality or religious faith, and their own self-determination.

The following briefing paper outlines the general situation of displaced female youth in the KRI and South Sudan study cohort from a MHPSS lens. The findings are both quantitative and qualitative, and disaggregated by country and by marital status. The paper closes with some specific recommendations to support the well-being and mental health and psychosocial functioning of female youth in displacement.

[17] It should be noted that the researchers are not clinicians.
[18] This report relies on the Interagency Standing Committee (IASC) MHPSS Pyramid to categorize MHPSS services. Focused care refers to "non-specialized support by trained and supervised workers for children and families, including general (non-specialized) social and primary health services." Specialized care refers to "specialized services by mental health clinicians and social service professionals for children and families beyond the scope of general (non-specialized) social and primary health services." See: UNICEF, "Community-Based Mental Health and Psychosocial Support in Humanitarian Settings" (New York: UNICEF, 2018), 15. See Annex A for the reproduction of this pyramid.
[19] This report relies on Save the Children's definition of resilience: "the ability to overcome adversity and positively adapt after challenging or difficult experiences." See: Save the Children International, "Mental Health and Psychosocial Support (MHPSS) Cross-Sectoral Strategic Framework in Humanitarian Settings" (London, 2019), 5.
[20] This report relies on Save the Children's definition of well-being: "the positive state of being when a person thrives," often seen along three dimensions: personal, interpersonal, and skills and knowledge. See: Save the Children International, 5.

2. Three Quantitative Scales to Measure Trauma, Resilience, and Emotional and Behavioral Functioning

In addition to relying on participatory qualitative methods, the research team also asked participants to answer standardized questions along three separate scales in order to better understand their traumatic histories, resilience, and various dimensions of their emotional and behavioral functioning. These scales included: 1) a customized checklist to quantify traumatic experiences; 2) the Child and Youth Resilience Measure (CYRM);[21] and 3) the Strengths and Difficulties Questionnaire (SDQ).[22] Descriptions of all three measures can be found in Annex B, along with a description of quantitative analyses performed, as well as the average scores on the measures.[23]

In brief, participants across both countries experienced an average of 14 types of traumatic experiences (12.5 in the KRI and 15 in South Sudan), emanating from family, community, and conflict. This indicates that participants have experienced an astounding range and volume of traumatic events, particularly for their young age. When looking more closely at emotional and behavioral functioning, participants in South Sudan scored "very high" on the emotional problems scale of the SDQ. Participants from the KRI scored "high" on both the emotional problems scale and peer problems scales of the SDQ. Emotional problems are measured by self-reports on frequency and levels of headaches, worry, sadness, nervousness, and having many fears. Peer problems are measured by self-reporting on feeling solitary, having few friends, not being liked by others, being bullied by others, and getting on better with older people than with people their own age. In terms of resilience, which measures an individual's resources and capacity to cope with various adversity, participants from South Sudan scored "low" on the resilience measure, while those in the KRI scored "high." These findings are unpacked below and integrated with qualitative analyses.

3. War, Abuse, and Mental Health

Trauma, resilience, emotional and behavioral problems

> ***Trauma and resilience have an inverse statistical relationship. In the KRI, the more types of traumas a participant experienced, the lower her resilience score and the more emotional and behavioral problems she reported. In South Sudan, the more family traumas a participant experienced, the lower her resilience score.***

Traumatic experiences, not surprisingly, were found to have strong statistical relationships with levels of resilience, and emotional and behavioral difficulties. In the KRI, the more types of traumatic events a participant experienced, the lower her resilience score on the CYRM.[24] These results are graphically displayed in Figure 1, which shows a clear inverse linear relationship between trauma and resilience—across low, medium, and high numbers of traumatic events experienced. These results show that prior traumatic events may impact a participant's current

[21] Resilience Research Centre, "CYRM and ARM User Manual" (Halifax, Nova Scotia: Resilience Research Center, Dalhousie University, 2018), http://www.resilienceresearch.org.
[22] Robert Goodman, "Strengths and Difficulties Questionnaire," 2009, https://www.sdqinfo.org/a0.html.
[23] The averages reported in this section refer to median scores.
[24] P value < .01. For each additional type of trauma experienced, the total resilience declines by .36 points. The relationship is linear, so even at high levels of trauma, the effect remains the same.

Figure 1: Relationship between Trauma and Resilience Scores

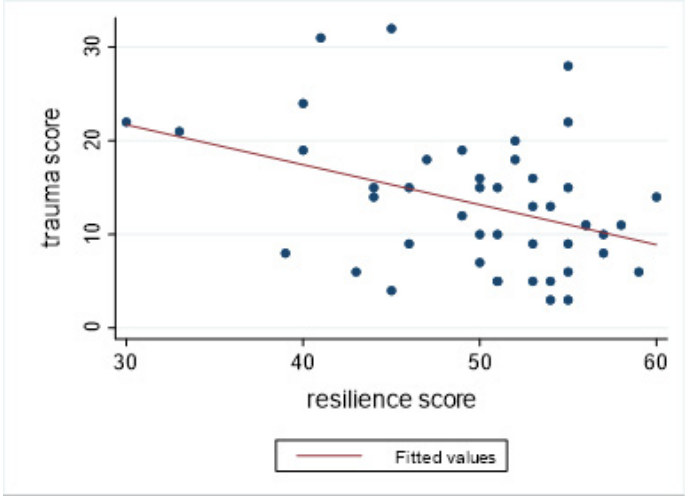
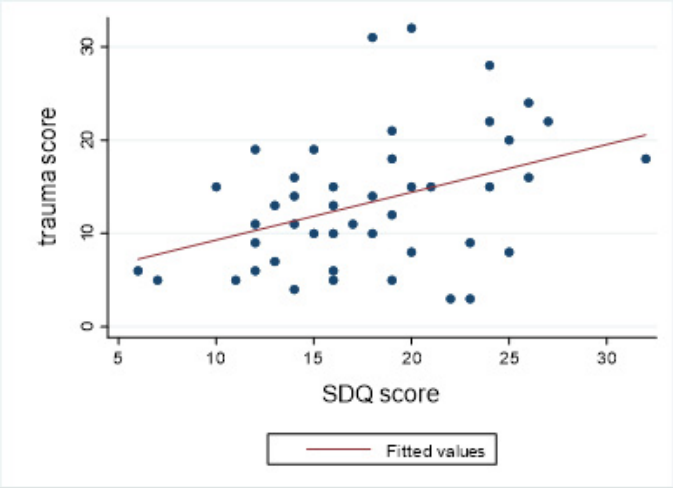


Figure 2: Relationship between Trauma and SDQ Scores



internal resources and coping strategies. In addition, the more types of trauma experienced in the KRI sub-sample, the higher her score on the SDQ, which shows a higher level of combined emotional and behavioral difficulties.[25] These linear results are displayed in Figure 2.

The trauma checklist is divided into three types of traumatic experiences—those emanating from the family, the community, and the context of war. For sub-samples in both the KRI and South Sudan, the more types of *family traumas* a participant experienced, the lower her resilience score.[26] This finding is unsurprising given the central importance of family relationships for physical protection and emotional support in both contexts, according to study participants, which may in turn support functioning, internal resources, and coping in the face of continued adversity. This topic will be discussed in more detail in Section 7.

In the KRI only, the more types of *community* traumas experienced, the lower a participant's resilience score.[27] Also in the KRI, the more types of *war* trauma experienced, the higher the SDQ score, indicating higher levels of emotional and behavioral problems.[28] Thus, the more types of war and conflict events a participant in the KRI experienced, the worse her functioning across multiple domains, which includes emotional problems, conduct problems, hyperactivity, and peer problems.

Traumatic experiences and effects on well-being and mental health

Participants in the KRI and South Sudan explained how the death of loved ones and separation from family provoke ongoing emotional pain as well as social isolation.

Across the sample and inclusive of all marital statuses, participants described the negative emotional impacts of the traumatic experiences stemming from conflict and displacement. In particular, the death of family members and separation from family members were some of the most distressing. A 20-year-old in Juba described her experiences with loss:

> My younger brother was shot, and he was carried to the UNMISS [United Nations Mission in South Sudan] hospital inside the camp. He died after one week. It was the worst moment for my family. My mother was very sad. She said that all of her children would die. She did not talk for many months, and there were gunshots everyday everywhere in 2016 and 2017. People were just living in fear. I felt very sad. I lost hope

[25] P value < .01. For each additional type of trauma experienced, the total SDQ increases by 0.31 points.
[26] P value < .01. For each additional type of family trauma experienced, the resilience score decreases by 1 point.
[27] P value = 0.025. For every additional type of community trauma, the resilience score goes down by .83 points.
[28] P value = 0.048. For every additional war trauma, the total SDQ goes up by .53 points.

> in life. In 2019, my father died of heart disease. They said he was thinking too much. When my father died, I was crying every day and night without eating or doing anything. My life was so meaningless. I did not know how to comfort my mother. I wanted to just die also.[29]

In South Sudan, several participants described being separated from their parents or siblings during the displacement process. During the study period, many participants still did not know where their relatives were, how to get in touch with them, or if they were still alive. This 21-year-old unmarried mother described the following of her family: "I do not know where they are. I don't feel anything. I am used it now. I don't have any family around me, only my son."[30] Another participant, now married, described her experience of arriving in the displacement camp in Juba with her stepmother, only to be left soon after. She said: "She didn't even tell me that she was leaving. She just left. I was here alone until a woman took me in. I was so sad at that point. I didn't want to go to school. I didn't want to do anything. I was so alone, and I didn't have anyone to call family."[31]

In South Sudan, girls and women face threats of violence from the community, with profound consequences for their psychosocial well-being. Seven participants reported being abducted, raped, and forcibly married to their abusers.[32] A 16-year-old unmarried participant confided to the research team that she had been raped by a neighbor in the Bentiu displacement camp between rounds of interviews. She described:

> I feel very bad about what happened to me, and I want you to keep this as a secret. I was raped by our neighbor at night in May. The following day, my brother went to tell my uncle that somebody came to our home. My uncle asked me until I told him. He took me to the hospital and told me not to tell anybody about what happened to me because it is shameful. That man that raped me has run away from the camp, and we have never found him. I never told anyone apart from my mother and my uncle, but they told me not to tell anyone because such news can ruin my reputation, and maybe one day I may not be able to even get married.[33]

In the KRI, several of the female participants from the Yazidi community were particularly concerned about girls returning from being held captive by ISIS, commonly known as "ISIS survivors." While our study population included only a handful of ISIS survivors, Yazidi respondents knew many others (including close relatives) in this situation. Participants said that suicides were common among this population and that focused and specialized MHPSS services were lacking to help them manage their experiences. In addition, participants reported that their communities verbally insulted and discriminated against female ISIS survivors, seeing them as damaged due to the loss of sexual chastity. At the same time, key informants described that Yazidi religious leaders had spoken out publicly in support of ISIS survivors and had effectively "cleansed" them after their experiences. These differing perspectives indicate the complexity of this issue, which continues to have profound effects on both ISIS survivors and members of their broader community, including the female youth in our study cohort.

