



EVALUATION

Arts-Based MHPSS Program in Balochistan

August 2026

PEACE OF MIND
FOUNDATION




**THE MHPSS
COLLABORATIVE**

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ACRONYMS

CI	Confidence interval
CYRM	Child and Youth Resilience Measure
FGD	Focus Group Discussion
IASC	Inter-Agency Standing Committee
INEE	Inter-Agency Network for Education in Emergencies
IRR	Inter-rater reliability
LMIC	Low- and middle-income country
MEL	Monitoring, evaluation, and learning
MHPSS	Mental health and psychosocial support
OLS	Ordinary least squares (regression)
OOSC	Out-of-school children
PoM	Peace of Mind Foundation
RQ	Research question
SBK	Sardar Bahadur Khan Women's University (Quetta) — referred to as SBK University
SD	Standard deviation
SDQ	Strengths and Difficulties Questionnaire
SLEC-26	Student Learning and Emotional Checklist — 26 item version
TATG	Trauma Art Therapist Group (YAD internal reflective practice group)
ToC	Theory of Change
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YAD	Youth Association for Development

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EXECUTIVE SUMMARY

Since 2023, the Youth Association for Development (YAD), funded by and in partnership with the Peace of Mind Foundation (PoM), has implemented a trauma-informed, arts-based Mental Health and Psychosocial Support (MHPSS) program for Afghan refugee and host community children aged 6–12 in Quetta, Balochistan. The program, “Supporting Mental Health and Healing for Vulnerable Children,” is implemented in eight partner schools in Hazara Town, where specialized Healing Rooms provide dedicated spaces in which children process emotions, build resilience, and develop emotional and social skills through creative expression. Four therapeutic modalities — play-based, art-based, music-based, and collective healing and reflection activities — are delivered through a structured 22-week curriculum by trained Trauma Art Therapists (TATs). The program served 320 children per six-month cohort, for a total planned reach of 1,280 children across four cohorts between 2024-2026.¹

The program's Theory of Change (developed collaboratively by YAD and the MHPSS Collaborative; see Figure 1) articulates the mechanisms through which arts-based activities are expected to produce change. In the short term, this includes strengthened psychological safety, emotional expression, peer relationships, trusting relationships with adults, and healthy coping strategies. In the medium and longer term, this leads to increased confidence, prosocial behavior, and emotional regulation. The program also seeks to increase caregiver and community awareness of MHPSS needs of learners, and increased application of trauma-informed approaches by teachers and the wider school community.

This report presents the findings of an outcome evaluation of Cohort 3 of the program (September 2025 – February 2026), commissioned by PoM and conducted by the MHPSS Collaborative in close partnership with YAD. This is an outcome evaluation: it measures change in children's wellbeing over the program period using a single-arm, pre-post design, and does not measure causal impact, since there is no comparison group or counterfactual. The evaluation served two purposes: (1) to assess the program's outcomes for children's psychosocial wellbeing, and to generate evidence and learning to inform ongoing refinement of program design and delivery. Ten research questions guided the evaluation, spanning the following thematic areas:

- Program relevance and appropriateness to the MHPSS needs of Afghan refugee and host community children;
- The program's contribution, direct or indirect, to children's psychosocial wellbeing and to caregivers' and teachers' knowledge and practice;
- Differential needs and outcomes across groups, including gender, refugee/host status, and disability;
- Unintended positive or negative consequences of the program; and
- Sustainability and pathways to greater local ownership.

¹ The first phase of the program began as a pilot from April 2023-March 2024. It has operated at an expanded scale since September 2024 under its current phase, “Supporting Mental Health and Healing for Vulnerable Children,” which is the subject of this evaluation.

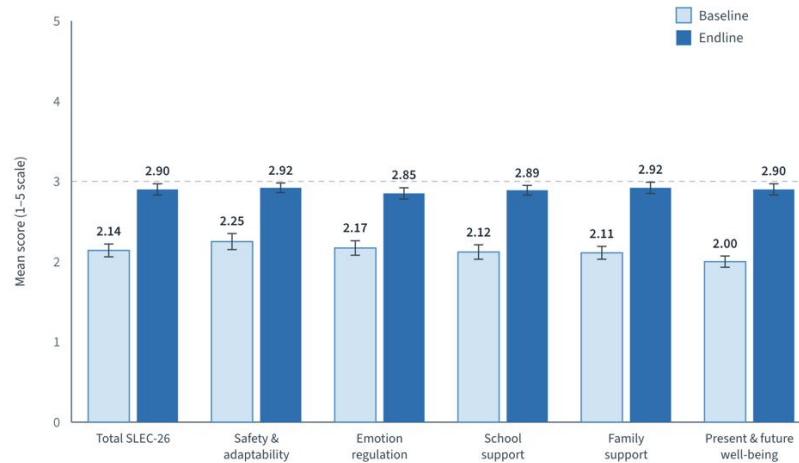
Methods

The evaluation used a mixed-methods design. The quantitative component used a single-arm, repeated-measures pre-post design, assessing the same children at baseline (October-November 2025) and endline (March - April 2026) using the Student Learning in Emergencies Checklist (SLEC-26). This is a 26-item validated self-report scale covering five domains: sense of safety and adaptability, emotion regulation, school support, family support, and present and future wellbeing. The final matched sample comprised 135 children. The target sample size was 151 — a subset of the roughly 320 children enrolled in the cohort, selected via stratified random sampling to be representative of the full cohort and powered *a priori* for the pre-post comparison. The matched sample used in the analysis included 135 records (89% of target) that could be matched across baseline and endline; see Section 2.2.2 for detail.

Qualitative data was collected between May and June 2026 through 13 focus group discussions with 63 participants across five groups: learners, teachers, parents and caregivers, YAD program staff, and local education and psychology stakeholders. Learner sessions incorporated a structured before-and-after drawing exercise to support child-friendly, age-appropriate data collection. Data were analyzed using deductive thematic analysis based on the Theory of Change and the evaluation's ten research questions, with findings triangulated across participant groups and against the quantitative results.

Key Findings

- Children carried a real and substantial psychosocial burden before the program, and the program addressed a documented gap in available support. Across all participant groups, there was consistent description of children experiencing emotional distress, behavioral challenges, and disengagement from learning. These were described as the ordinary conditions, rooted in poverty, displacement-related insecurity, and disrupted access to services, of many children's lives in the communities the program serves.
- **Children showed a statistically significant and substantial improvement in self-reported psychosocial wellbeing.** Across 135 matched children, the mean total SLEC-26 score rose from 2.14 to 2.90 on the five-point scale (note that the SLEC-26 has no established cut-off or benchmark score for comparison across contexts; these values are best interpreted as within-group change over time — see Section 2.5) — a gain of 0.76 points (95% CI 0.68–0.84) and a large effect size ($d_z = 1.57$). Improvement was consistent and statistically significant across all five domains after correction for multiple comparisons, with the largest gains in present and future wellbeing (+0.90) and family support (+0.81).



Error bars = 95% CI. Dashed line = scale midpoint (3.0).

Figure 1: Mean SLEC-26 scores

- Arts-based activities gave children an effective channel for expression that they otherwise lacked.** Drawing, painting, music, and storytelling allowed children to communicate feelings they had no other way to express— a finding described consistently by learners, parents, teachers, and YAD staff alike, and validated by external education and psychology professionals as well-suited to a population that often lacks the verbal emotional literacy or cultural permission to discuss feelings directly.
- Children described increased psychological safety, confidence, and emotional regulation.** Children consistently described feeling physically and psychologically safe in the Healing Rooms. Increased confidence and self-esteem were among the most widely reported changes, often described by children in relation to consistent facilitator affirmation. Improved emotional regulation was corroborated by parents and teachers who observed reduced aggressive outbursts and calmer responses to frustration at home and in the classroom.
- Peer belonging, school/learning engagement, and hope for the future improved.** Children who described isolation before the program described friendship and belonging afterward. Parents and teachers noted improved engagement with learning and school activities, and specifically increased prosocial behavior with peers and family members. Learners described specific, hopeful future aspirations — becoming a teacher, doctor, or psychologist — often explicitly linked to their own experience of the program. The SLEC-26 present and future orientation domain showed gain of +0.90.
- Caregiver awareness of children's needs grew, but unevenly and mostly through observation rather than deliberate engagement.** Evidence of increased understanding was strongest among mothers, who described an initial state of feeling helpless that shifted as they observed their children using creative practice to manage distress. Fathers described similar behavioral changes in their children but did not describe the same shift in understanding, suggesting this outcome was only partially achieved and unevenly distributed.

- **No participant described a negative or unintended consequence of the program; one clear positive unintended effect emerged.** Teachers described their own wellbeing improving as classroom management became easier and daily stress reduced as students became calmer and more cooperative. Importantly, though, this was raised alongside teachers' own named need for more direct support and training.
- **Three areas emerged as priorities for program development.** Caregiver engagement was the most consistent gap named across adult participant groups, with awareness growing primarily through observation or experience rather than continuous program engagement. Teacher integration of trauma-informed practice showed weak evidentiary support of all Theory of Change outcomes, with communication between teachers and Healing Room facilitators described as informal and limited. Community engagement (both a short- and longer-term outcome) showed only early, informal signs of traction, such as mothers sharing progress with neighbors, rather than the deliberate, sustained engagement the program aspires to.
- The evaluation's design does not permit systematic comparison of outcomes across demographic groups, but qualitative evidence offers some insight into differential need. Afghan refugee children and host community children faced overlapping but distinct challenges, with refugee-specific stressors (such as deportation fear, restricted movement, exclusion from host community peer networks) named by program staff and external stakeholders. Adult participants also identified children with disabilities and out-of-school children as groups the current school-based delivery model does not reach (with the latter being out of scope for the project). YAD staff noted that girls face distinct access barriers such as family responsibilities, restrictions on movement, and need for caregiver permission; however, programming data reflects even participation by gender across cohorts was achieved despite this. In addition, YAD staff and teachers noted that younger and older children may benefit from more differentiated activity design.
- **Sustainability will require a shift from program-delivered support to capacity embedded in schools, families, and communities.** Program staff described this shift as depending on caregivers being equipped to support children's emotional needs at home, teachers applying trauma-sensitive classroom approaches, schools being equipped to support the MHPSS needs of learners, and communities recognizing distress and knowing where to turn. The evidence suggests this knowledge and skills transfer has not yet happened systematically, though informal mechanisms— such as parent-to-parent information sharing— are already emerging organically and offer a foundation to build on.

The evidence supports a positive overall assessment of the program. It reached children who genuinely needed it in a context where alternative support was largely absent, and was associated with significant, broad-based improvements in psychosocial wellbeing that were corroborated across independent data sources and participant groups.

The program did not achieve everything its Theory of Change envisioned. Caregiver and community engagement and teacher integration remain underdeveloped, but both are embedded in program design and offer opportunity for growth and improvement. However, the effects on children themselves were clear, consistent, and significant. The recommendations below are grounded in this assessment, building on what is working, addressing the gaps the evidence has surfaced, and investing in the conditions that would allow the program's effects to outlast a single cohort.

Recommendations

Program design and delivery

- Develop differentiated activity approaches for the 6–8 and 9–12 age ranges within the existing curriculum.
- Systematically document and share facilitators' real-time session adaptations to build institutional knowledge and support onboarding.
- Establish a structured annual feedback process that includes children's and caregivers' voices in program review.

Caregiver and community engagement

- Provide caregivers with simple psychoeducation tools and take-home materials, including basic art supplies and a distress-recognition guide.
- Conduct dedicated caregiver sessions, separately for mothers and fathers, given their different levels of awareness and engagement.
- Expand outreach beyond parents where relevant, since grandparents, extended family, and other community caregivers often play a significant day-to-day role in children's lives and could be brought into awareness-building efforts, as well.
- Extend programming to address caregiver wellbeing alongside child-focused support.
- Formalize informal parent-to-parent information sharing through identified parent ambassadors in each school community.

Teacher integration and school embedding

- Build on YAD's existing Psychological First Aid training with a fuller, ongoing trauma-informed practice curriculum for teachers, with continued support rather than a single session.
- Establish a structured, regular communication channel between Healing Room facilitators and classroom teachers.

Reach, inclusion, and access

- Partner with disability organizations to adapt session materials and train facilitators in inclusive facilitation.
- Address gender-specific barriers to girls' access and participation through caregiver sessions and flexible scheduling.

Monitoring, evaluation, and learning

- Maintain a single, consistent pre-post measurement tool across future cohorts to allow cumulative evidence to build over time.
- Develop simple monitoring tools to track caregiver awareness and teacher skill application specifically — the two Theory of Change outcomes with the weakest evidentiary base.
- Assess longer-term outcomes through a follow-up study conducted after the program cycle ends.

- Treat the Theory of Change as a living document, revisited through participatory review at the end of each cohort cycle.

Donor and policy-level action

- Continue multi-year, flexible funding that supports program continuity and the relationship-building that caregiver and teacher engagement require, as well as the flexibility to learn and adapt the program activities within the grant cycle.
- Fund further documentation and dissemination of the program model for wider uptake by peer organizations and government counterparts.
- Advocate for incorporation of school-based MHPSS into provincial education policy in Balochistan.
- Invest in local facilitator capacity and a sustainable training pipeline.

1. INTRODUCTION

1.1 Context

Balochistan is the second-largest refugee-hosting province of Pakistan, home to approximately 209,000 registered Afghan refugees which represents around 25% of Pakistan's total registered refugee population.² As of 2023, more than half (approximately 52%) of refugees in the country were under the age of 18.³ The province shares a 1,268-kilometer border with Afghanistan and has hosted Afghan refugee communities in recurring waves since the 1970s. Approximately 32% of registered refugees reside in official refugee camps and villages, while the majority lived in urban and semi-urban areas alongside Pakistani host communities.⁴ Since 2023, under Pakistan's 'Illegal Foreigners' Repatriation Plan', over 1.6 million Afghans have been returned or deported from Pakistan to Afghanistan, including more than 8,000 UNHCR-registered refugees as of October 2025.⁵

Balochistan is Pakistan's least developed province, with a multidimensional poverty rate of approximately 70% and a complex security situation that complicates access to humanitarian assistance.⁶ In recent years, conditions for Afghan refugees have deteriorated sharply. Escalating enforcement operations— including harassment, arbitrary detention, bribery by law enforcement, and large-scale deportations— caused widespread fear and psychological distress across refugee communities.⁷ Afghan refugees have experienced anxiety driven by uncertainty about their future, the expiration of registration documentation, and constant fear of deportation. According to mental health practitioners in the region, such fear has negatively impacted mental health and wellbeing.⁸ The deportation crisis has disrupted family structures, with male family members often deported while women and children remained, and forced many refugees into confined, hard-to-reach

² UNHCR. (2026, July 1). *Country profile for Pakistan*. United Nations High Commissioner for Refugees. <https://data.unhcr.org/en/country/pak>

³ UNHCR. (2025, November). *Forced displacement survey – Pakistan 2024*. <https://www.unhcr.org/publications/forced-displacement-survey-pakistan-2024>

⁴ UNHCR. (2026, July 1). *Country profile for Pakistan*. United Nations High Commissioner for Refugees. <https://data.unhcr.org/en/country/pak>

⁵ European Union Agency for Asylum. (2025). *Afghanistan: Country focus* [COI report]. <https://www.euaa.europa.eu/coi-report-afghanistan-country-focus/14-treatment-persons-returning-abroad>

⁶ Pakistan Institute of Development Economics (PIDE). (2023). *Multidimensional poverty in Pakistan*. <https://file.pide.org.pk/pdfpideresearch/rr-multidimensional-poverty-in-pakistan.pdf>

⁷ Action Against Hunger. (2024, January 3). *In Pakistan, Afghan refugees are in dire need of humanitarian assistance and mental health support*. Action Against Hunger Featured News. <https://www.actioncontrelafaim.org/en/news/headlines/in-pakistan-afghan-refugees-are-in-dire-need-of-humanitarian-assistance-and-mental-health-support/>

⁸ Peace of Mind Foundation. (2026). *Exploring the mental health of children and adolescents of host and Afghan refugee communities in Balochistan, Pakistan* [Draft research brief, internal document]; MMC. (2026). *Life in the shadows: Protection and assistance needs of Afghan children and youth in Pakistan*. Mixed Migration Centre. <https://mixedmigration.org/resources/protection-and-assistance-needs-of-afghan-children-and-youth-in-pakistan/>

locations to avoid detection. This has compounded the isolation of communities, and notably restricted access to services.⁹

The mental health and psychosocial needs of children in Balochistan are currently extensive and largely unmet across both refugee and host communities. Afghan refugee children and adolescents face heightened risk of depression, trauma-related symptoms, and anxiety, driven by exposure to war-related violence and displacement and compounded by daily stressors including discrimination and economic insecurity.¹⁰ Children exposed to trauma display a wide range of psychological symptoms, including anxiety, depression, emotional dysregulation, difficulties forming peer relationships, and disruptive or aggressive behavior, as well as long-term impacts on psychosocial development.¹¹ A 2025 study of Afghan refugee children in Pakistan showed that 70% reported feeling depressed and 44% reported feeling anxious as a result of the protection risks and instability they face.¹²

Host community children in Balochistan face overlapping but distinct mental health and psychosocial challenges. Depression and trauma-related symptoms have been documented in Quetta's population broadly, with females reporting higher rates of depressive symptoms than males.¹³ Host community children were affected by enforced disappearances of family members, rising suicide rates, child labor, child marriage, and the psychological toll of poverty and political instability.¹⁴

In 2025, mental health professionals in the province were critically scarce, with psychiatric services available in only 5 of 36 districts.¹⁵ According to Peace of Mind research, MHPSS specialists and psychologists reported that up to 70% of cases of psychological distress among both refugee and host community members went unreported, driven primarily by stigma, limited mental health literacy among caregivers, and the widespread preference for religious or traditional healers over professional mental health services.¹⁶

Limited access to education compounds the above challenges. Balochistan has Pakistan's highest out-of-school rate at 69% and a literacy rate of approximately 42%— both the lowest of any

⁹ MMC, 2026.

¹⁰ Qamar, K., Priya, Rija, A., Vohra, L. I., Nawaz, F. A., & Essar, M. Y. (2022). Mental health implications on Afghan children: An impending catastrophe. *Global Mental Health (Cambridge)*, 9, e5. <https://doi.org/10.1017/gmh.2022.3>; Panter-Brick, C., Grimon, M.-P., Kalin, M., & Eggerman, M. (2015). Trauma memories, mental health, and resilience: A prospective study of Afghan youth. *Journal of Child Psychology and Psychiatry*, 56(7), 814–825. <https://doi.org/10.1111/jcpp.12350>

¹¹ Joshi, P. T., & Fayyad, J. A. (2015). Displaced children: The psychological implications. *Child and Adolescent Psychiatric Clinics of North America*, 24(4), 715–730. <https://doi.org/10.1016/j.chc.2015.06.004>

¹² MMC, 2206.

¹³ Fatima, M., Ul Haq, N., Nasim, A., Bibi, M., Ali, K., Ereej, N., & Naveed, R. (2021). Impact of gender on the prevalence of depression in the population of Quetta, Pakistan. *Asian Journal of Research in Medical and Pharmaceutical Sciences*, 10(4), 40–47. <https://doi.org/10.9734/ajrimps/2021/v10i430176>

¹⁴ Riaz, M. M. A., Imdad, I., Hisam, B., & Zeshan, M. (2024). From despair to hope: Tackling Balochistan's suicide crisis with sustainable solutions. *BJPsych International*, 21(4), 88–90. <https://doi.org/10.1192/bji.2024.8>

¹⁵ Peace of Mind Foundation, 2026.

¹⁶ Peace of Mind Foundation, 2026.

province.¹⁷ Barriers were particularly pronounced for Afghan refugee children, who faced language barriers, discrimination, lack of documentation, and additional constraints rooted in gender norms for girls.¹⁸ Children who are out of school face heightened risk of psychological distress, exploitation, and involvement in child labor, creating cycles that further undermine wellbeing.¹⁹

1.2 The Program

Inside the Healing Rooms

Each of the eight partner schools has a dedicated Healing Room, staffed by YAD's art and music therapists who visit Monday through Thursday. Each room runs four sessions a day, roughly 40-60 minutes each. Fridays are reserved for team reporting, planning, and individual support sessions for children who need one-on-one attention, sometimes at their homes. A school-designated Shadow Art Therapist (a staff member selected from the school itself) is present throughout to support coordination between YAD and school staff.

Before a child joins the Healing Room, YAD psychologists conduct an individual psychological history and needs assessment; participation is then adjusted over time based on ongoing assessment and referrals, with groups typically consisting of approximately 37-43 children.

Within sessions, therapists draw on four modalities:

- *Art-based activities*— Drawing, painting, and creative work using colors, patterns, and symbols that are locally and culturally familiar, giving children a way to express memories, identity, and emotion without having to put it into words.
- *Play-based activities*— Child-led play, games, and imaginative or symbolic activities that build confidence, emotional development, social connection, and coping skills.
- *Music-based activities*— Rhythm, movement, and singing, adapted to what's culturally familiar and comfortable, supporting emotional regulation and connection.
- *Collective healing and reflection activities*— Facilitated group discussion, mindfulness, and community-building exercises that give children a shared, supportive space to process alongside peers.

Since June 2023, the Youth Association for Development (YAD), funded by and in partnership with the Peace of Mind Foundation (PoM), implements a trauma-informed, arts-based Mental Health and Psychosocial Support (MHPSS) program for Afghan refugee and host community children aged 6–12 in Quetta, Pakistan. The program is embedded in eight partner schools in Hazara Town, Quetta, where

¹⁷ Government of Pakistan, Ministry of Finance. (2025). Chapter 10: Education. In *Pakistan Economic Survey 2024–25*. https://finance.gov.pk/survey/chapter_25/10_Education.pdf

¹⁸ Ullah, H., & Wassan, A. A. (n.d.). Educational barrier and its effects on Afghan refugee children in Quetta, Balochistan. *Asian Social Studies and Applied Research (ASSAR)*. <https://asarcouncil.com/papers/1670222984.pdf>

¹⁹ Hamdan, N., Adnan, A., & Burak, E. (2018). Child labor and health: A systematic literature review of the impacts of child labor on child's health in low- and middle-income countries. *Journal of Public Health*, 41(1), 18–26. <https://doi.org/10.1093/pubmed/fdy018>

specialized Healing Rooms were established to provide dedicated, nurturing spaces in which children could process emotions, build resilience, and develop emotional and social skills through creative expression.

The program integrated four primary therapeutic modalities: play-based activities (including structured and free play and trauma-informed play therapy); art-based activities (drawing, painting, crafts, and guided art therapy); music-based activities (musical exploration, music therapy, movement to music, and folk singing); and collective healing and reflection activities (facilitated group discussion, mindfulness, and community-building exercises). These modalities are delivered through a structured 22-week curriculum; sessions are facilitated by specialized Trauma Art Therapists (TATs). YAD facilitates these therapists to meet regularly in a Trauma Art Therapist Group (TATG), to support shared learning, reflective practice, and program fidelity.