It is not only past war experiences and current threats to insecurity that weigh on the minds of those heavily impacted by conflict. Uncertainty about the future worries the parents of participants, and other male family members, who feel responsible for the economic situation and security of their families. The continued and intergenerational experience of traumatic events was also a concern. The sister-in-law of one participant described, "I have a daughter that was taken by ISIS—she was 7 at the time and she is still missing…I have two sons, and I'm afraid they will commit suicide because their heads are so

[29] Interview with participant # SS_CO_31_ F_W_18, Juba, South Sudan.
[30] Interview with participant # SS_CO_24_F_EP_21, Juba, South Sudan.
[31] Interview with participant # SS_CO_17_F_M_23, Juba, South Sudan.
[32] More details are provided on this phenomenon in the briefing paper on "Perspectives on early marriage" on our project website: https://fic.tufts.edu/research-item/child-marriage-in-humanitarian-settings/.
[33] Interview with participant # SSB_CO_5_U_16, Bentiu, South Sudan. We asked the respondent if we could assist her in any way, including by making a counselling referral. She refused, saying, "I don't want anyone to know about this."

full of negative things."[34] The 21-year-old brother of another participant explained that he was contemplating joining the army, despite the high risk of injury or death, because he felt disempowered by being unable to provide for his family. Both his mother and sister needed urgent medical treatment that he could not pay for. He had several debts that he was unable to repay and felt deeply shameful.[35] Joining the military seemed to be a way for him to reclaim a sense of responsibility or purpose.

Several participants in the KRI sample described having experienced a specific type of sexual harassment that had provoked extreme and long-lasting psychological impacts. A few unmarried respondents had had romantic (but nonsexual) relationships with boyfriends and now found themselves the victims of revenge from the boyfriends at the end of these largely secretive relationships. The ex-boyfriends took revenge usually through photography—posting pictures of their ex-girlfriends on social media without consent—or spreading rumors about her sexual chastity.[36] These misogynistic attacks caused extreme reputational harm to the girl and her family, and her ability to socialize, attend school, and work. For many, this experience was believed to negatively affect her prospects for marriage, as the community placed the blame on her for having romantic relationships outside of marriage. Participants who had experienced this sexual abuse explained that their lives were ruined and reported severe and chronic distress in the form of despair, insomnia, social isolation, anxiety, and depression. They also described that marriage (even if they were underage) was viewed as a potential survival strategy to prevent further violence against them as women.

Returning home: continued distress and risk for Yazidis in the Sinjar region

Five Yazidi participants from the cohort had returned to the Sinjar region from where they had been displaced after the ISIS occupation in 2014. Several others were contemplating returning or were spending part of their time in Sinjar and part in displacement camps. Although no longer displaced, participants continued to face the ongoing threat of insecurity and the presence of traumatic memories. This 22-year-old participant who was married as a minor described, "The situation is insecure, and you never know what will happen…Also I have so many memories. I was one of those people who suffered. My father was killed by a mine—he was returning to check the house and he was killed. Every time I go to that location, it retraumatizes me. And every family has a story like this. I would like to be able to leave these memories behind me—to go to a new place and start over."[37] Another participant, also married as a minor, returned to her home village in Sinjar during the course of the study. She explained, "I don't want to be here. I never wanted to come back. My brother's house is in front of me. ISIS killed him there. The place I was captured [by ISIS] is nearby. I have a lot of bad memories here. We are forced to live this life, we are forced to be strong."[38] As someone who survived ISIS captivity, she explained her situation and that of others like her: "After I escaped [ISIS], planes threw down some tents, so we lived there, until I became a psycho [psychologically ill]…I know some Yazidi women who take more than six pills just to sleep and forget what happened to them. From 2014 until now, I haven't had a single moment of happiness in all of these years."[39]

Many participants expressed chronic fear about continued insecurity. One participant in the KRI had escaped ISIS with her father, but the rest of her siblings were still missing. Participants

[34] Interview with family member of participant # KRI_CO_13_F_DIS_22, Kurdistan Region of Iraq.
[35] Interview with family member of participant # KRI_CO_10_F_DIS_16_F, Kurdistan Region of Iraq.
[36] In Western contexts, this is known as "revenge porn" and is considered a criminal offense in many states. In the KRI, the photographs do not necessarily include nudity, but the implications are similar.
[37] Interview with participant # KRI_CO_28_F_M_23, Kurdistan Region of Iraq.
[38] Interview with participant # KRI_CO_21_F_M_23, Kurdistan Region of Iraq.
[39] Interview with participant # KRI_CO_21_F_M_23, Kurdistan Region of Iraq.

living in Sinjar showed particular chronic anxieties as Turkey perpetually threatened bombardment, and local self-defense forces were continuously on high alert. In the winter/spring of 2022, Turkey bombed several areas in Sinjar where participants had resettled.[40] However, war-related events occurred in Sinjar even before the more well-known ISIS occupation. One participant had lost both of her parents and another participant lost her father in a terror attack in Sinjar in 2007—a coordinated four-site explosion that killed more than 500 people and wounded more than 1,500 others, with no group ever having claimed responsibility.[41] These losses have had profound and long-lasting mental health and economic impacts on the lives of these participants and their families.

4. Marital Status and Mental Health

The relationship between marital status, traumatic experiences, and resilience

- » ***In both countries, being divorced is significantly associated with experiencing more traumatic events and having lower resilience scores; in the KRI, being widowed has the same associations.***
- » ***In the KRI, the less decision-making power an adolescent girl had when she married, the lower her resilience score and the more traumatic events she experienced.***

The circumstances under which an adolescent girl marries in the KRI—including the degree to which she participated in the marriage process—had a statistically significant relationship with her trauma and resilience scores. As described in a separate briefing paper,[42] the sub-sample of female youth who married as minors participated to varying degrees in the decision to marry. The research team coded each girl's marital stories along a 5-point scale to capture the range of experiences from full participation to full force. We find statistical relationships between the degree to which a respondent participated in the decision to marry, trauma, and resilience. In the KRI sub-sample, the more "force" a participant experienced in the marriage process, the higher the number of traumatic events experienced—within the family, community, and during war—*and* the lower her resilience score.[43] These findings add empirical weight to the global discourse that underage and/or forced marriage leads to poor impacts on mental health, even long after the marriage occurs.[44]

Experiencing divorce also showed a statistical relationship with trauma and resilience. In South Sudan and the KRI, being divorced was associated with a significantly lower resilience score than not being married.[45] In the KRI specifically, being

[40] Note that these bombardments took place after the last round of data collection, so the research team is not aware of how participants were impacted. See: https://www.thenewhumanitarian.org/news-feature/2022/2/10/Iraq-Sinjar-Yazidi-returns-halt-Turkish-airstrikes.
[41] See: https://www.nytimes.com/2007/08/22/world/middleeast/22iraq.html.
[42] See the briefing paper on "Perspectives on early marriage" on our project website: https://fic.tufts/edu/research-item/child-marriage-in-humanitarian-settings/.
[43] For every additional increase on the participation scale (toward force in marriage), the number of types of traumatic experiences increases by 3.34 (p value = 0.001). (When the trauma scale is divided by type of trauma, the increases are: for every unit increase in "force," family trauma increases by a factor of 1.42 (p value = 0.01); for every unit increase in "force," community trauma increases by a factor of 1.56 (p value = 0.002); and for every unit increase in "force," there is a 1-point increase in war trauma (p value = 0.02)). For every additional increase on the participation-in-the-decision-to-marry scale (towards force in marriage), the resilience score decreases by 2.12 points (p value = 0.007).
[44] Rochelle Burgess et al., "Overlooked and Unaddressed: A Narrative Review of Mental Health Consequences of Child Marriages," *PLOS Global Public Health* 2, no. 1 (2022).
[45] 12.3 points on average for South Sudan (p value = 0.02); 9.3 points lower for KRI (p value = 0.001). When comparing married with divorced participants in the KRI, divorced participants scored 5.5 points lower on average (p value = < 0.02) than married participants. For the South Sudan sample, no findings were significant when changing the referent group to "married."

divorced is statistically associated with a higher trauma score than not being married.[46]

Becoming widowed in the KRI is also statistically associated with a significantly lower resilience score as compared to not being married.[47] The severe difficulties that divorcees and widows face have been outlined in a separate publication.[48]

The relationship between marital experience and mental health

Female youth who married as minors in both countries expressed a range of different mental health outcomes from very poor to extremely positive. The variation seen in psychosocial statuses across participants appeared to be largely a function of the number of traumatic events previously endured, the degree of force in the marriage, and the quality of relationship with her husband and in-laws.

Forced marriage

Forced marriage has profound and long-lasting negative consequences on the well-being and mental health of female youth.

Across both samples, participants who were forcibly married described significant negative impacts on their mental health, which followed them throughout their lives. For those participants forcibly married by their fathers or uncles, they described a deep sense of betrayal. In South Sudan, some bravely fled these marriages and subsequently found themselves without support from their natal families. They were often living in fear and in hiding. One 22-year-old who was married at 15 described her experience of forced marriage: "I was sad. I kept crying for weeks, and I felt even bad when my father did not come to get me again. I missed my family. I was not talking to anyone, even when my husband took me to his home. His mother and sisters tried comforting me and treated me well, but I was not happy because it was not my wish to get married."[49]

Another participant in South Sudan described having been forcibly married at 14 to a 60-year-old man with "many wives." She quickly ran away, had no contact with her family and was in hiding during the study period. She described the circumstances of her marriage:

> My father called me in the evening and told me that he will be taking me soon to this man's house. I told him I don't want to go, and he started talking very harshly with me. He said, "You must marry this man. You are lucky because you will be the last wife. He has already given me your cows and if you try to refuse, I will kill you." So, I just accepted, and after five days my stepbrother took me to that man's house. He was very old even—I was afraid to greet him. I was very unhappy, every day I was really crying a lot at night…every day I was thinking of how to run away or just kill myself. After five days I ran away.[50]

In the KRI, participants lamented the impacts of forced marriages on their relationships with natal family members and disruptions to their personal goals after marriage. A participant who was forcibly married at 17 described:

> My father forced me to marry my husband, and it was a big shock for me. He was very aggressive and a close-minded person. He was a very abusive father and husband [to my mother]—that's why I always describe my life as a series of shocks with few happy moments. My education was a big goal and dream for me, but my father forced me to stop. When he came to take me from school, the teachers told him that I was very clever [and that I should stay in school]… but he refused.[51]

Another participant from the KRI described how she was forcibly married by her family: "They beat me. I had to say yes to everything. I couldn't decide what to buy to prepare the house. I couldn't decide what to wear. I didn't want to wear makeup or a white dress [for the ceremony], and they said, 'Why? Are

[46] 12.4 higher score on the trauma scale than non-married (p value < 0.001). When comparing married with divorced participants, the difference is also significant, with divorced participants scoring 11 points higher than married (p value < 0.001).
[47] 7.7 points lower (p value = 0.02).
[48] See briefing paper about divorced and widowed female youth on our project website: https://fic.tufts.edu/research-item/child-marriage-in-humanitarian-settings/.
[49] Interview with participant # SS_CO_27_F_M_22, Juba, South Sudan.
[50] Interview with participant # SSB_CO_24_FM_18, Bentiu, South Sudan.

you in love with someone else?' I couldn't make any decisions. I had no choice."[52]

This participant continues to experience flashbacks, nightmares, insomnia, hypervigilance, sadness, and deep feelings of betrayal by her family. These feelings are a result of both the forced marriage and the abuse she faced after she married.

A girl's decision to marry

> ***Two drivers for girls choosing to marry early are a lack of social connection and a lack of meaningful activity in their lives.***

Social isolation, poor psychological functioning, and abuse in the natal home were found to be drivers for some girls to seek to marry early. While these push factors are described in a separate briefing paper,[53] a few examples are presented here. In her first interview, a 17-year-old Syrian refugee participant described her life in a recently constructed camp that had no schools or other services:

> Participant: Now I have nothing to do, I just sit in the tent all day and think.
> Interviewer: What do you think about?
> Participant: We always think about our homeland. But we know we can't go there. We don't know what to do. We miss our homeland. I think about my people. A few days ago it was the one-year anniversary since we came [to the KRI from Syria]. Everyone was sad. Everyone was crying around us. My family was in a very bad mood. We all felt so sad.
> Interviewer: What do you do when you feel bad like this?
> Participant: I do two things usually. Sometimes I talk to people I trust, but more often, I spend time alone and cry."[54]

A few months later this participant traveled to Syria to marry a young man, who came from a "good family." She continued to be interviewed as part of the study from Syria. Her mental health improved over the subsequent year, as she made close connections with her in-laws and happily became a first-time mother.

A participant in South Sudan who married at 14 explained that, despite her age, marriage was an attractive alternative to an otherwise mundane life without school. She explained, "I had refused to go to school. I was just home doing household chores and nothing else. I loved my boyfriend and when he mentioned marriage, it was the only thing I wanted….[if I could go back and change things] I would wait until I finished school and have done something with my life before marriage."[55]

Life after early marriage

> ***Early marriages improved the well-being of some participants and worsened that of others. These differences were predominantly related to quality of relationships with husbands and in-laws.***

We found that even when many female youth actively participated in the decision to marry, their marriages were not always fulfilling or beneficial to their mental health.[56] Some married youth described being overwhelmed by caring for the needs of their in-laws, husbands, and children, often amidst ongoing insecurity, poor economic conditions, and uncertainty about the future. Others described that their husbands had become abusive after marriage, and they had developed emotional difficulties as a result. Some participants had left their husbands, and others were contemplating this decision. Several married participants in South Sudan explained that their relationships with their husbands deteriorated over time, largely as a result of economic pressures. They explained that their husbands became abusive because of this stress—making a clear link between economic insecurity related to displacement and poverty, domestic abuse, and mental health.

At the same time, other respondents in both countries who had married early described

[51] Interview with participant # KRI_CO_38_F_W_35, Kurdistan Region of Iraq.
[52] Interview with participant # KRI_CO_4_F_D_23, Kurdistan Region of Iraq.
[53] For more on this topic, see the briefing paper on "Perspectives on early marriage" on our project website: https://fic.tufts.edu/research-item/child-marriage-in-humanitarian-settings/.
[54] Interview with participant # KRI_CO_11_F_U_17, Kurdistan Region of Iraq.
[55] Interview with participant # KRI_CO_28_F_M_20, Juba, South Sudan.
[56] The research team has produced a separate briefing paper on life after early marriage. See this publication on our project website: https://fic.tufts.edu/research-item/child-marriage-in-humanitarian-settings/.

mental health and psychosocial benefits of their relationships. These benefits included companionship, economic support, the ability to become a mother, and opportunities for educational advancement or third-country resettlement (in the case of KRI). In Juba, a female participant who married at 16 explained that her life "is better than before I was married because I see [my husband] cares about me. He tells his family to treat me and my daughter well….right now he is the one who pays my school fees."[57] In the KRI, a 20-year-old who married at 17 chose to answer the following question through photography as part of the PhotoVoice activity responding to the question: What is the source of your strength? She sent the research team a picture of her husband and explained, "He loves me, understands and respects me. He takes my ideas into his plans and we collaborate. For this reason, he is the source of strength in my life."[58]

Divorced and widowed female youth

> ***Divorced and widowed female youth, on the whole, have very poor mental health and psychosocial functioning, including suicidal ideation and suicide attempts. They face ongoing violence and abuses because of their status.***

As discussed earlier, results from the quantitative scales showed a clear relationship between low resilience, poor emotional and behavioral functioning, and being divorced or widowed. Qualitative research uncovered extreme emotional distress among these two sub-samples. Divorced and widowed female youth reported suicidal ideation and suicide attempts, feelings of severe depression, shame, anxiety, physical problems, and a range of conditions they described as debilitating, including poor memory, inability to concentrate, insomnia, and difficulties parenting. Participants linked their mental health outcomes directly to their marital status. A separate briefing paper covers these two sub-samples of participants in depth, and hence here we highlight only a few aspects related directly to well-being.[59]

Economic hardship was particularly pronounced in these two populations in both the KRI and South Sudan. Divorced and widowed participants in South Sudan reported heightened levels of chronic stress about food shortages and the ability to feed their children. They reported frequent headaches because of severe stress and needing to engage in difficult physical labor (such as burning charcoal) to make ends meet.

Widows in the KRI also faced difficulties in meeting the needs of their children. Several widows reported working at small jobs, often in conditions that subjected them to sexual harassment. Many widows expressed shock and disappointment that their in-laws did not support them financially, and two widows in the sample described facing abuse by their in-laws over custody of their children. One case of abuse was so severe that the participant and her children were resettled to Norway through a protection pathway during the course of the study. In South Sudan, widows faced "inheritance" by their brothers-in-law after the death of their husbands, often without their full consent. Several widows also reported that they were being exploited by government officials and humanitarian representatives because of their marital status.

Customary rules in both country contexts mean that divorced mothers were likely to lose custody of their children, either at the time of separation (in the KRI) or when the child turned 7 or 8 years of age (in South Sudan). This loss was devastating for mothers and had profound, long-term impacts on their sense of well-being. A 20-year-old who had to give up her daughter the day she was born because she was pursuing a divorce from her abusive husband described: "After they took my girl, I was in pain all the time…I couldn't share my pain with anyone. The divorce itself is a stigma in the community. I didn't get any support. I became sick after that. I have a thyroid illness because I am sad all the time."[60] She described that even two years later (at the time of the study), she cried herself to sleep every night.

[57] Interview with participant # SS_CO_25_F_M_18, Juba, South Sudan.
[58] Interview with participant # SS_CO_109_F_M_20, Kurdistan Region of Iraq.
[59] For the full briefing paper on divorced and widowed female youth, see our project website: https://fic.tufts.edu/research-item/child-marriage-in-humanitarian-settings/.
[60] Interview with # KRI_CO_9_F_D_20, Kurdistan Region of Iraq.

Social stigma, and the accompanying feeling of shame, was particularly pronounced for the sub-sample of divorced female youth. Many also reported abusive behavior from their families because of their "divorcee" status. In the KRI, participants who were divorced, often when still teenagers, described feeling that their lives were ruined, that they had tarnished the reputations of their families, and that they could never escape the shame of being "divorced." Many were forbidden by their families from attending school, working, socializing, or even going outside the home. Others "chose" to restrict their activities because they anticipated facing or had already faced gossip and harassment within their communities.

In addition to extreme social exclusion, all divorcees from the KRI sub-sample had experienced severe domestic abuse in their marriages, and many had lost custody of their children. These layers of trauma, when combined with limited opportunities for a normal life and a bleak future, often left participants in an extreme state of emotional suffering, physical illness, and longing for escape, including through suicide. A 24-year- old divorcee who married at 13 described the long-lasting effects of her divorce: "Last week I went to Lalish [a Yazidi shine where a pilgrimage is made during a religious celebration], and people were harassing me. They were saying that I was a prostitute, that I was 'used' because I was divorced. This upset me so much. I can't take it anymore. I want to kill myself."[61] This participant had lost her parents during a terrorist attack when she was a child and had also been forced to give up her newborn daughter at the time of divorce. Unfortunately, this participant's story of suffering is not uncommon. We had at least three other participants who were actively suicidal during the study period. Access to MHPSS focused and specialized MHPSS services will be discussed in more detail in Section 8 of this paper.