The program included 320 children per six-month cohort across eight partner schools, for a total planned reach of 1,280 children across four cohorts over a two-year implementation period from 2024-2026.

1.2.1. Collaborative Partnership

The MHPSS Collaborative was brought on both to conduct this evaluation and to work in close collaboration with YAD on a range of related efforts to learn about and strengthen the program. This meant refining how the program itself considers and measures outcomes, both for ongoing program improvement and to contribute to the wider evidence base on what works in arts-based MHPSS programming for children in humanitarian contexts. Additionally, this partnership with the MHPSS Collaborative included a deliberate push toward a more holistic framing of MHPSS from the outset of the partnership and evaluation— moving beyond a narrow focus on trauma itself to consider the fuller range of outcomes, as well as people who benefit from the programming such as caregivers, teachers, and the wider school community.

Establishing a shared Theory of Change grounded in the program's current inputs and activities — and mapping a clear pathway from those activities through to outcomes — was a first step in this process. This began with an interactive ToC workshop, jointly facilitated by the MHPSS Collaborative and YAD, engaging YAD programme staff to identify assumptions about program mechanisms and expected outcomes. YAD staff participation included the technical lead, staff psychologists, program officers, and art and music therapists. The MHPSS Collaborative then developed a draft ToC from this workshop and used a structured questionnaire completed by YAD staff to consolidate further programmatic detail, inputs, and priorities for the outcome evaluation. This was followed by several additional rounds of consultation with YAD over the following months to refine and validate the framework together, alongside production of the MEL Plan.

This preparatory period also included direct capacity-building support led by the Evaluation Coordinator, including close work with YAD to refine their monitoring tools and systems for tracking activities and actions, and conducting school visits together with YAD's clinical psychologist. The Coordinator also helped facilitate a Psychological First Aid (PFA) training for YAD staff— a need identified directly through the ToC workshop process— delivered not only to the frontline Trauma Art Therapists working directly with children, but to all YAD staff. This work took place over approximately four months, between May and August 2025, prior to the Cohort 3 baseline began in October 2025.

Finally, the two organizations worked through a range of options for outcome measurement and monitoring tools. This included review and selection of the SLEC-26 for the outcome evaluation, as it

covered a range of outcomes identified in the ToC and has been developed specifically for school-based psychosocial programs. External technical experts in Quetta were also consulted to understand the contextual appropriateness and fit of the tool. The tool was translated by the Evaluation Coordinator, but time constraints did not allow back translation of the tool. All protocols for qualitative data collection were also reviewed and input on by YAD staff prior to their use during endline data collection.

This iterative, collaborative process — rather than a single discrete workshop — directly shaped the final ToC, the outcome measures prioritized in this evaluation, and the MEL Plan developed for the program.

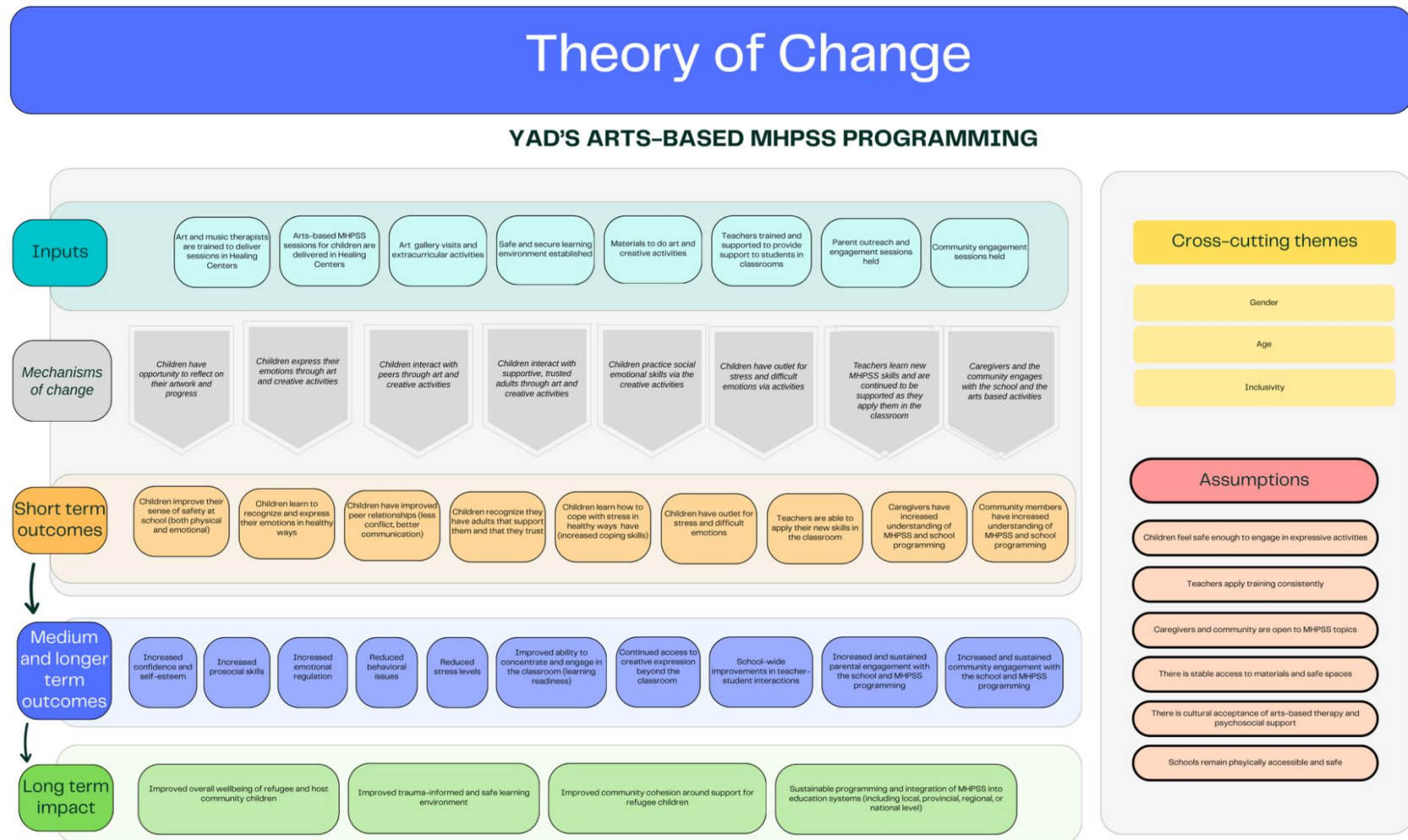
1.2.2. Program Theory of Change

The program's Theory of Change (ToC) was developed by the lead researcher at the MHPSS Collaborative with inputs from the local evaluation coordinator and YAD through an interactive workshop and subsequent consultations, described above. The ToC articulates the mechanisms through which the arts-based activities were expected to produce change, and fully understanding the program logic was a necessary foundation for both the evaluation design and outcome prioritization.

Based on the collaboration between YAD and the MHPSS Collaborative, an initial version of the ToC was crafted which describes the following expected outcomes of the project. In the short term, program participation was expected to strengthen children's sense of psychological safety, improve their ability to recognize and express emotions, build positive peer relationships, foster trusting relationships with adults, and support the development of healthy coping strategies. Over the medium and longer term, these gains were expected to consolidate into increased confidence and self-esteem, prosocial behavior and cooperation, emotional regulation, reduced behavioral difficulties, improved learning readiness, and a strengthened sense of hope and future orientation.²⁰ The ToC includes non-learner outcomes such as increased caregiver and community awareness of children's wellbeing needs and the increased application of trauma-informed approaches by teachers. See Figure 1, below, for depiction of the program ToC.

²⁰ The medium and long term, here, were measured within the six-month cohort cycle itself. The ToC does not assume, and this evaluation does not measure, whether gains persist after a child's cohort ends, since no post-program follow-up data are collected — see Recommendation 5.5)

Figure 2 Theory of Change



1.3 Purpose and Scope of This Evaluation

This report presents the findings of the outcome evaluation of Cohort 3 of YAD's arts-based MHPSS program. The evaluation was commissioned by PoM and conducted by The MHPSS Collaborative, an independent organization with expertise in evaluation of MHPSS programs in humanitarian contexts. The evaluation was implemented in close partnership with YAD and all data collection was led by the locally-based Evaluation Coordinator.

The evaluation was co-designed and implemented in close partnership with YAD throughout. The MHPSS Collaborative's evaluation team led and facilitated the initial Theory of Change workshop to identify the program's expected outcomes and prioritize those most relevant to the evaluation, and co-led several subsequent meetings with the full YAD team over the following months to finalize the MEL Plan. The locally-based Evaluation Coordinator consulted with YAD on their broader MEL work, including their monitoring and tracking tools, and conducted site visits with YAD staff. The MHPSS Collaborative developed all data collection protocols, which YAD staff then reviewed and provided input on. Tool selection—including the decision to use the SLEC-26—also drew on consultations with outside technical experts coordinated by the Coordinator. Data collection at both baseline and endline was jointly coordinated by the Evaluation Coordinator and the YAD team, with YAD staff co-facilitating all qualitative data collection sessions alongside the EC. Findings were shared with YAD at the end of the evaluation in a full staff meeting, where feedback and input were sought before finalizing this report.

The evaluation covered Cohort 3, the third six-month program cycle (September 2025 –February 2026).²¹ The evaluation served two purposes: to assess change in the psychosocial wellbeing of participating children over the program period, and to generate evidence and learning that could inform ongoing refinement of program design and implementation. Ten research questions (Table 1) guided the evaluation, spanning program relevance, perceived impact, differential outcomes by group, unintended consequences, and sustainability.

Table 1 Evaluation research questions

No.	Research question
RQ1	How relevant and appropriate is the current programme design and implementation to the MHPSS needs of Afghan refugee and host community children? How could it be more relevant and appropriate?
RQ2	To what degree is the programme designed and implemented based on the perceptions and priorities of Afghan refugee children and parents? Is it perceived as relevant by them? If so, how?
RQ3	To what extent are the different needs of various groups (females, males, out-of-school children, children with disabilities, Afghan refugee, host children) perceived to be considered? How can the programme better target these groups to become more inclusive?
RQ4	How has the program contributed directly or indirectly to the psychosocial wellbeing of the children participating?

²¹ This date range covers seven months to account for annual winter school closures, but the program is implemented for six months in total.

No.	Research question
RQ5	What is the perception of impact from children, families, and community members?
RQ6	How has the program contributed to improved knowledge and understanding of children's wellbeing amongst targeted families and communities?
RQ7	What is the perception of this impact from families and community members?
RQ8	Were there any unintended positive or negative consequences of the intervention?
RQ9	What are communities' perceptions of the sustainability of the program moving forward? What are perceived ways in which greater local ownership could be achieved?
RQ10	How can program and organizational learning through the first years inform the revision of the theory of change? What could be strengthened to achieve greater impact in areas identified as important by children, their parents, and communities?

2. METHODOLOGY

2.1 Evaluation Design

This evaluation employed a mixed-methods convergent design, integrating quantitative and qualitative approaches to produce a comprehensive assessment of program outcomes. The two strands were developed to complement and triangulate each other; the quantitative component provided pre-post measurement of psychosocial wellbeing outcomes and the qualitative component provided explanatory depth, centered participants' own voices, and surfaced the nuanced, context-specific ways in which the program operated and was experienced. The Theory of Change served as the evaluation's primary organizing framework, providing the conceptual structure against which evidence collection and interpretation were considered.

2.2 Quantitative Component

2.2.1 Design and instrument

The quantitative component used a single-arm, repeated measures pre-post design. The same children were assessed at two time points— baseline (October-November 2025) and endline (March - April 2026) - with no comparison group. This design was selected as appropriate for a program evaluation context because the intervention was first delivered at the classroom-level by teachers to all eligible students, after which students requiring additional support were referred to the Healing Rooms. As all students received the classroom-based intervention, it was not feasible to include a control group within the same cohort.

The measurement instrument was the Student Learning in Emergencies Checklist (SLEC-26), a previously validated child self-report tool developed by the Norwegian Refugee Council and the University of Tromsø to measure promoters of and barriers to learning and psychosocial wellbeing

among conflict-affected children.²² The 26-item tool is included in English as Annex 1. The tool was translated in Dari and local technical experts were consulted to understand the comprehensibility and contextual fit of the tool. No changes were made to the tool based on these consultations. The SLEC-26 comprises 26 items rated on a five-point ordinal scale (1–5), where higher values indicate more positive wellbeing. Previously conducted psychometric validation established a five-factor structure defining five domains: sense of safety and adaptability (9 items); emotion regulation (4 items); school support (3 items); family support (3 items); and present and future wellbeing (7 items). Domain scores and a total score were computed as the mean of constituent items, keeping all scores on the original 1–5 scale. One item (A10, a negatively worded emotion regulation item) was reverse-coded before scoring.

2.2.2 Sample

The target sample was 151 children (approximately 19 per Healing Room across 8 schools), based on an *a priori* power calculation for a paired-samples t-test assuming a two-tailed α of 0.05, 80% power, a standardized effect size of Cohen's $d_z = 0.33$, adjustment for clustering of participants within the eight healing rooms (assuming an intraclass correlation coefficient of 0.05), and a 10% allowance for attrition. Participants were selected using stratified random sampling by healing rooms across the eight partner schools in Hazara Town, Quetta. At baseline (October–November 2025), we surveyed 159 children and at endline (March – April 2026), we surveyed 153 children, both above the target sample of 151 children.

Participants were initially matched across the two time points using a composite identifier comprising participant ID and name. This resulted in 145 matched pairs, each of which were subsequently checked for consistency based on gender and age variables. In 10 pairs, gender and/or age were not consistent between time points, making it difficult to confirm that the records belonged to the same child. These 10 pairs were therefore excluded, resulting in the final sample of 135 matched pairs, with which the pre-post analysis was conducted. This represented approximately 89% of the target sample. Subgroup analyses were based on smaller sample sizes and should therefore be interpreted as exploratory. Although regression analysis is conducted using the full matched sample, it should also be treated as exploratory because the study was powered for the primary pre-post comparison rather than for multivariate modelling.

2.2.3 Analysis approach

Quantitative analysis was conducted in R according to a pre-specified analysis plan. The primary outcome was the change in the mean total SLEC-26 score (calculated as the mean of all the 26 items) and reported with 95% confidence interval and the corresponding p-value. To understand if the pre-post change was statistically significant, a paired-samples t-test was used when the distribution of paired differences was approximately normal, and the Wilcoxon signed-rank test was used when the normality assumption was not met. Effect sizes were reported as Cohen's d_z for paired-samples t-tests and matched-pairs rank-biserial correlation for Wilcoxon signed-rank tests. Secondary outcomes comprised changes in the mean scores for each of the five SLEC-26 domains (calculated as the mean

²² Forsberg, J., Dolan, C., & Schultz, J.-H. (2023). Development and Psychometric Testing of the Student Learning in Emergencies Checklist (SLEC): Measuring Promotors of Academic Functioning and Wellbeing in Palestinian Youth Affected by War and Conflict. *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, 21(1), 30–46. https://doi.org/10.4103/intv.intv_17_22

of the items under each domain). The same analytical approach was used for each of the five domain scores, with Holm-Bonferroni correction applied across the five-domain p-values to control the family-wise error rate. Exploratory analyses described changes by gender and age subgroup (descriptive only, no between-group significance testing given sample size constraints) and fitted an exploratory ordinary least squares regression model examining pre-specified predictors of change in the mean SLEC-26 scores.

2.3 Qualitative Component

2.3.1 Overview of data collection

Qualitative data were collected between May and June 2026 through a series of focus group discussions (FGDs) with five participant groups: learners (program participants aged 9–12), teachers, parents or caregivers, YAD program implementers, and local actors and education stakeholders. All sessions were facilitated by the Evaluation Coordinator, with co-facilitation from YAD staff for some learner sessions. Sessions were conducted at six schools where program implementation takes place, as well as at the YAD office in Quetta. All sessions were carried out in local languages (Hazragi/Persian for learner, caregiver, and teacher groups; Pashto, Persian, and Balochi for YAD staff and the local actors group) and transcripts translated into English for analysis.

Learner FGDs were conducted in five of the eight partner schools. Schools were selected to ensure variation in community composition (assuring mixed refugee and host community participation) and geographic spread within Hazara Town, while keeping the number of sessions proportionate to the ethical burden of qualitative participation for children in an already high-stress context. No new codes emerged after the third learner FGD, providing empirical support for the adequacy of five sessions.

Learner sessions incorporated arts-based activities, including a structured before-and-after drawing exercise, to facilitate child-friendly, age-appropriate data collection consistent with the ethos of the program itself. Learner, caregiver, and teacher FGDs each took place at the respective school in Hazara Town, Quetta.²³ YAD staff interviews took place with the organization’s clinical psychologist and one of the art therapists. The local actors group comprised professionals with relevant expertise in education, child psychology, and social work, several of whom had contributed technical advice to or otherwise engaged with the program.

A total of 13 sessions were conducted across the five groups, with 63 participants in total (Table 2).

Table 2: Qualitative data collection: overview of all sessions

Participant group	No. of sessions	Session gender breakdown	Total N (gender)
Learners	5	All FGDs mixed gender	30 (17F, 13M)
Teachers	2	1 FGD all F / 1 FGD mixed	8 (7F, 1M)
Parents / Caregivers	3	All FGDs single gender	18 (6F, 12M)

²³ Learner FGDs took place at Kanishka School, Firdowsi High School, Istiqlal School, Scholar School, and Al-Biruni School. Parent FGDs took place at Istiqlal School, Al-Furdasi School, and Kanishka School. Teacher FGDs took place at Firdowsi High School and Kanishka School.

Participant group	No. of sessions	Session gender breakdown	Total N (gender)
YAD Program Team / Implementers	2	Mixed	2 (1F, 1M)
Local Actors / Education Stakeholders	1	Mixed	5 (3F, 2M)
TOTAL	13		63 (34F, 29M)

2.3.2 Sampling

Sampling was purposive (schools and participants were deliberately selected to capture a relevant range of perspectives, rather than randomly sampled), using a maximum variation approach to ensure diversity of perspectives across schools, participant roles, gender, and community status. Participation in all FGDs was voluntary; participants were informed they could decline or withdraw at any point. Partner schools were selected from the eight schools implementing the Healing Room program in Hazara Town, Quetta, with variation in community profile that specifically ensured representation of both mixed refugee and host community children. Learner FGDs were conducted in five of the eight partner schools rather than all eight, reflecting both the purposive sampling logic (i.e. sufficient variation was achieved across the five selected schools) and the ethical principle of proportionality or undue burden in qualitative research with children in high-stress contexts.²⁴

Thematic saturation was observed across the learner FGD data. No new codes emerged after the third session, consistent with evidence that saturation in qualitative research is better assessed through the data itself than through fixed numerical thresholds.²⁵ The total qualitative sample of approximately 63 participants across 13 sessions is consistent with established guidance for FGD-based research, and the qualitative component was designed to complement rather than replicate the quantitative pre-post data.²⁶ Within schools, participants were identified and recruited with support from YAD staff and school leadership. Demographic data were collected at the aggregate group level by the local Evaluation Coordinator; session-level details are summarized in the tables above.

²⁴ Bennouna, C., Mansourian, H., & Stark, L. (2017). Ethical considerations for children's participation in data collection activities during humanitarian emergencies: A Delphi review. *Conflict and Health*, 11, 5. <https://doi.org/10.1186/s13031-017-0108-y>; Graham, A., Powell, M., Taylor, N., Anderson, D., & Fitzgerald, R. (2013). *Ethical research involving children*. UNICEF Office of Research – Innocenti. <https://www.unicef.org/innocenti/reports/ethical-research-involving-children>

²⁵ Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLOS ONE*, 15(5). <https://doi.org/10.1371/journal.pone.0232076>; Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, 292, 114523. <https://doi.org/10.1016/j.socscimed.2021.114523>

²⁶ Wutich, A., Beresford, M., & Bernard, H. R. (2024). Sample sizes for 10 types of qualitative data analysis: An integrative review, empirical guidance, and next steps. *International Journal of Social Science Research and Review*, 23, <https://doi.org/10.1177/16094069241296206>

2.3.3 Qualitative analysis

Qualitative data were analyzed using a deductive thematic analysis approach, anchored to the Theory of Change and the evaluation's ten research questions. A coding framework comprised of 21 codes was developed prior to analysis and organized into four sections: (A) Context and challenges, capturing the pre-program psychosocial environment; (B) Short-term program outcomes, mapped directly to the ToC's short-term outcomes; (C) Medium and longer-term outcomes, mapped to the ToC's medium/long-term; and (D) Implementation and program quality. An additional emergent category was used to flag themes that did not fit the framework.

Coded passages were extracted from all 13 FGD transcripts and organized by code and participant group to enable cross-transcript pattern analysis. All coding and analysis was completed using Excel. Code frequency was tracked as an orientation tool to identify themes with strong versus limited evidentiary support across the dataset, but frequency counts are not reported as findings. The number of times a theme was coded reflects the structure of the question guides as much as the salience of a theme for participants. In other words, topics that were directly asked about will naturally generate more coded passages than those that emerged unprompted. Findings are illustrated with participant accounts attributed by participant group only to protect confidentiality.

Findings were triangulated across participant groups and, where available, across qualitative and quantitative data sources. For each thematic finding, the evaluation considered consistency across multiple FGD groups, convergence or divergence across stakeholder perspectives (e.g., whether learners, teachers, and parents reported similar accounts of program impact), and alignment with quantitative trends. Where a finding was supported by only one participant group or data source, this is noted explicitly in the findings.

2.4 Ethical Considerations

Ethical approval for the evaluation was acquired through Save the Children's central ethics review mechanism, as well as locally through Bolan University of Medical and Health Sciences Quetta. All data collection activities followed established protocols for ethical research with children and vulnerable populations. Informed consent was obtained from all adult participants prior to each session. For learner groups, parental and caregiver consent was obtained in advance, and oral assent was sought from children at the start of each FGD. Children were informed in age-appropriate language of the voluntary nature of their participation, their right to decline any question or withdraw at any time, and the confidentiality of their responses. All data collectors were previously trained by YAD in trauma-informed approaches and equipped with referral pathways to YAD support mechanisms and external psychosocial services in the event of participant distress. Data was fully anonymized; participants are identified in this report only by participant group. All recordings and data with identifying information will be deleted following report approval.

2.5 Assumptions and Limitations

Several significant limitations should be borne in mind when interpreting the findings of this evaluation.

- **Exceptionally challenging data collection conditions.** Data collection took place against a backdrop of context-related disruption. In March 2026, the Balochistan provincial government

closed all public and private schools across the province (initially until 23 March, then extended to 31 March 2026), citing a national fuel crisis and energy conservation measures linked to Middle East geopolitical tensions affecting Pakistan's fuel supply. These closures directly affected the partner schools and data collection scheduling. Beyond school closures, data collection activities were conducted in a context marked by electricity outages, broader energy shortages, and the severe movement and security constraints facing the Afghan refugee community described in the introduction. Taken together, these conditions affected the timing of data collection activities, the availability of facilitators and participants, and the environment in which FGDs were conducted at both baseline and endline.