5. Early Pregnancy, Motherhood, and Mental Health

Experiences of mothers in South Sudan

- ***Female youth in South Sudan who had unintended pregnancies suffered severe and long-lasting negative emotional consequences as a result of these pregnancies, which arose from intense shame, family abuse, and discrimination within the community.***
- ***The experience of motherhood was mixed in South Sudan. On the one hand, mothers described that their children brought them joy and meaning in their lives. On the other, all mothers reported having trouble providing their children with basic necessities like food and medicine, which provoked intense anxiety, headaches, and stomachaches.***

In South Sudan, many participants had unintended pregnancies under the age of 18, which had profound impacts on their lives, including on their self-esteem, social relations, family relations, education, and marriage and bridewealth prospects.[62] Not surprisingly, these unplanned pregnancies also had mental health impacts. After learning of their pregnancies, nearly all of the participants experienced fear, intense shame, and sadness—particularly from their natal families. Several also expressed disappointment, saying it was not their intention to fall pregnant. The reputation of the girl and her family is damaged as a result of community attitudes towards unintended early pregnancies. Bridewealth payments to her family also decrease, with important economic repercussions. As such, the news of a premarital pregnancy often provokes intense family conflict

[61] Interview with participant # KRI_CO_41_F_D_24, Kurdistan Region of Iraq. The researcher offered to try to connect her with formal psychosocial services, but she refused. However, the researcher maintained frequent contact with her, and she did not express suicidal ideation again.

[62] For more on the topic of early pregnancy in South Sudan, see our briefing paper on our project website at: https://fic.tufts.edu/research-item/child-marriage-in-humanitarian-settings/.

and at times, abuse. One participant, who had an unintended pregnancy at age 15, described that it "was the darkest moment of my life when I got pregnant. My mother was crying every day, and I felt very bad seeing her crying because of me...She said she was struggling with us by herself, and I was shaming her in the community…that people would blame her for my getting pregnant, saying that she did not raise me well."[63]

Another participant, who was raised by her older brother and his wife, had an unintended pregnancy and described ongoing abuse because of this pregnancy, even four years later. The participant's sister-in-law explained:

> I had to call my own brother. I was worried that my husband might kill [the participant]. My brother came and rescued her. And then we got the [father of the baby], and the community leader came. It was a bit better, but when the people left, my husband started beating her again. If I tried to defend her, he would beat me too. [The participant's] relationship with her brother has changed so much. He doesn't want to do anything for her or her children. He won't buy her shoes or clothes, or even milk for the children. He is still so angry. I thought she should go back to school. But he said, "No way will I ever allow her to go back to school again." That is why she is staying home right now. It is a very bad situation.[64]

In South Sudan, young mothers consistently expressed two opposing emotions. They simultaneously talked about the emotional benefits of having children: children provided them with a sense of meaning and purpose. This positive discourse even emanated from participants who had been forcibly married or had felt shame at becoming unintentionally pregnant. One described that being a mother provided her with an antidote to being unhappily married, while another saw it as a way to recover from having never been loved by her own mother. A third felt pride at being looked up to by her children, while a fourth was happy to know that she would be remembered after her death.

At the same time, participants expressed that motherhood brought about increased worry, stress, and anxiety. These included not being able to provide for the basic needs of their children—food, medicine, clothing, and education. The ambiguity between positive and negative sentiments was present in nearly all mothers. For example, a 23-year-old widowed respondent in South Sudan with two children explained: "I like my life now with my children in it. I like to see my children together with me every day, it makes me happy…I'm worried about their future, I don't know how life is going to be."[65] Another participant, divorced and age 20, described that "I feel great to know there is someone I call my daughter…[but] I worry about what she will eat and worry a lot about her well-being."[66]

Experiences of mothers in the KRI

> ***All of the pregnancies in the KRI took place in the context of marriage, and most were planned. Most participants reported that motherhood improved their mental health, and some specifically saw their children as an antidote to war and loss. Mothers in the KRI also worried about providing necessities for their children, as well as about future educational opportunities.***

In the KRI, all of the early pregnancies took place in the context of marriage, and most pregnancies were planned. Overwhelmingly, young mothers in the sample described being very happy at the news of their pregnancy. This included the joy of having someone to care for and feeling pleased that they were following a traditional role of becoming mothers after marriage. There were, however, a few exceptions such as one Yazidi participant who was not happy in her relationship with her husband and felt pressure to bear children before she was ready. Another felt "hatred" when she discovered her pregnancy, as she had been sexually abused by the man she was later forced to marry. This young woman escaped and is currently in hiding, but suffers from severe emotional disturbance, which she blames on her experience of multiple traumatic events.

[63] Interview participant # SS_CO_8_F_EP_18, Juba, South Sudan.
[64] Interview with family member of participant # SS_CO_15_EP_19_FAM, Juba, South Sudan.
[65] Interview with participant # SS_CO_48_F_W_23, Juba, South Sudan.
[66] Interview with participant # SS_CO_42_F_DIV_20, Juba, South Sudan.

When asked about their experiences of motherhood, respondents in the KRI described mostly positive feelings. One described that having children helped with her "poor psychological situation," another described feeling immense joy, and a third detailed that the happiest moments of her life were the day of her marriage and each of her children's births. A Yazidi participant who married largely by choice at 16 and had her first child at 17 described, "I was so happy, happy to become a mom and to establish a family and have this responsibility. Sometimes even when I go through difficult situation, I remain thankful, as I have this family."[67] Another participant, who had difficulty conceiving over a two-year period but became pregnant during the study, described her desire to become a mother: "My main reason for wishing to become a mother is that I am alone here. I feel lonely, especially because my husband is at work during the day. So, I always sleep. But when I have a child, I will feel I have a partner in the house and will be busy with him or her."[68] A different participant described that being a mother had helped her to manage the psychological difficulties of war. She explained that "before the baby came, we [my husband and I] always thought about the difficult circumstances of my family, and conditions of the displaced, and what happened to Sinjar. But after the birth of my child, we care a lot about him."[69] Another described that becoming a mother brought her closer to her husband and in-laws.

As in South Sudan, mothers in the KRI worried about meeting the basic needs of their children—although their concerns were generally less dire than in South Sudan. In the KRI, mothers were concerned about the quality of food, wanting to be able to pay for (non-life threatening although important) medical procedures, and future educational and economic opportunities for their children. Some mothers in the KRI also described missing their pre-motherhood freedoms and described being overwhelmed by the responsibility of motherhood. A few had wished that they could work but they had felt it was not appropriate to work with small children at home.

6. The Intersection of Mental Health and Disability

Female youth living with disabilities face social exclusion, harassment, and difficulties accessing school. Most feel that they are a burden to their families.

This study followed a small sub-sample of female youth living with physical, psychological, and intellectual disabilities across the two countries (n = 12). The most marked challenge for these participants—regardless of type of disability—was social isolation and exclusion, and the accompanying negative mental health repercussions. One form of isolation stems from participants' inability to attend school *because* of their disability. Schools were either not accessible to adolescent girls with physical disabilities, did not provide specialized services or adaptations for learning needs, or did not provide extra support or flexibility for those participants who missed school due to medical procedures or chronic illnesses. In South Sudan, an 18-year-old described how her severe vision and hearing impairments affected her ability to attend school regularly: "[These physical problems] really affect my life. They don't let me live well. When it becomes painful, I stay in the house and sleep. I can't go to school, I can't communicate with people, and sometimes I bleed from my ears. When I have severe headaches, I go to the hospital to ease the pain, but after some time, it starts again. It has always been like this [since infancy]."[70]

Female youth with disabilities who did not attend school lacked social connections with peers, had few opportunities to engage in activities, and no culturally appropriate space outside the home where they could participate in broader society.

[67] Interview with participant # KRI_CO_27_F_M_20, Kurdistan Region of Iraq.
[68] Interview with participant # KRI_CO_113_F_M_20, Kurdistan Region of Iraq.
[69] Interview with participant # KRI_CO_112_F_M_22, Kurdistan Region of Iraq.
[70] Interview with participant # SS_CO_30_F_DIS_18, Juba, South Sudan.

Participants living with disabilities often described that their lives were exceedingly narrow, and these circumstances made them feel "psychologically not good," "depressed," or angry or combative with family members. A 19-year-old participant in Juba, whose physical disability prevented her from attending school, described: "I have a lot of difficulties. I can't go to school or work because of my difficulties. This makes me think a lot about my life and makes me very emotional…[Other girls my age] can go to the tap and get water for their houses. They can do physical activities that I cannot do. Sometimes I faint when I try and do physical things. Most of the time I just stay at home."[71]

Many participants with disabilities described feeling burdensome to their natal families. This "burden" was described along several lines—they anticipated not marrying and would reside with their natal families indefinitely, they were not skilled or educated enough to earn an income to support their families, or their disability prevented them from working. A Syrian refugee living with a physical disability described her reduced aspirations: "I used to want to be a doctor and help treat sick people. But now I just want not to be a burden on my family."[72]

Some described how their disability could be debilitating. One Yazidi youth explained that her struggles are both a cause of conflict-related traumatic experiences and are exacerbated by living in displacement. She faints multiple times a day and must therefore always be accompanied by a family member. This condition also prevents her from attending school regularly: "My psychological situation is so bad; it can't get any worse. I'm very, very sick. I have headaches all the time, and sometimes I can't breathe properly. I lost my father and my three brothers. My brother died in front of me [he was electrocuted in the camp]. I think about things, and I fall down and I don't know what is happening around me…When I think too much, or when I feel very sad, I fall down."

In addition to the death of several family members, her older sister and her cousin were captured by ISIS in 2014 and have not returned. She described, "I've never been to a doctor's clinic…sometimes NGOs visited us, and they told me that it was because of my thoughts, my history, that I faint."[73] She has never received any specialized treatment for her symptoms.

Participants in both countries explained that girls with disabilities are usually considered unmarriageable. If they do marry, they are expected, in South Sudan, to either bring less bridewealth or be one of many wives. In the KRI, a disabled female is most likely to marry a disabled or widowed male. One participant with a disability in South Sudan had become pregnant by her boyfriend. He had promised to marry her during the pregnancy but later withdrew the offer. She explained: "He is here in the POC [Protection of Civilian site], but he does not communicate with me anymore. Since I had my child he has never seen him and does not support him in any way. My mother went to meet him, and he told her that he wants his child and he will not marry a crippled girl…I feel bad because people don't want me and they see me as nothing because I don't have one leg."[74]

A 14-year-old participant in Bentiu had a chronic fainting problem that prevented her from attending school. Her father had betrothed her to a man she didn't know, and, at the time of the interview, she had been spending nights with him until the marriage was secured. She had become pregnant. When asked how she felt about the marriage, she said, "I just accept what [my father] told me, because [the man] will marry me." She also described that she has few friends because she "mostly stays at home."[75]

Participants living with physical disabilities described regular social ridicule and harassment in public. This type of ostracization had profound impacts on their mental health. A Syrian refugee

[71] Interview with participant # SS_CO_1_F_DIS_19, Juba, South Sudan.
[72] Interview with participant # KRI_CO_106_F_DIS_23, Kurdistan Region of Iraq.
[73] Interview with participant # KRI_CO_13_F_DIS_22, Kurdistan Region of Iraq.
[74] Interview with participant # KRI_CO_16_DIS_20, Bentiu, South Sudan.
[75] Interview with participant # SSB_CO_22_DIS_14, Bentiu, South Sudan.

who has severe visual impairment explained why she had dropped out of school before completing one year: "My childhood wasn't happy. I couldn't see anything properly and because of that I couldn't play with any children. All the children around me were bullying me, and I escaped from them by hiding at home. They were laughing at me. This was both in the school and in the neighborhood."[76]

A Yazidi participant with a disability who had graduated from Mosul University described being bullied throughout childhood and adolescence. She explained the continued experiences of discrimination when traveling with her NGO colleagues: "When we go to any area—for example, when we cross a checkpoint—even though I am in an NGO vehicle, they stop us every time. They say, 'Who is this person? Why is she with you, I don't believe she is working with you.' This makes me very sad. Yesterday I came from Erbil with an NGO, and there wasn't a single checkpoint that we crossed without this question."[77]

She described that people with physical disabilities are seen as "less than" in their families and communities, and she was aware of several cases of suicide because of harassment and exclusion. This participant, however, is an excellent example of a female youth living with a disability who is exceptionally resilient in the face of hardship. She has dedicated her life's work to promoting the inclusion of people living with special needs. Another participant, a Syrian refugee living with a severe physical disability, had started a small business in a camp with the help of an NGO. Both of these participants said that their families were instrumental in providing them with support; their parents treated them as worthy and capable, and attempted to protect them against the most damaging forms of ostracism and exclusion. The Yazidi woman described the source of her fierce strength: "My family was very supportive of me. Not just financially because it is not all about money. They were emotionally supportive of me. They said things like, '[Participant name], you can do it, you are a strong person, you can achieve all of your goals.'"[78]

7. Sources of Strength, Well-Being, and Resilience

Female youth across all marital categories described that they derived strength and well-being primarily from social connections, including with friends, boyfriends, husbands, members of their natal families, and in-laws. Others emphasized their religious beliefs, their educational goals, or supporting others as key components of their well-being.

Researchers asked participants in both countries about the aspects of their lives that provide them with strength and a sense of well-being. Participants across marital statuses overwhelmingly spoke about the importance of social connections—with boyfriends, husbands, friends, and members of their nuclear and extended families (both natal and in-laws). Inversely, the absence of these social connections negatively influenced the well-being and psychosocial functioning of this population. Participants often described the importance of sisters and mothers when explaining who they admired, derived strength from, and confided in. Some also named aunts, fathers, and husbands. Others listed close female friendships. A 23-year-old displaced Yazidi in the KRI explained: "Because of the support and qualities of my father and mother, I can face any challenge in life. In 2014, we were displaced, and I lost the hope of going back to school. But my father and mother gave me so much support and helped me continue with my life. I was able to graduate and receive a certificate. Whenever I face any issues in my life, I can discuss it with my

[76] Interview with participant # KRI_CO_23_F_DIS_20, Kurdistan Region of Iraq.
[77] Interview with participant # KRI_CO_20_F_DIS_23, Kurdistan Region of Iraq.
[78] Interview with participant # KRI_CO_20_F_DIS_23, Kurdistan Region of Iraq.

father and mother. I can discuss everything with them."[79]

A divorced participant in the KRI who had been abused and rejected by her natal family described the importance of a particular friend. She hopes to help other female youth in the way this friend helped her:

> I would like to mention a name, and I want you to remember it. "M" had been in the same situation as me—she had been married, she had been abused, she had had children, she was wearing a hijab, then she stopped and then she was threatened. She supported me so much. She would help me even in the middle of the night. She told me, 'You are not wrong, everyone else is wrong. You need to try and convince them.' So in the end, I did the correct thing. I felt encouraged and I started to gather girls with UNHCR and teach them about their rights. I want to be like "M" was for me, for other girls. I want to be a mentor and a role model for other girls."[80]

In South Sudan, the tone was similar, such as expressed by this 23-year-old widow: "When I go to my friends in the community, we tell stories and it makes me feel better. I have three friends here in the camp, and we meet every day."[81]

As discussed earlier, many mothers derived strength from their children, regardless of their marital status and in spite of economic difficulties of raising children in displacement settings. A 19-year-old from Juba, who married at 17, described, "I feel good because I have this baby. Every time I look at her, I feel happy."[82] A widow in the KRI explained:

> I know you have asked me to share with you a picture of something very meaningful or important for me. I thought about it for long time, and I decided what gives me hope and fulfills my life is my children. Although God gives me hope, my life is my children. When I see them in front of my eyes, I see a bright life, a wonderful future like a beautiful flower. And when I feel sad or feel like I am hopeless, I look at my children and feel so better. That's why I want to take good care of them so they can have a perfect life.[83]

Religious faith as a source of strength was a common theme among participants in the KRI. Some female youth described that they lacked positive relationships—either with family or community—and that they relied on themselves and their faith to get them through. A 23-year-old living with a physical disability who had faced harassment and social exclusion had recently converted to Christianity. She explained that this had incensed several family and community members, but that her faith gave her the strength to stand her ground: "[Family and neighbors] said to me [about my religious conversion], 'This is wrong, you are doing something bad.' I tell them, 'You will not be in my grave. I will be accountable for my own life. I can have my own beliefs.'"[84] Others talked about taking strength directly from God or feeling empowered and soothed after reading from the Qur'an during times of distress.

Several participants in the KRI and South Sudan who had been abused by relatives or friends (husbands, family members, or friends) described an increased sense of self-reliance and a loss of trust in others. A 20-year-old divorced participant explained: "I talk to myself and express my feelings, and I lean on myself. When I was married, I was trying to ask for support from my mother-in-law but she told others lies about what I was saying. I lost trust in everyone. I try to rely on myself now. I know that life will never stop. I need to continue. I need to be strong by myself."[85]

In South Sudan, a 21-year-old widow explained: "Now that I have children, I am the only one taking care of them. I push myself to look after them and sell tea. I don't dwell on the past, and I focus only on the present."[86]

[79] Interview with participant # KRI_CO_117_F_U_23, Kurdistan Region of Iraq.
[80] "M" name shortened to maintain confidentiality. Interview with participant # KRI_CO_4_F_D_23, Kurdistan Region of Iraq.
[81] Interview with participant # SS_CO_10_F_W_23, Juba South Sudan.
[82] Interview with participant # SS_CO_5_F_M_19, Juba South Sudan.
[83] Interview with participant # KRI_CO_33_F_W_35, Kurdistan Region of Iraq.
[84] Interview with participant # KRI_CO_F_DIS_20, Kurdistan Region of Iraq.
[85] Interview with participant # KRI_CO_9_F_DIV_20, Kurdistan Region of Iraq.
[86] Interview with participant # SS_CO_12_F_W_21, South Sudan.

Those who were enrolled in school regularly cited their education as a source of strength. A divorced participant from the KRI described how education became a coping strategy to buffer against the negative pushback from family and community: "The community wasn't accepting me [because I was divorced]. Even my relatives were talking about me negatively. I started to challenge myself and push myself to study. I was the first one in my class, I got 99 out of 100. Then they started to look at me differently."[87] She is now enrolled in university.

Several participants in the KRI described how they felt a sense of meaning and pride when they were able to help others. This included volunteering for camp management or local NGOs to support new arrivals or vulnerable families. One divorced participant was active in creating supportive networks for abused girls and women. As described in the previous section, another Yazidi participant designed, sought funding for, and implemented projects (on her own) to help support people living with special needs in Sinjar.

8. Services

- ***In South Sudan, female youth reported a complete absence of focused and specialized MHPSS services in their displacement camps. Participants described the need for improved education, prevention of early and forced marriage, support groups, and improved skills in communication for families.***
- ***In the KRI, focused and specialized MHPSS services were uneven. Specialized MHPSS services were often inaccessible due to their location and cost of treatment. Participants in the KRI requested focused and specialized MHPSS services, as well as supports to strengthen community and family.***

This research project did not include comprehensive mapping of available services, including MHPSS projects or programs, in the study locations. As such, what is reported here is based only on the perceptions and direct experiences of study participants. As will be described, depending on the location, participants longed for supportive interventions at all levels of the Interagency Standing Committee (IASC) MHPSS Intervention Pyramid[88]—from basic services, to strengthening community and family supports, to focused and specialized mental health services. See Annex A for a reproduction of this pyramid.