- **Specifically:** Baseline data collection took place In October-November 2025, staggered across the partner schools for logistical reasons (namely, scheduling with schools and number and availability of data collectors). In all schools, program activities had commenced prior to baseline survey completion. Delay in baseline data collection was due to multiple, coinciding factors: (1) finalization of the MEL plan and full understanding of exact program activities, monitoring and assessment tools in use, and outcomes already tracked took longer than anticipated with multiple lengthy sessions with YAD to assure a full picture of the program and how to properly measure outcomes; (2) selection and review of the quantitative tool took more time than initially planned in order to assure review and feedback from experts in location. This included initial search for and review of tools already in use in the location; in the local language. The SLEC, which was selected for strong overlap with the program outcomes and ToC, was both translated and reviewed by experts in Quetta, which added further time; (3) Time taken for the above meant delays to the submission of modification of ethics approval before which data collection could not be started. The delay in baseline assessment meant that children had already been exposed to the intervention for several weeks before the baseline data was collected, implying that baseline scores may reflect some program related change. If improvements occurred during this period, the results likely underestimate the true change associated with the program. The predominantly positive qualitative accounts provide support to the likelihood of this interpretation. Endline data collection took place approximately three to four weeks after the cohort concluded in March 2026, rather than immediately upon program completion, due to the school closures named above.
- **Delay between data collection and report finalization.** This draft was finalized approximately ten months later than the original reporting timeline anticipated, which was put forth in the original evaluation proposal. The original schedule was developed based on the information and assumptions available at the time. As the project progressed, the timeline and evaluation approach were adjusted to reflect a clearer understanding of the project and the evaluation process. These adjustments, along with the time needed to align on the evaluation scope and outcomes, contributed to the timeline extending beyond the original expectations. Additional delays were experienced as endline data collection was about to begin in early 2026. These were attributable to the context-related disruptions described above, including school closures and electricity outages that affected data collection.
- **Single-arm pre-post design without a comparison group.** Observed changes in SLEC-26 scores over the program period cannot be causally attributed to the intervention, as maturation, regression to the mean, and other concurrent influences cannot be separated

out. This design is standard and appropriate for a program evaluation context in which experimental control is not feasible, but it is an important interpretive constraint.

- **Limitations linked to subgroup comparisons.** Subgroup analyses based on quantitative data should be considered descriptive and exploratory, as between-group significance testing was not conducted because of small subgroup sample sizes. Further, subgroup analyses could not be conducted for variables such as ethnicity, religion, language, because of insufficient variation in the sample, with most participants belonging to the same category. Exploratory analyses examined differences in magnitude of change assessed by gender and age, as well as whether baseline total SLEC score, age, gender, and grade of the child and caregiver income were associated with improvements in total SLEC-26 score using regression analysis. We found improvement of similar magnitude in the total SLEC-26 score across age and gender groups and regression analysis indicated weak associations between change in SLEC-26 scores and age, gender, grade, and parental income were weak (see Section 3.2 for more detail). Lower baseline scores were sig. associated with greater improvement in total SLEC-26 score, but this finding should be interpreted with caution, as it may partly reflect regression to the mean.
- **Missing qualitative inputs from youngest children.** Learners who participated in the FGDs were ages 9-12, meaning the qualitative data lacks the perspective of the youngest program participants (ages 6-8). Assuring the full age range was a priority in recruiting participants, but participation was ultimately finalized by those children who were accessible during the data collection windows and where child and parental consent was available. The lack of children's voluntary participation may reflect younger children's more limited verbal and attentional capacity for group discussion formats. The survey data reflects participation across the larger age range (5-13), and no meaningful differences in results were found by age. Future cohort reviews by YAD should specifically assure the viewpoint of the youngest children in qualitative data collection, possibly by oversampling for this age range.
- **SLEC-26 measurement limitations.** The SLEC-26 was originally validated in a different conflict-affected context (Palestine) and its psychometric properties have not been established for this location and population. Two domains (emotion regulation; present and future wellbeing) had below-threshold reliability in the original validation, which may attenuate domain-level sensitivity.²⁷ Self-reported wellbeing in children aged 6–12 is additionally subject to comprehension and response-style effects; thus, quantitative results are interpreted alongside qualitative evidence throughout. The SLEC-26 was nonetheless selected because it captures a number of outcomes included in the program's Theory of Change and has been previously used to understand changes over time in psychosocial outcomes among children affected by humanitarian crises. The tool also does not have established cut-off scores or international standards indicating what constitutes a "good" or "bad" outcome in absolute terms; only a small number of published studies have used it, and available evidence is not sufficient for meaningful cross-contextual comparison. Differences in

²⁷ The internal consistency score, as assessed by Cronbach's alpha was 0.66 and 0.69 for the subdomains emotion regulation and wellbeing and hope, respectively, based on the validation study in Palestine. These values are only slightly below the commonly use threshold of 0.70 for acceptable internal consistency. See: Forsberg et al., 2023.

scores across settings can also be misleading, as they may reflect a range of contextual factors (exposure to adversity, education systems, family and community support, etc.) rather than differences in intervention effect alone. The scores in this report are therefore interpreted in terms of change over time within this group and context, rather than through comparison with other settings or against a benchmark score.

- **Baseline data correction.** During analysis, the original baseline data file showed statistical patterns inconsistent with a valid SLEC-26 administration— specifically, near-zero internal consistency and item responses that did not align with the scale. Investigation traced this to a data-entry error in which response-scale anchors had been recorded in the wrong direction for a number of items. The implementation team reviewed and fully re-entered the baseline dataset. The corrected file was verified before use, with total-scale internal consistency returning to an acceptable level ($\alpha = 0.64$ at baseline, 0.77 at endline). All results reported here are based on the corrected baseline data. The endline data were unaffected throughout.
- **Social desirability bias.** Participants were recruited through YAD-affiliated schools and FGDs were conducted in the program context. Participants (particularly learners and parents) may have provided more positive accounts of the program than would emerge in an entirely independent setting.

3. FINDINGS

The findings are organized into three thematic sections, each mapped to relevant research questions. Evidence is presented cross-group throughout— drawing on accounts from learners, caregivers, teachers, program implementers, and external stakeholders— rather than organized by participant group.

3.1 The psychosocial context: Challenges facing children

This section explores the psychosocial landscape in which the program operated during Cohort 3 as a descriptive finding. One of the evaluation's central questions is whether the program was relevant and responsive to the needs of the children it served. In order to answer this question, the following section explores what those needs looked like, as described by both children themselves and by the adults in their lives.

Accounts were notably consistent across participant groups. This included learners reflecting on their own before-states, parents describing children's behavior at home, teachers characterizing what they observed in the classroom, and program staff and external education professionals describing the population they worked with. All accounts aligned around themes of emotional distress, behavioral difficulties, social withdrawal, and disengagement from school; these were described as the ordinary condition of many children's lives in the particular context of the program.

3.1.1 Emotional distress as baseline condition for children

The most noted description of children's state of wellbeing was characterized by emotional distress, including descriptions of fear, anxiety, loneliness, sadness, and the suppression of emotions. Every participant group described a version of this specifically. Children described their distress in terms of quiet and disengagement; this included staying quiet when they were upset, keeping worries inside,

preferring to be alone, and feeling afraid of being laughed at or judged. Several described not having the words for what they felt, or believing that expressing emotion would signal weakness.

These accounts were corroborated by adults, including caregivers, teachers, and implementing staff. Fathers described children who were emotionally withdrawn at home, and noted that their children's quiet and lack of communication regarding what was wrong was worrying to them. Mothers described daughters who cried quietly or when alone instead of talking to them. Multiple caregivers noted that their children (and specifically boys) had stopped laughing.

My child was emotionally sensitive and fearful most of the time. It was difficult for him to express emotions verbally. Even when upset, he preferred to be quiet rather than discussing feelings openly. Going to school also became irregular because he lacked confidence. Anxiety and fear were affecting his daily life significantly. (Father)

Teachers described students who were 'physically present but mentally disconnected,' clearly carrying emotional burdens into the classroom that affected everything from concentration to peer interaction. YAD program staff observed children arriving at Healing Room sessions 'feeling shy, anxious, distracted, or emotionally closed off.' Local education and psychology professionals, including faculty from SBK University, described the same array of expressions of distress that included anxiety, low confidence, and emotional insecurity. They noted these as defining features of the student population across partner schools.

One dimension of emotional distress that appeared with particular frequency was the suppression and non-expression of emotion. Children described learning (from family, cultural norms, or the experience of not being heard) that emotions were better kept inside. One male learner described his before-state as believing that expressing his feelings would make him 'appear weak,' and staying silent as a result. This pattern of emotional suppression rather than expression was a key contextual detail that helps to explain why creative, non-verbal approaches were well-suited to this population.

Many children, especially those affected by distress or instability, find it difficult to openly discuss their feelings with adults. However, through music, drawing, painting, and storytelling, they gradually become more expressive and emotionally engaged. (YAD art therapist)

3.1.2 Behavioral challenges and social withdrawal

Alongside emotional suppression, a significant number of children exhibited reactive anger, peer conflict, and aggressive outbursts. Learners described arguing with classmates over small things, reacting before thinking, and finding it difficult or impossible to cooperate. Fathers described children whose emotional dysregulation created tension at home, observed as intense arguments with siblings, non-cooperation with family members, and emotional outbursts that disrupted the household. Teachers described students who 'became frustrated very quickly over small issues' and whose emotional reactivity affected classroom dynamics.

These two patterns— withdrawal and reactivity— were consistently described as expressions of the same underlying distress, manifesting differently in different children. As YAD program staff articulated, children who lacked safe emotional spaces at home and in school had nowhere for stress

to go. It thus accumulated internally and eventually surfaced as aggression, withdrawal, frustration, or disengagement. The children who turned inward and the children who acted out were responding in different ways to the same problem.

My child had significant difficulty managing anger and emotions before joining the program. Small situations often led to frustration, shouting, or emotional outbursts. At home, we struggled to calm him during emotional reactions, and relationships with siblings were frequently affected by conflict. (Father)

Social withdrawal was a prominent theme in learner accounts. The majority of children across all five learner focus groups described pre-program states of isolation that included avoiding classmates, preferring to be alone, not knowing how to make friends, or fearing that peers would reject or ridicule them. Several children named isolation and feelings of not belonging, particularly those who had recently changed schools or joined new communities.

One learner described frequent arguments with classmates over small disagreements, reacting before thinking, and feeling that nobody understood what they were going through. This pattern of emotional reactivity had affected their friendships and their ability to cooperate in group settings.

3.1.3 Disengagement from learning

School disengagement was a third consistent theme, including descriptions of low motivation, poor concentration, avoidance of classroom participation, and irregular attendance. Learners described viewing school as joyless or stressful before joining the program. Several described being physically present in class while feeling entirely disconnected from the material, teaching, or daily classroom activities. Others described avoiding participation out of fear of failure or criticism. Caregiver accounts provided similar description.

Before the program, my son had very little motivation to study. He completed homework only after repeated reminders and often became frustrated with difficult subjects. His teachers explained that he was capable of learning but lacked concentration and self-confidence... As a mother, I was more worried about his emotional state than his grades, because I believed the two were closely connected. (Mother)

Teachers' accounts further emphasized this disengagement, describing students who were difficult to engage, who lacked the motivation to participate, and whose emotional challenges impacted their capacity for learning. All participating teachers identified emotional distress as the primary driver of the academic difficulties (mainly observed as poor concentration, hesitance to participate, and low confidence or self-belief) they observed.