In South Sudan, participants from the Juba POC, Bentiu POC, and Mangateen IDP camps in Juba were unaware of any support services for female youth related to mental health or psychosocial well-being. When participants were asked about what they thought was needed "to help female youth like you in the community with the challenges they face," education was the most frequently cited response. Participants spoke about the need to educate parents on the importance of sending girls to school, the need to provide girls with emotional and logistical support to attend school and vocational trainings, and material support such as school fees, materials, or menstrual supplies. They linked education and skills to greater independence and self-sufficiency, including anticipated economic improvements and pride. One participant, a 23-year-old widow, talked about the negative side of a female youth being dependent on others: "Girls should be taught how to work in different areas so they can work and buy the things they want, and pay school fees, so they don't always wait for someone to give them something. Girls should be given [vocational/livelihood] trainings on different things, so they can do for themselves."[89]

The majority of participants in South Sudan also named the prevention of early marriage and forced marriage as priority areas to improve the overall situation of girls in their communities. A few

[87] Interview with participant # KRI_CO_17_F_DIV_19, Kurdistan Region of Iraq.
[88] UNICEF, "Community-Based Mental Health and Psychosocial Support in Humanitarian Settings," 15.
[89] Interview with participant # SS_CO_48_F_W_23, Juba, South Sudan.

participants in South Sudan asked specifically for help with communication skills in order to reduce family tensions and support their mental and psychosocial health needs. A 19-year-old participant who had an unintended, underage pregnancy described the need for stress management skills: "Girls should be taught how to deal with stress because a lot of girls have a lot of stress, and sometimes they even want to commit suicide." And, in a similar vein, this 20-year-old divorced participant suggested that "girls should be given a training so that they can talk to each other about their problems, so that they can learn from each other and give each other support."[91]

In the KRI, participants had more contact with focused and specialized MHPSS services than in South Sudan, although the availability of free services was inconsistent across research sites, and other services required travel and/or payment, which was often not possible for participants. A key informant explained that some locations where refugees and IDPs reside have no focused or specialized MHPSS services. The services that do exist in camps are very limited and generally not considered good quality because of a lack of professional training. Also in camp settings, MHPSS staff reside within or are embedded within the community, so many people fear that confidentiality will not be respected. Private psychiatric services are limited and expensive (20 USD/session), and transport costs can be exorbitant.[92]

Five participants in the KRI described having contact with focused and specialized MHPSS services, although such services were often intermittent or not well adapted to participant needs. The research team referred three participants, with their consent, to NGOs for MHPSS services, with largely negative results. One organization never made contact with the participant. The second organization conducted a home visit with a divorced 19-year-old who had expressed suicidal ideation, only to later tell the research team, "She is fine, she comes from a caring and loving family. We see girls like her a lot, those that make up stories and make their lives look hard because they want support from NGOs."[93] After her symptoms worsened, the participant's family became alarmed and agreed to bring her to a private psychiatrist for treatment. She reported significant improvements as a result of her sessions. Another divorced female youth had a negative experience with a mental health worker at one of the camp's Women's Listening Centers.[94] She explained:

> Participant: I prefer to talk with myself and to try and support myself. The doctor was asking me questions, and he was making me feel worse.
> Interviewer: The counselor was a man at the Women's Listening Center?
> Participant: Yes…the problem I had was the type of questions he was asking. He was asking me about having sex with my husband, and how I felt about it. I told him that he would beat me before sex and he would beat me after. These conversations would make me have flashbacks, and that is why I prefer to do this alone.[95]

As described above, focused and specialized MHPSS services were often nonexistent in camps. One female youth living with a disability was referred to a doctor at a hospital, but she was unable to afford the medication prescribed, so her debilitating symptoms continued. This participant had attended a support group in her location that she found very helpful, but because of COVID-19 the service was suspended. A married participant in another location described that she wanted mental health support but was unable to find service providers. She described, "I have a psychological sickness—my situation isn't good. Sometimes I can't breathe properly...I also have headaches. We don't have the financial resources to see a doctor. There are no NGOs around us that provide this kind of treatment…Since I was married, I had this problem."[96]

A few participants in the KRI had connected with service providers that they felt helped them with their mental health and psychosocial difficulties. This included medical doctors who prescribed medications for symptoms that helped some participants "relax"

[90] Interview with participant # SS_CO_15_EP_19, Juba, South Sudan.
[91] Interview with participant # SS_CO_42_DIV_20, Juba, South Sudan.
[92] Interview with key informant # KRI_KII_3_F, Kurdistan Region of Iraq.
[93] Interview with participant # KRI_CO_36_F_DIV_19, Kurdistan Region of Iraq.
[94] A key informant explained that a Women's Listening Center generally provides women with social, recreational, legal, and psychological support.
[95] Interview with participant # KRI_CO_9_F_DIV_20, Kurdistan Region of Iraq.

and "sleep." Another described attending support sessions for ISIS survivors: "I relax a lot when I go to these sessions. I meet new friends and hear other people's stories...it gives me a good feeling."[97] A widow described that she sees a psychiatrist to "help her cry," and a divorced participant described visiting a medical doctor regularly and reported that "he is very supportive, he puts me at the end of his patient list, so he can sit down and talk to me at the end of the day. He makes jokes and we laugh. He knows about my situation. Every time I visit him, I feel better and I have positive feelings."[98]

Several participants in the KRI expressed a clear need for MHPSS services, ranging from focused to specialized support. Participants spoke about the urgent need for a safe, physical space for girls and women to congregate. A Syrian refugee who is 20 years old and living with a physical disability described, "There should be clubs or places for women and girls…to have activities and receive psychological support…it is the girls who need psychological support that have the most need [in the community]."[99] Others talked specifically about the need for specialized services for divorced girls, survivors of ISIS captivity, or girls living with disabilities, as they have the most marked emotional distress. As in South Sudan, a few participants also described the need to support parents of girls and overall skills training to improve communication within families. A 17-year-old unmarried respondent felt that female youth need "centers where they can receive support like mental support, mentoring sessions, awareness, small projects…especially now that most of the girls don't have a good relationship with their families."[100] Others talked about how female youth, particularly those who are in distress, need specialized, low- or no-cost services from skilled psychiatrists.

9. The Research Process as an Unintended MHPSS Intervention

Respondents described that the process of participating in the study itself improved their well-being.

The research team asked participants to reflect on their experiences of having been involved in the study. We were surprised at how often participants described the research process as having had a positive impact on their well-being. Many described that it had "helped" them and that they shared things with the research team that they hadn't shared with others. Participants uniformly expressed a wish for the study to continue. The female youth who seemed to particularly benefit from the study were some of the most isolated and socially excluded, as well as those who had had particularly severe traumatic experiences. The research team had not expected such positive reflections from participants, but we hypothesize that it is related to the design of the study itself. As described in the methods section, the research process was participatory, and respondents were able to largely direct the content of discussions and expressive materials (e.g., drawings and photography). Participants were followed over time, which assisted in the development of a trusting relationship between researcher and participant. Researchers were formally trained in trauma-informed research methodologies. Their experiences of the research process are described below.

A 19-year-old participant from South Sudan, who lives with a disability, described that the study "helped" her "psychologically."[101] An Iraqi Arab who is widowed described, "Your calls to me helped me to feel better…knowing that someone is asking about me, how I am…especially because I don't go out very much."[102] A Yazidi youth described,

[96] Interview with participant # KRI_CO_25_F_M_19, Kurdistan Region of Iraq.
[97] Interview with participant # KRI_CO_112_F_M_22, Kurdistan Region of Iraq.
[98] Interview with participant # KRI_CO_9_F_DIV_20, Kurdistan Region of Iraq.
[99] Interview with participant # KRI_CO_23_F_DIS, Kurdistan Region of Iraq.
[100] Interview with participant # KRI_CO_11_F_U_17, Kurdistan Region of Iraq.
[101] Interview with participant # SS_CO_1_F_DIS_19, Juba, South Sudan.

"I'm very sad to know that this study will be over. I looked forward to talking each month. It forces me to reflect on what I've done and how I've changed. It is like a motivation for me, and it also helps me psychologically."[103]

A Syrian refugee widow described her experience of being interviewed: "I cannot tell people the things I tell you. People will laugh at me or they won't understand. I am so happy that you understand me, and I feel so good now"[104] Another participant, who was divorced and the target of abuse by her family and community, reflected on her experience in the study: "I want to thank you so much for checking in on me. Whenever you call me, even if it is once a month, I feel like there is someone caring about me, [says first name]. And someone is hearing me. If I disappeared one day, I know you would still be thinking of me. Don't worry, nothing will happen, but I just wanted to say thank you."[105]

An 18-year-old widow in South Sudan said, "Thank you so much for listening to me. I feel comfortable with you, and I would be so happy to talk to you again. I've never had this type of talk with someone in the POC, ever."[106] And a 20-year-old divorced Syrian described, "I feel very relieved. I told some things that I've never told anyone before, not even my mother. I am happy to be listened to."[107] Based on these responses, we hear that participants appreciate being listened to and cared for—and that the researchers were perceived as trustworthy with intimate and sensitive information. The fact that researchers bore witness to the participants' stories—past and present—also appeared to have a supportive and perhaps even healing affect.

10. Patriarchy

Poor mental health and psychosocial functioning among participants, at their root, stem from patriarchal norms and gender inequalities—dictating the types of abuse and deprivation they suffer, as well as family, community, and legal responses.

Participants in both countries regularly cited that patriarchal norms and related gender inequalities negatively impacted the well-being of female youth living in displacement. These norms and inequalities are integrated throughout the paper, but will be summarized here. Female youth experienced a wide range of abuses linked specifically to their gender, which negatively impacted their mental health and psychosocial functioning and prevented them from living up to their full potential. This included systematic sexual, physical, and emotional violence and other forms of abuse perpetrated by fathers, uncles, brothers, neighbors, employers, representatives of government and humanitarian organizations, and armed actors. Female participants experienced forcible marriage through the threat of violence and actual violence. Bridewealth practices in South Sudan are seen as a driver of early and forced marriage, and prevent many girls and women from leaving abusive marriages. Other participants faced stigmatization by their families and communities if they had an unintended pregnancy, or were divorced or widowed—with girls and women consistently being blamed for their situations. Each of these categories of participants faced economic deprivation and unwanted loss of custody of their children as well. Many were unable to attend school, engage in economic activity, socialize, or move freely. In addition, girls and women are often socially policed—where they go and at what time, what they wear, where they work, and with whom they speak. Falling outside of these strict social codes can have devastating reputational consequences for the girl and her family. As described above, female youth

[102] Interview with participant # KRI_CO_30_F_W_35, Mosul, Iraq.
[103] Interview with participant # KRI_CO_15_F_U_26, Kurdistan Region of Iraq.
[104] Interview with participant # KRI_CO_38_F_W_35, Kurdistan Region of Iraq.
[105] Interview with participant # KRI_CO_4_F_D_23, Kurdistan Region of Iraq.
[106] Interview with participant # SS_CO_31_F_W_18, Juba, South Sudan.

also described falling victim to abuse on social media—usually when an ex-boyfriend shared images of her without her consent.

Patriarchal norms also manifest in the lack of protective action and services for the above-described abuses—whether within the family, community, or at the state level. Patriarchal and structural gender inequalities within families, schools, and public spaces also limit access to education for girls as well as livelihoods opportunities. These circumstances together, unsurprisingly, create a set of stressors, traumatic experiences, and unequal opportunities for girls and women that lead to perpetual mental health disturbances, psychological vulnerabilities, and difficulties in attaining a sense of well-being, with few informal or formal services to support them.

These norms and inequalities are not merely our interpretation as outside researchers engaged in a critique of "other," non-Western cultures. These themes and injustices were introduced by the participants themselves.[108] The following recommendations should be embedded within a broader understanding of structural patriarchy and gender inequality.

11. Recommendations for Humanitarian Action

Advocacy and policy

» Advocate for donors and decision makers to further acknowledge that early marriage and its aftermath have a broad variety of social determinants and that they have the potential for long-term negative impact on mental health, well-being, and functioning.

» Advocates and policy makers should understand the differential needs of girls who married as children, as well as those who later divorced or were widowed.

» Advocate for consistent inclusion of cross-sectoral, multilayered MHPSS in humanitarian responses that include both the prevention of and response to early marriage.

» Use the opportunity to influence governments committed to the call for action against child marriage—referring to the Sustainable Development Goal 5, particularly by addressing target 5.3 on ending all harmful practices such as child, early, and forced marriage—to include MHPSS on all levels of policy, investment, and implementation.

» Advocate for IASC Guidelines on sexual and gender-based violence (SGBV) in humanitarian action to include key insights and findings from the research, with a focus on contextualized, participatory solutions.

» Advocate for IASC Guidelines on MHPSS in emergency settings and accompanying guidelines on SGBV, to consider new findings from this research, with a focus on the varied social determinants for mental health and well-being of young females in early marriage, as well as those who are divorced, widowed, experience early pregnancy, and/or live with disabilities.

» Advocate for enhanced support to—and investment in—integration of MHPSS in health and nutrition programs, including infant and young child feeding (IYCF), with a special focus on early pregnancy and motherhood.

» Advocate for earmarked funding for humanitarian response capacity on social determinants, prevention, and response to early marriage in case management, livelihoods, violence prevention, and other relevant sectors.

Programming

» Continued and deepened support for cross-sectoral, multilayered MHPSS, with a special attention to girls/young women with different

[107] Interview with participant # KRI_CO_9_F_D_20, Kurdistan Region of Iraq.
[108] See the briefing paper on "Perspectives on early marriage" on our project website: https://fic.tufts.edu/research-item/child-marriage-in-humanitarian-settings/.

marital statuses, including female youth after early marriage, divorcees, and widows, as well as girls who had early pregnancies and/or are living with disabilities. This includes protection, education, health, and livelihoods responses. For example:

  - Education should be made more accessible, including for engaged, married, pregnant, post-partum, divorced, and widowed youth. Special efforts should be made to reach female youth living with disabilities.
  - Female youth in all these categories spoke of the importance of livelihoods skills programs, which female youth see as a source of social interaction, improved well-being, greater independence, and enhanced gender equality. Livelihood trainings should be designed with the participation of the female youth and their communities. They should take place only after a thorough market assessment of market demand and market saturation. Trainings should provide enough skills and start-up support to foster successful outcomes.

- Interventions should include all four levels of the "MHPSS Pyramid" and should also include:
  - Rapid, free crisis services available to female youth living in displacement, as participants expressed suicidal ideation, have attempted suicide, and/or are experiencing ongoing or imminent abuse and violence.
  - Safe, culturally appropriate physical spaces for female youth to congregate and socialize, and engage in activities, including but not limited to MHPSS-focused services.
  - Female youth in the study requested specific MHPSS skills related to improving communication within families, stress management, and general psychological support.
- Ensure and strengthen coordination between SGBV and MHPSS/health working groups on the ground, with special attention to girls and young women experiencing early marriage.
- Prevention of all forms of violence, exploitation, abuse, and neglect includes attention to risks and determining factors for early marriage.
- Responses and programs should include a focus on resilience and prevention and, as always, be based on solid local partnerships and include participation of the children/young people themselves.
- Improve the training and skill sets of MHPSS staff within humanitarian settings to be more trauma focused, gender sensitive, age sensitive, and culturally appropriate, with an emphasis on respecting confidentiality. This could also improve by increasing the number of females who work with psychological first aid and within existing women's centers.
- Despite the above recommendations, programs will still take place in a global society characterized by gender inequality and patriarchy. While rectifying these aspects is beyond the scope of humanitarian interventions, humanitarian actors and programs should seek to ensure the protection of, inclusion of, and positive messaging to girls and women throughout all aspects of their work. Staff at such organizations should engage in regular and continuous training to recognize patriarchal and gender-unequal structures, and to assist staff in modelling appropriate behavior. Allies could also be sought in the community as partners for supporting social normative change.

Recommendations for research to inform programs

- Participatory research can be viewed in and of itself as a form of MHPSS intervention. Female youth are eager to participate in research, brainstorm, and problem-solve solutions to their situations. More research should be conducted to co-design solution-focused interventions and test their efficacy within specific populations.
- More research should be conducted on trauma scales, CYRM, and the SDQ to understand their validity and relevance for a wider range of populations, languages, and cultural contexts.
- More research should be done on social norms and processes for normative change regarding expressions and practices of patriarchy and gender inequality that harm the well-being of female youth. This research could inform the

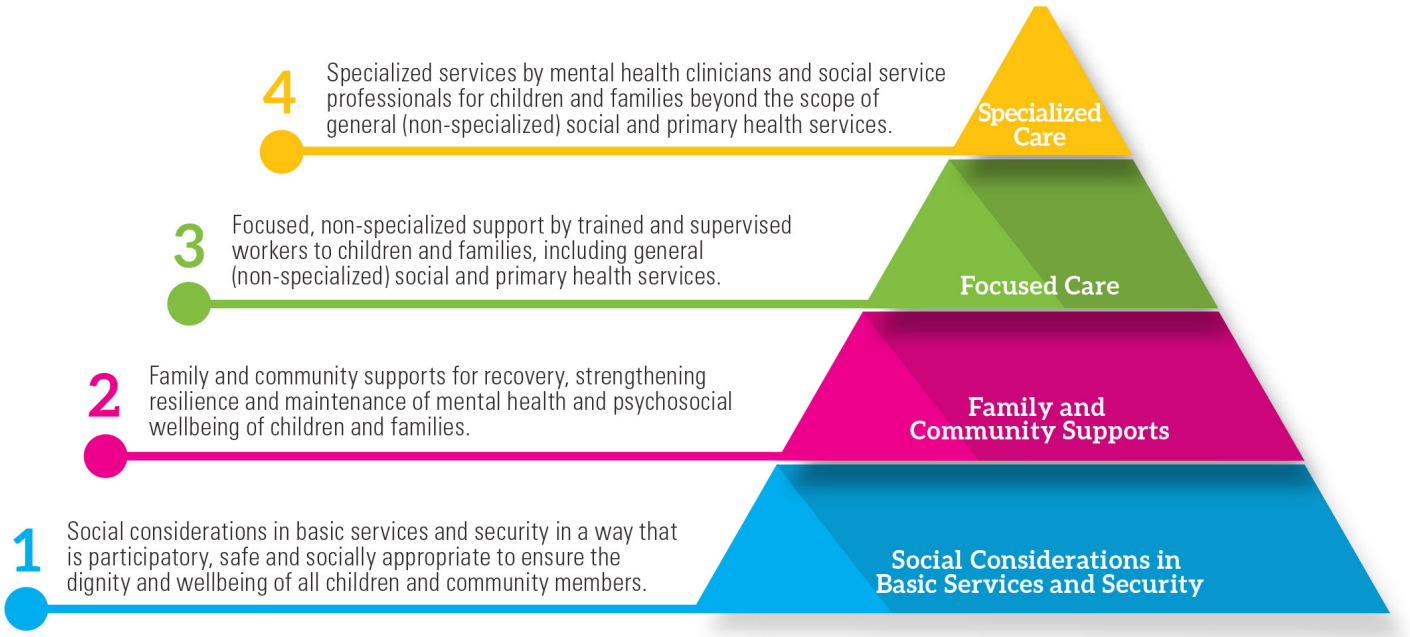
design of interventions to support positive change.

  - In addition, more research should be conducted on unpacking the causes and correlates of shame and pride.
  - Relatedly, additional research should include men and boys about their experiences of living in displacement and their roles and interactions with girls and women.

- In reference to the Children in Armed Conflict Agenda[109] and given the dynamic nature of conflict in both settings (e.g., Turkish bombardments in Sinjar, continuing political uncertainty and violence in South Sudan), longitudinal mixed-methods research is important to follow these and similar populations as they face threats and actual insecurities to understand the impacts on MHPSS, resilience, and what services could be developed in a dynamic situation.

[109] For more information see: https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/conflict-post-conflict/csos/Save-the-Children.docx.

Annex A. The IASC MHPSS Pyramid



Annex B: Description of Quantitative Scales to Measure Trauma, Resilience, and Emotional and Behavioral Functioning

As described in the body of the report, the research team asked participants to answer standardized questions along three separate scales in order to better understand their histories, resilience, and aspects of their emotional and behavioral functioning. These scales included: 1) a customized checklist to quantify traumatic experiences; 2) the Child and Youth Resilience Measure (CYRM);[110] and 3) the Strengths and Difficulties Questionnaire (SDQ).[111] All three scales were administered once and are based on self-reporting. The trauma checklist was created by the research team, borrowing items from established trauma checklists[112] and adapting the roster to be more gender sensitive and reflective of traumatic events likely to have occurred in each study site. The trauma checklist was translated into Arabic and Nuer by the research team. The SDQ and the CYRM were chosen because they have been widely used around the world and translated into dozens of languages. For this study, the research team relied on the existing Arabic translations of the SDQ and CYRM for the KRI sub-sample. For South Sudan, both scales were translated into Nuer by the South Sudan research team. As mentioned above, the sample of research participants is not representative, and as a result, we cannot generalize these findings to larger communities or cultures. However, the sample size is large enough to conduct statistical analyses across the sample and between specific sub-groups within it. In total, 73 participants completed all three surveys, 27 in South Sudan and 46 in the KRI. The English versions of the trauma scale developed for this project can be requested from Kimberly Howe.