3.1.4 Displacement, instability, and adversity as compounding factors

The emotional and behavioral challenges described above did not exist in a vacuum. Across multiple participant groups, these challenges were explicitly linked to the broader circumstances of children's lives. This included financial hardship, family instability, disrupted schooling, and, for Afghan refugee families, the acute and ongoing stressors of living under threat of deportation.

Children frequently experience anxiety, emotional insecurity, and low self-esteem. Many students hesitate to express themselves because they fear criticism or rejection. Without emotional support, these challenges gradually affect social relationships, learning abilities, and overall wellbeing. (Teacher)

Program staff offered comprehensive picture of this context. The children served by the program came from both refugee and host community backgrounds, most from families navigating financial precarity and social or community stress. Many had experienced displacement, interrupted schooling, and/or family separation. For refugee families specifically, the threat of deportation had become an acute and pervasive source of fear. Additionally, restricted movement and the inability to access community services without risk of detection had produced a state of profound anxiety and confinement across refugee households.

The impact of this political environment on children's psychosocial wellbeing was described as distinct from the challenges facing host community children, though there was significant overlap in presentations. Host community children faced their own adversities (including poverty, lack of opportunity, and family stress) but they did not carry the same uncertainty about their right to remain in the country.

The evaluation period itself was marked by acute disruption that further compounded these pre-existing stressors. School closures due to the national fuel crisis in March 2026, electricity outages, and restricted movement for refugee families shaped both children's experience and the conditions under which data collection took place. These contextual details are part of what it meant to be a child navigating this program during this particular moment.

3.1.5 Differential needs

The evaluation's third research question asks about the differential needs of different groups of children— by gender, refugee or host community status, and disability or vulnerability. The qualitative data provides a partial response to this question and honest acknowledgement of its limits.

The data does support the observation that Afghan refugee children and host community children faced overlapping challenges. The refugee-specific stressors described above (deportation fear, restricted movement, social exclusion from host community peer networks) were named consistently by program staff and external stakeholders as compounding factors that did not apply equally to host community children.

The data does not indicate major difference by gender. The learner FGDs included both girls and boys, and the accounts they produced were broadly similar in content and character. One exception was that male learners were somewhat more likely to describe pre-program emotional suppression framed in gendered terms, namely the belief that expressing emotion was incompatible with strength

or masculinity. This suggests that the program may need to work against active cultural resistance to emotional expression for some boys, not merely the absence of opportunity.

Program staff and local actors identified children with disabilities and out-of-school children as groups that were not effectively reached by the program, but who may strongly benefit from its effects. Out of school children were out of scope for the current school-based delivery model, so this is a logical gap in coverage and not a shortcoming in implementation. Children with disabilities were not a group the program was designed to specifically target, but program staff and local actors nonetheless named them as a group the current model does not effectively reach — citing the absence of adapted activities for different physical or cognitive needs and a lack of specialist disability expertise on the team. This was framed as an access issue rather than a finding about differential need among those who did participate. This is discussed further in Section 3.3.

Two additional observations were raised by YAD program staff, though neither was independently corroborated elsewhere in the dataset and both should be read as staff-level programmatic insight rather than triangulated findings. First, YAD staff noted that younger children tend to respond better to play-based and interactive activities, while older children engage more deeply with reflective storytelling and discussion — a distinction not tested directly in either the learner FGDs or the SLEC-26, which found broadly consistent gains across age bands.

Secondly, YAD staff identified female-specific barriers to access and full participation, including family responsibilities, cultural restrictions on girls' movement and behaviors, and the need for caregiver permission, distinct from the emotional-suppression pattern boys described in their own accounts above. However, YAD's own enrollment and referral data do not show a consistent pattern of girls being excluded or declined by parents, and there is gender parity in participation in YAD program reporting. It is worth considering that these two points are not mutually exclusive; gender parity in rates of participation does not necessarily mean that barriers for girls participation do not also exist. YAD makes notable (and successful) efforts to assure girls' participation, and also emphasizes that some girls in need may not have access or ability to participate in full. Some YAD staff described this as case-specific and linked more to limited familiarity with psychosocial support than to restrictions on girls' movement per se.

Both observations are plausible and worth further attention, but as with other differential-needs questions raised in this section, the current data collection tools were not designed to probe them directly, and they were not raised spontaneously by learners, parents, or teachers.

3.2 Program outcomes

The findings presented in this section draw on pre-post measurement of psychosocial wellbeing using the SLEC-26 and the 13 focus group sessions. The quantitative component provides systematic and statistical evidence of change over the program cycle; the qualitative evidence elaborates the nature of that change and the mechanisms through which it was produced while highlighting the perspectives of learner participants and the adults around them. The two data sources are presented together throughout.

Importantly, because the evaluation used a single-arm pre-post design without a comparison group, observed changes cannot be attributed solely to the program. Other factors, including the passage of time, the school environment, or maturation of learners, may also have contributed. The qualitative

evidence, and the specificity with which participants described the program as a source of change, supports a positive program contribution.

3.2.1 Quantitative overview: Measured change in psychosocial wellbeing

Children who participated in the arts-based MHPSS programme showed a statistically significant and substantial improvement in self-reported psychosocial wellbeing between baseline and endline. Across 135 matched children, the mean total SLEC-26 score (calculated as the mean of all the 26 items) rose from 2.14 to 2.90 on the five-point scale, an average gain of 0.76 points (95% CI 0.68 to 0.84). Improvement was consistent across all five measured domains — sense of safety and adaptability, emotion regulation, school support, family support, and present and future well-being — and gains in every domain remained significant after correction for multiple comparisons.

Table 3 Sample at a glance

Matched sample	Mean-score gain	Effect size
135 children	+0.76 points (1–5 scale)	Large (dz = 1.57)

Interpretation of effect sizes follows conventional benchmarks (small ≈ 0.2, medium ≈ 0.5, large ≈ 0.8).

Analyzed sample

Table 4 summarizes sample characteristics.

Table 4 Characteristics of the matched sample (n = 135)

Characteristic	Group	n
Gender	Female	74
	Male	61
Age band	5–7 years	28
	8–10 years	45
	11–13 years	62
Total matched pairs		135

The sample is drawn from eight Healing Rooms across partner schools in Hazara Town, Quetta. The near-constant demographic composition limited subgroup analysis to gender and age.

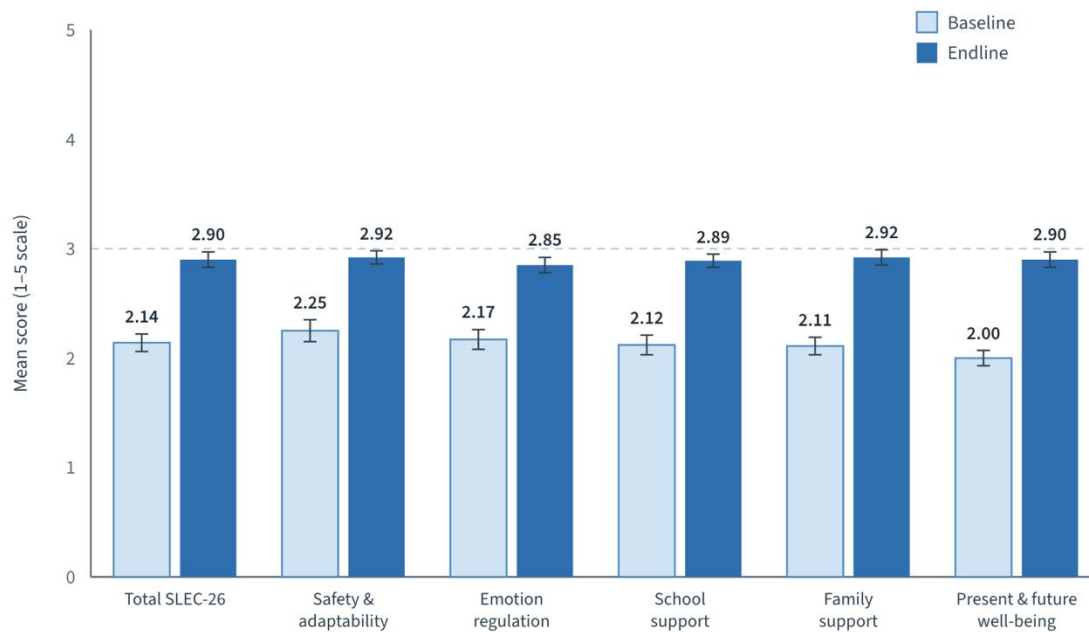
Change in wellbeing from baseline to endline

Scores rose on the total scale and on every domain between baseline and endline. Table 2 reports descriptive change; Table 3 reports the inferential tests, effect sizes, and p-values.

Table 5: Baseline and endline SLEC-26 scores (n = 135)

Scale	Baseline M	Baseline SD	Endline M	Endline SD	Mean change
SLEC-26 total	2.14	0.27	2.90	0.40	+0.76
Sense of safety & adaptability	2.25	0.37	2.92	0.46	+0.67
Emotion regulation	2.17	0.51	2.85	0.56	+0.68
School support	2.12	0.57	2.89	0.68	+0.77
Family support	2.11	0.47	2.92	0.68	+0.81
Present & future wellbeing	2.00	0.30	2.90	0.54	+0.90

Figure 3 Baseline and endline SLEC-26 scores (n = 135)



Error bars = 95% CI. Dashed line = scale midpoint (3.0).

Baseline and endline SLEC-26 scores (n = 135). Mean SLEC-26 scores at baseline (light) and endline (dark) for the total scale and each domain. Error bars show 95% confidence intervals. Every scale increased.

Table 5 Pre-post tests, effect sizes and significance

Scale	Mean Δ (95% CI)	Test	Effect size	Holm p
Total SLEC-26	+0.76 (0.68–0.84)	Paired t	$d_z = 1.57$	< .001 †
Sense of safety & adaptability	+0.67 (0.56–0.77)	Paired t	$d_z = 1.10$	< .001
Emotion regulation	+0.68 (0.55–0.81)	Paired t	$d_z = 0.90$	< .001
School support	+0.77 (0.62–0.92)	Wilcoxon	$r = 0.77$	< .001
Family support	+0.81 (0.68–0.95)	Wilcoxon	$r = 0.85$	< .001
Present & future wellbeing	+0.90 (0.79–1.01)	Paired t	$d_z = 1.42$	< .001

Δ = change (endline – baseline). † The total score is the single primary test and is not part of the Holm-corrected family; its unadjusted p -value is shown. All domain p -values are Holm-adjusted. d_z = Cohen's d_z ; r = matched-pairs rank-biserial correlation.

Figure 4 Mean improvement per scale with 95%

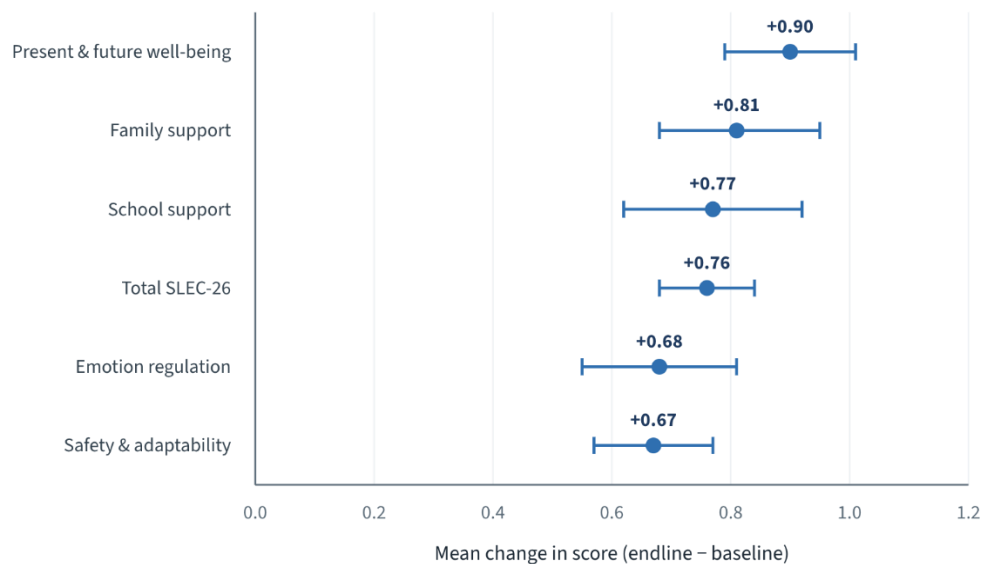
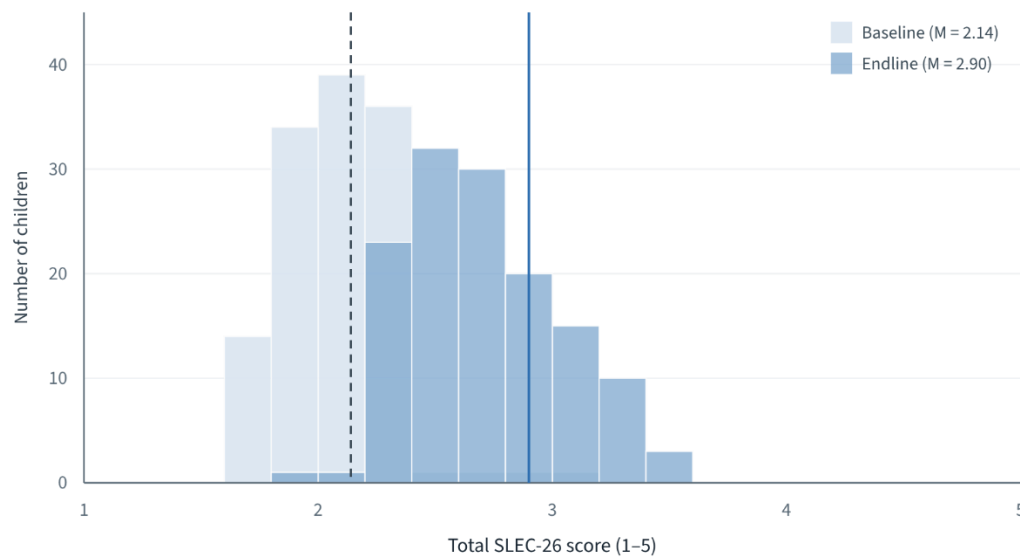


Figure 5 Distribution of total SLEC-26 scores at baseline and endline



Distribution of total SLEC-26 scores at baseline and endline. The whole distribution shifts upward; dashed and solid vertical lines mark the baseline and endline means.

The primary outcome (total SLEC-26 score) improved by 0.76 points on the five-point scale (95% CI 0.68–0.84), a large effect ($d_z = 1.57$) and was statistically significant. Every domain showed significant improvement after Holm correction for multiple comparisons. The largest gain was in present and future wellbeing (+0.90, $d_z = 1.42$), followed by family support (+0.81) and school support (+0.77). The smallest gain — still large by conventional benchmarks — was in sense of safety and adaptability (+0.67, $d_z = 1.10$). The consistency of improvement across all domains, rather than change concentrated in one or two, indicates a broad-based positive shift in children's self-reported wellbeing over the programme period.

Exploratory analysis did not find gender and age as predictors of change in total SLEC-26 score over time; a full explanation of this analysis is included as Annex 3.

3.2.2 Arts-based activities as a channel for expression

One of the most consistent findings across the dataset is that drawing, painting, music, and storytelling gave children in the program an effective way to communicate feelings they had no other way to express.

Adults (teachers, implementing staff, local experts) explained that many children in the program arrive with emotional pain and no verbal outlet. These children often lack the language for difficult feelings, the permission to express them, or both. Art allowed them a medium for expression entirely separate from verbal articulation. One facilitator described that art allowed children to communicate feelings that they may not yet have the language or confidence to describe openly, in ways that feel 'natural and less threatening.' Teachers noted that children who had remained emotionally

withdrawn and silent became more open and communicative after participating in creative activities, specifically because they were not being asked to speak.

The sessions are organized in a way that keeps children interested and emotionally engaged. Students often look forward to participating because the activities are interactive and different from regular classroom lessons. One important aspect is that the program does not pressure children to speak directly about emotional difficulties. Instead, children communicate naturally through creative activities. This approach is especially effective for children who struggle to express emotions verbally. (Local Actor)

According to YAD, the underlying principles of trauma-informed art, play, and music-based support are treated as broadly applicable across contexts, but their specific implementation in Hazara Town was substantially localized rather than delivered as a fixed, imported template. Guided by principles of do-no-harm, cultural appropriateness, and respect for local values, YAD's therapists report adapting sessions on an ongoing basis. This included drawing on locally familiar colors, patterns, landscapes, and cultural symbols; selecting themes that respect local religious and cultural sensitivities; communicating with children in Urdu and other locally understood languages; and adjusting music and movement activities to match children's cultural familiarity. YAD describes this as a continuous and iterative process, and non-YAD actors (teachers, parents, local actors) all confirm the cultural fit and appropriateness for the context.

Children's accounts additionally confirmed this, and the before-and-after drawing activity itself demonstrated the experience. In the FGDs, children were asked to draw and then describe what the drawing meant. This produced accounts of life and emotional experience that direct questioning might not have. One learner described their before-state by drawing a child standing alone beside a damaged house; the image communicated family difficulty, displacement, and isolation that the child described as feelings they could not easily explain with words.

Parents corroborated this, as well. Fathers and mothers both described children who had become expressive at home in new ways— bringing drawings home to share, singing songs after sessions, using creative activity as a way of processing what they felt. These were behaviors that had not existed before. Mothers in particular described observing children engage in spontaneous drawing or art-making when distressed, a self-initiated use of the strategies they had learned.

The biggest improvement is that he now talks openly about his feelings. Before, he kept everything inside and rarely shared what was troubling him. Now he tells me about his day, his friends, and even when he feels sad or worried. His confidence has also improved. He willingly participates in school activities, enjoys spending time with friends, and smiles much more than before. (Mother)

The consistency of this pattern across all groups makes this a notably robust finding. The arts-based modalities of support for children in the Healing Rooms provided a functional emotional channel for children who struggled to find other options for emotional and self-expression. This consistency, combined with YAD's account of an ongoing, locally grounded adaptation process rather than a fixed imported template, supports reading these arts-based modalities as a genuinely culturally responsive and appropriate approach.

3.2.3 Psychological safety within the Healing Room

Across all learner accounts, children described feeling safe in the Healing Room in a way they did not feel elsewhere. This was both safety from physical harm, but also about the experience of psychological and emotional safety. In the Healing Rooms, learners could express themselves without judgment and participation was invited rather than demanded.

The SLEC-26 sense of safety and adaptability domain showed a gain of 0.67 points, a large effect. This domain covers children's feelings of safety and their capacity to adapt to challenges, both of which are consistent with what participants described. The quantitative gain aligns with the qualitative accounts of children feeling safer and more settled over the program period.

Program staff described the session architecture as explicitly designed to produce this sense of safety. Sessions opened with a warm-up or check-in that allowed children to settle before engaging with more emotionally demanding material. Participation was never coerced; children could express themselves through creative work without needing to share verbally. The facilitators adapted the session in real time based on children's emotional state on a given day, sometimes changing planned activities entirely when the group needed something different. One facilitator described completely modifying sessions 'depending on children's mood, energy, or emotional reactions.'

During sessions, we encourage participation without forcing children to share more than they feel comfortable with. Some children openly discuss their artwork or feelings, while others express themselves silently through creative work. We respect both approaches. Group reflection is another important part of the session — children often learn from listening to one another, and peer interaction creates a sense of belonging and support. (YAD Implementing Staff)

The Healing Room itself— a physical space dedicated to the program within each school— mattered too. Several children described it as feeling different from the classroom. External stakeholders who had visited or observed sessions described the environment as notably calm and child-centered, distinct from the general school atmosphere.

Teachers shared that children who had been fearful or hesitant in the regular classroom often showed different behavior in and around the Healing Room sessions. They were more willing to communicate, less defensive, and more emotionally present. The creative context appeared to lower the stakes of participation in ways that the academic classroom, with its expectations of correct answers and visible performance, did not.

The YAD program is very structured and well-integrated into school activities. We observed that children actively engage during drawing, painting, storytelling, and group sessions. These activities reduce stress and encourage participation even among children who are normally very quiet. I believe the program succeeds because it creates emotional safety while remaining enjoyable and child-friendly. (Local Education Actor)

3.2.4 Confidence and self-esteem

Increased confidence was a widely and consistently reported outcome in the dataset. Improved confidence was named by learners reflecting on their own experience, by teachers observing classroom behavior, by caregivers describing changes at home, by program staff characterizing what they saw over multiple sessions, and by external education and psychology professionals who had observed or engaged with the program.

In the ‘before-state’ activity, learners drew and described a picture of themselves characterized by low self-worth and lack of confidence. They described staying silent when teachers asked questions, preferring to remain at the back of the room, and not participating in activities out of discomfort. Several children described comparing themselves unfavorably to peers and concluding they were not capable. One learner recalled believing she was ‘not good at anything’ and so avoided participation, which in turn shaped her relationship with school and with other children.

The shifts in the ‘after-state’ drawings were specific about this improvement. Multiple learners pointed to the same mechanism: facilitators praising their creative work and that praise helping them, over time, to change how they felt about themselves. One child described how this praise of her drawings led to her beginning to believe in herself. Another child described how doing different kinds of activities—often very different from those in the classroom—helped show her that ‘everyone has things they are good at.’ Rather than confidence emerging simply through repeated participation, children’s accounts suggest that facilitator affirmation acted as the catalyst through which creative success was translated into broader self-belief.

One learner described believing she was ‘not good at anything’ before the program — avoiding competitions, stepping back from activities. She described a specific moment when a facilitator praised her drawings as the point when she began to believe in herself.

The SLEC-26 does not include a dedicated confidence or self-esteem scale. The present and future wellbeing domain— which showed the largest gain in the dataset (+0.90)— captures constructs that are theoretically related to confidence, particularly children’s sense of academic self-efficacy (Q17: “I am able to do my best at school”) and positive future orientation (Q18, Q20, Q26). These items reflect the kinds of self-belief shifts that participants described qualitatively, and the domain gain is treated here as quantitative support for the confidence finding rather than a direct measure of it.

For some children, the confidence gain was visible outside of the Healing Rooms. Children who had previously refused to speak in front of groups described taking part in class discussions. Children who had remained in the back described willingness or even excitement to present their artwork. Teachers described students who had been ‘shy or socially hesitant’ becoming ‘more willing to interact and participate.’ One teacher noted positive changes in confidence, classroom behavior, and emotional stability in the same student.

Parents confirmed this effect and described witnessing it in the home. Fathers described children who had become more communicative, more willing to share thoughts, more present in family conversations. Mothers described specific changes, such as one noting that her daughter had stopped

complaining of stomach aches before school. She described her daughter as 'genuinely happy' when she returned from school.