Average scores on measures [113]

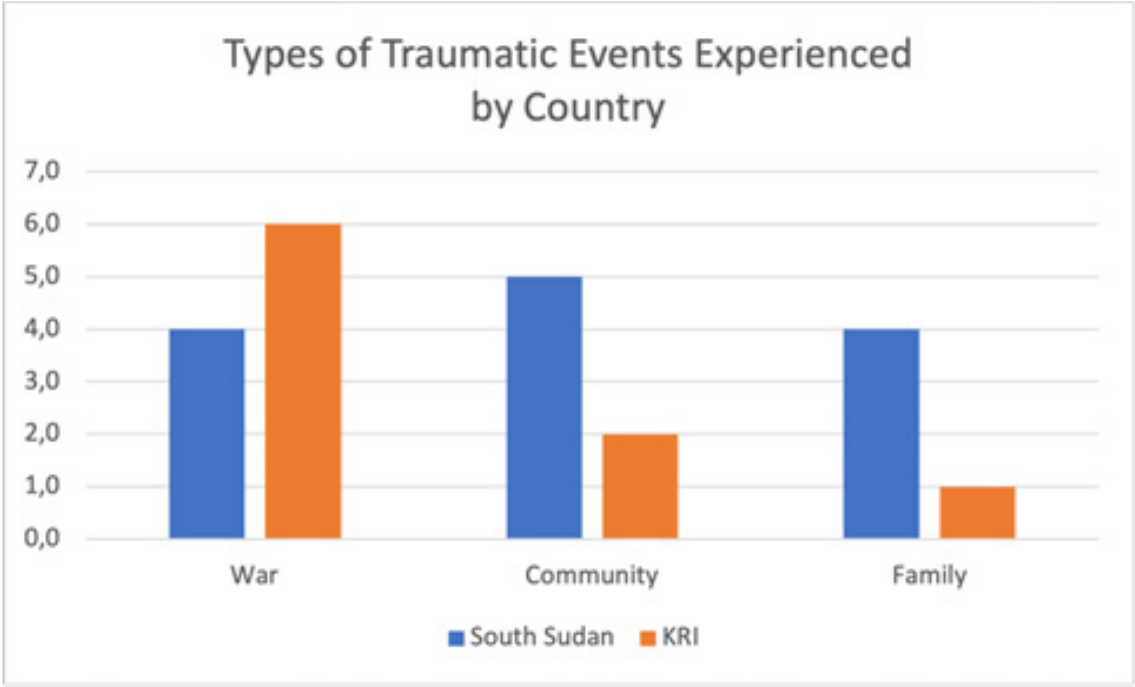
Trauma scale

Participants from the KRI and South Sudan samples experienced a large range of traumatic events, with an average of 14 types of traumatic events per participant[114].

As part of the trauma checklist, 32 traumatic events were grouped into three types of traumatic experiences—those perpetrated by family, by community, and as part of conflict and war.[115] Within each category, statements covered emotional, physical, and sexual traumas. Participants were read a statement about a traumatic event and asked if they had experienced such an event in their lifetime by responding yes, no, or "I prefer not to answer." The scale thus identifies the range of traumatic events experienced by a participant. Note that this scale does not indicate the number of times a participant experienced each event. Participants across both samples, experienced an average of 14 types of traumatic events. In the KRI, the average was 12.5 and in South Sudan, the average was 15. Participants in the KRI experienced slightly more types of war-related traumatic events than those in South Sudan, but this difference was not statistically significant. However, participants in South Sudan were significantly more likely to have experienced more types of traumatic events coming from community and family than in the KRI sample.[116] It should be noted that all traumatic experiences included on the checklist

[110] Resilience Research Centre, "CYRM and ARM User Manual" (Halifax, Nova Scotia: Resilience Research Center, Dalhousie University, 2018), http://www.resilienceresearch.org.
[111] Goodman, "Strengths and Difficulties Questionnaire."
[112] This includes the Childhood War Trauma Questionnaire (Macksoud, 1998); the Gaza Traumatic Events Checklist (Thabet & Thabet 2017); and the Harvard Trauma Questionnaire (HTQ) (Harvard Program on Refugee Trauma).
[113] The averages reported in this section refer to median scores.
[114] UNICEF, "Community-Based Mental Health and Psychosocial Support in Humanitarian Settings," 15.
[115] We acknowledge that a respondent could have had an experience that fit into different categories, as these categories are not mutually exclusive. We allowed the respondents to categorize these experiences in the way they saw fit without seeking additional information.
[116] P value of 0.02 for community trauma; p value of < 0.01 for family trauma.

Figure 3: Average Number of Traumatic Events Experienced by Country



are severe (e.g., forced marriage, detained by armed group member, witnessing a loved one tortured or killed, sexual violence from a community member, exploitation from a family member, etc.). Experiencing 12–15 types of severe traumatic events—particularly for female youth, most of whom are under 24 years—is extraordinary. Figure 3 displays the average number of traumatic events experienced by country.

Strengths and Difficulties Questionnaire (SDQ)[117]

Participants in South Sudan, on average, scored "very high" on the SDQ for experiencing emotional problems. Participants in the KRI, on average, scored "high" on the SDQ for both emotional problems and peer problems.

The SDQ is designed to measure different aspects of emotional and behavioral well-being in children and young adults. Participants were read 25 different statements and asked if the statement was "not true," "somewhat true," or "certainly true." These statements correspond to five separate scales that measure emotional problems, conduct problems, hyperactivity, peer problems, and pro-social behavior. In South Sudan, the median score across the sample was "average," except for the emotional problems scale, where participants scored "very high."[118] In the KRI, participants had average scores on the conduct, hyperactivity, and pro-social measures, but scored "high" on both the emotional problems scale and peer problems scales. In combining the two samples, the median score for all participants was "high" for both emotional problems and peer problems.[119] These results indicate that female youth across both samples demonstrate significant emotional problems—as evidenced by headaches, worry, sadness, nervousness, and having many fears. Emotional problems of this type are consistent with high levels of traumatic exposure.[120] The KRI sample experienced elevated problems with peers that involve feeling solitary, having few friends, not being liked by others, being bullied by others, or getting on better with older people than people their own age. As is discussed throughout the paper, female youth in the KRI struggle

[117] Goodman, "Strengths and Difficulties Questionnaire."
[118] The SDQ scoring guidelines present four categories for scoring: 1. close to average (or normal); 2. slightly raised; 3) high; and 4) very high.
[119] The median scores for the scales are as follows 1) Emotional Problems: KRI = 6, South Sudan (SS) = 7, Total Sample = 6; 2) Conduct Problems: KRI = 3, SS = 1, Total Sample = 2; 3) Hyperactivity: KRI = 5, SS = 1, Total = 3; 4) Peer Problems: KRI = 4, SS = 1, Total = 4; and 5) Prosocial Behavior: KRI = 10, SS = 10, Total = 10.
[120] Judith Herman, Trauma and Recovery (New York: Basic Books, 1997); Bessel van der Kolk, "Posttraumatic Stress Disorder and the Nature of Trauma," Dialogues in Clinical Neuroscience 2, no. 1 (2000): 7–22.

with social isolation, curtailed movement, and difficulty accessing school. They face community gossip and harassment.

Resilience (CYRM)[121]

Participants in South Sudan, on average, scored in the "low" range for resilience, while KRI participants scored, on average, in the "high" range for resilience, as measured by the CYRM.

As part of the CYRM, participants were read a series of 12 statements and asked the degree to which they agreed with the statement ("not at all," "a little," "somewhat," "quite a bit," "a lot"). To aid participants with these five choices, they were shown a picture of five water glasses with varying amounts of water in each glass with "not at all" being empty and "a lot" being full. These statements are meant to measure resilience from a socio-ecological perspective. Resilience is not a fixed set of personality traits, but rather a measure of an individual's functioning and resources in the face of adversity. On this measure, the higher the score, the more resilient a participant is deemed to be. The scores are interpreted according to four levels of resilience—low, medium, high, and exceptional resilience. Across both samples, the median score on the CYRM was 48 or "medium resilience." However, there are sizable and significant differences between the two samples. Participants in South Sudan had levels of "low resilience" according to the CYRM, while participants in the KRI sample scored as having "high resilience."[122]

Description of quantitative methodology

For the quantitative analysis, we ran multiple comparison tests based on the distribution of the outcome variable. For continuous, but non-normally distributed, outcomes (such as community or family trauma, for example) we ran the Kruskal-Wallis test, while for continuous, but normally distributed, outcomes (resilience and SDQ score) we ran a t-test. We also ran simple linear regressions to assess associations between two continuous variables when the outcome was continuous and negative binomial regressions to assess associations when the outcome variable was highly skewed. The distributions of the outcomes varied by site, with many of the outcomes somewhat normally distributed in the KRI sample as opposed to having a uniform or skewed distribution in the South Sudan sample. Where the p-value was less than 0.05, we identify the association as significant.

Reflections on use of measures for participants in South Sudan

Several strong statistical relationships were found within the KRI sub-sample; fewer were found in South Sudan. We feel there are two likely explanations for this difference. First, the scales may not have been sufficiently reliable or valid for Nuer populations. In contrast, the CYRM, SDQ, and some components of the trauma checklist have been used widely with Arabic-speaking populations. As such, the measures may not be as appropriate for use in the South Sudan context. This could explain the relatively fewer statistical relationships. An alternative explanation could be that the results are accurate for the South Sudan cohort. This would indicate that there is no statistical relationship between marriage status and the overall types of traumatic event experienced, resilience, and emotional and behavioral functioning within the sample population. This second explanation could be due, in part, to participants having experienced multiple decades of war and a history of displacement and loss. As such, among the South Sudan cohort, early marriage may simply not have the same relative impact on well-being as it does within the KRI sample. We lack adequate data to answer this question and emphasize that the validity of these scales would be greatly improved through further testing with Nuer populations.

[121] Resilience Research Centre, "CYRM and ARM User Manual," 25.
[122] Scores were 39 and 51 respectively. P value < .01.

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