The greatest change I have observed is my daughter's self-confidence. She now believes in herself and willingly participates in school competitions and classroom discussions. She even performs small presentations in front of the family, something she would never have done before. She has also become emotionally happier. She laughs more, talks openly with us, and enjoys drawing and creative activities at home. (Mother)

3.2.5 Emotional regulation

Alongside confidence, the change participants described most frequently was a shift in how children managed their emotions, particularly anger, anxiety, and general distress. Children described learning, from the program, to pause rather than immediately react. Parents described observing that shift at home, and teachers in the classroom. This was one of the most consistently described behavioral changes in the dataset.

Several children named concrete strategies related to emotional regulation skills, such as drawing when angry, listening to music when stressed, taking deep breaths, or talking to someone they trusted. Children could name and describe these functional coping strategies and how they used them outside of sessions.

The emotion regulation domain gain of 0.68 points aligns with the qualitative accounts of reduced emotional reactivity and improved self-management. It is worth noting that this domain had lower internal consistency in the original SLEC-26 validation and in this sample ($\alpha = 0.38$ at baseline, 0.35 at endline), which means the domain-level result should be read as indicative rather than precise. The qualitative evidence provides important triangulation, particularly given the consistency with which this change was independently described across participant groups.

Program staff and teachers pointed to the session's closing ritual as an important example. Staff described ending every session with calming exercises (such as breathing techniques, grounding activities, or quiet reflection) that was intended to help children leave the Healing Room feeling emotionally regulated. This was described as an important and effective mechanism wherein children were practicing regulation, repeatedly, in a supported environment.

Parents also observed improved emotional regulation skills at home. Fathers described the reduction in aggressive behavior and emotional outbursts at home, and this was one of the most frequently named changes. All caregivers noted how children who had previously reacted to small frustrations with shouting or conflict now managed those moments differently. Mothers observed that their children were more able to pause before reacting and were more able to talk about what was wrong. One mother described her son as having shifted from 'serious and withdrawn' to 'joyful and expressive,' noting that he had even started singing and drawing at home.

The program has helped my son control his anger. Previously, he reacted immediately whenever something upset him. Now he pauses, thinks, and tries to solve problems peacefully. This change has improved his relationships with

classmates and family members... His teachers say he participates in group work and communicates respectfully with other children. (Mother)

Teachers corroborated this finding in the classroom, describing reduced disruptive behavior, calmer responses to frustration, and less reactive conflict with peers. Improved emotional regulation via the examples above were described across teacher groups as among the most visible changes they had observed after the program. One teacher named improved emotional stability and stronger emotional control as the primary shift she had seen in participating students.

3.2.6 Peer belonging and social participation

The shift from isolation to connection was an important pattern in the learner data. Children who had described their before-state as one of friendlessness, exclusion, and preference for being alone described their after-state in terms of friends, feeling they belonged, and enjoying time with classmates. One child drew herself in her before picture 'sitting alone while other children played together,' and in her after picture 'working with friends on a painting activity.'

One major change was improvement in behavior and reduction in aggressive reactions in the classroom. Some students became calmer and more cooperative after joining the sessions. I also observed stronger emotional control and healthier interaction with classmates. (Teacher)

Several children described the group session structure itself as the mechanism, wherein everyone was encouraged to participate equally though no one was singled out, and the creative activities gave children a shared experience that did not require verbal confidence to join. The group format created a low-barrier entry point to connection with peers.

Peer belonging appears to function as a pathway to other outcomes, not only as a downstream effect. Children who described stronger peer connections also described feeling less lonely, more hopeful about school, and more motivated to attend and participate; social connection and emotional wellbeing appeared to reinforce each other.

Parents described observing improved peer relationships from the outside via fewer conflicts with siblings and peers, and more willingness to engage with neighbors and others in the community. Mothers in particular described children who had been socially avoidant becoming socially active by initiating conversations, spending time with other children, and expressing interest in others. Teachers described reduced peer conflict in classroom settings and stronger cooperative behavior during group activities.

I have noticed that my son has become more patient and cooperative. He is more polite with family members and has developed friendships with children in our neighborhood. He now seems to enjoy helping others instead of isolating himself...Although there is still room for improvement, I believe the program has had a very positive influence on his overall development. (Mother)

This family support domain of the SLEC-26 captures children's perceptions of support from family members (not family members' behavior directly). The questions within this domain include questions “I can talk to my parents about my worries,” and “When I feel scared, I can tell my parents. These questions thematically align with the qualitative descriptions about belonging and social skills (as well as about emotional expression and communication). On the SLEC-26, the family support domain gain of +0.81 is large and is consistent with the qualitative accounts of improved communication and relationship quality at home.

3.2.7 Hope and future orientation

At the end of the learner sessions, learners were asked to describe a future aspiration. The futures they named were specific and often prosocial, such as a teacher who would help children learn and feel good, a doctor who would make people feel healthy and safe, an architect who would design safe homes for people, a psychologist who would help other children manage their emotions. When the children described these futures, their reasons for specific careers often referenced their own experience of the program (as the examples above illustrate). The shared aspirations were specific, hopeful, and outward-looking.

It is important to note that the FGD structure prompted learners to reflect on their futures at the close of the session, which means the pattern reflects the question as much as the underlying experience. It is not corroborated by adult participants, who were not asked explicitly about future orientation of learners in the program (and it did not emerge spontaneously). The SLEC-26 present and future wellbeing domain gain (+0.90) provides some quantitative support for a shift in how children perceive their present circumstances and future prospects, though the instrument captures this at a general level.

The finding is presented here as a learner-perspective outcome— one that emerged clearly from children's own accounts, and that the quantitative data supports directionally. On the SLEC-26, the present and future wellbeing domain showed an improvement of +0.90, which was the largest domain gain in the dataset. This is consistent with children's accounts of positive future orientation.

3.2.8 School support and learning engagement

Improved school engagement (including increased motivation, better concentration, increased classroom participation) was described consistently by learners, parents, and teachers. Children described enjoying school more after joining the program; parents described improved attendance and attention; teachers described students who were more present and participatory in the classroom.

I noticed positive changes in... classroom behavior and emotional stability. Students became more engaged during lessons and more willing to communicate with teachers and peers. The program created a visible positive impact on both emotional wellbeing and learning participation. (Teacher)

The proposed mechanism was also consistent across the accounts provided by adults. Namely, emotional regulation improved first, and better emotional regulation freed up cognitive and attentional resources for learning. As one teacher put it, emotional difficulties had been 'gradually affecting social relationships, learning abilities, and overall wellbeing' — implying that addressing the

emotional preconditions had effects that rippled into the academic domain. This is consistent with the program's Theory of Change, which positions learning readiness as a medium-term outcome that grows from stabilized emotional wellbeing, rather than a directly targeted goal.

Many students struggle with concentration and maintaining attention during lessons. Emotional stress affects memory, participation, and motivation to learn. Children need both emotional and academic support systems working together because one directly influences the other. (Local Actor)

The SLEC-26 school support domain does not directly measure academic engagement or learning motivation. It captures children's perceptions of whether they feel supported by their teachers and school environment—a relational construct that is related to engagement but not in the exact ways as described in the qualitative data. The qualitative evidence mostly suggests the mechanism of the program supporting children's emotional regulation, and that emotional stability allowing for increased cognitive and attentive capacity for learning and engagement in learning. The SLEC-26 school support domain gain of +0.77 is consistent with this pathway — children who feel safer and more supported at school are better positioned to engage — but the two constructs are a bit thematically distinct, and should be read as such. Both are supported to different extents by the data.

3.2.9 Caregiver awareness of children's psychosocial needs

Improved awareness of children's psychosocial needs amongst parents and caregivers was an explicit intended outcome of the program. This was primarily addressed in the caregivers' FGDs, with the strongest evidence of impact provided in the mothers' group. The SLEC-26 family support domain—with gain of +0.81—is consistent with the accounts of improved home communication and growing caregiver awareness as described, mainly by mothers, below.

Mothers described an initial state of limited understanding. Most reported that before the program, they had noticed something was wrong with their children but had not had a framework for understanding it as an emotional or psychosocial need. Several described feeling helpless—aware that their child was suffering but uncertain how to respond. One mother described watching her son become increasingly withdrawn and joyless, and feeling 'helpless because I did not know how to support him emotionally.'

Mothers described that, as their children's behaviors changes, they also began to consider these behaviors differently. When they observed their children use drawing or music to manage distress, brought artwork home, and became more communicative about their feelings, mothers were prompted to reflect on what their children had needed. Several described paying more attention to children's emotional states as a direct result of the program. A few described sharing what they had observed with other families, which had encouraged those families to allow their own children to participate.

Community involvement is still limited, but some parents have started discussing the positive changes they have observed in their children. This has encouraged other families to allow their children to participate. (Mother)

The fathers' groups did not produce this theme with the same depth or specificity. Fathers described behavioral changes in their children (calmer, less aggressive, more communicative), but did not describe a shift in their own awareness of children's emotional needs in the way mothers did despite a similar line of questioning. Whether this reflects different levels of engagement with the program, different access to information about what the Healing Room was doing, or different relationships with children's emotional lives, the data is unclear.

3.2.10 Creative expression beyond the program space

Parents—and particularly mothers—shared that children engaged in drawing, painting, music, and creative activity at home, independently and spontaneously, after sessions. This was a short-term outcome identified in the ToC, but was not explicitly addressed in the questionnaires. Its unprompted accounts of children doing just that are therefore noteworthy.

My daughter has become much more emotionally open. She now goes to school happily and no longer complains of stomach aches or fear before leaving home... She also enjoys drawing at home and often explains the meaning of her pictures. I feel that these creative activities have helped her express emotions that she previously kept hidden. (Mother)

Importantly, this suggests that the program produced something beyond a within-session experience. Children had learned and internalized arts-based practices as a way of managing their emotional lives and were choosing to use them without prompting. Mothers described sons who 'sing songs and draw pictures to share with the family,' daughters who 'draw or write about feelings' when stressed, and children who spent time creating artwork in the evenings. These were new behaviors that had not been present prior to the program.

Teachers and fathers added an important reflection to this point. While some children practices creative activities outside of the Healing Rooms, this was inconsistent and limited due to the absence of materials. This points to a constraint that participants across all adult groups raised. Without art materials at home, the continuation of creative practice between sessions and after the program ends will be limited. This is discussed further in Section 3.3.

Since joining the Healing Room, my son regularly draws pictures at home. Almost every evening after completing his homework, he spends time drawing different scenes or coloring pictures. Sometimes he explains the meaning of his pictures to the family. I feel this has become a healthy habit that helps him relax. (Mother)

The significance of this finding is not just behavioral. Children choosing to use creative expression to manage distress, without being asked or supported by a facilitator, represents an internalization of the program's core approach. It is also, in practical terms, a mechanism for sustaining some of the program's effects beyond the cohort period, though the durability of this without ongoing reinforcement is uncertain.

3.3 Implementation and Learning

This section addresses how the program was delivered, what supported its effectiveness, what limited its reach, and what participants and stakeholders recommended for improvement. It also addresses the questions of unintended consequences and sustainability, where the data allows. Evidence here is drawn primarily from the adult participant groups (teachers, parents and caregivers, YAD program staff, and local actors) with learner accounts where relevant.

3.3.1 Program design and cultural fit

Across all adult participant groups and the external stakeholder FGD, the program's relevance and cultural appropriateness were affirmed consistently. Teachers, parents, and local actors all described the creative methods as appropriate for the community and well-received by children. Several participants noted explicitly that activities were respectful of local norms and traditions, an observation that was offered voluntarily without being directly prompted. YAD's own account of implementation is consistent with this: therapists did not deliver a fixed, imported model but continuously adapted activities to children's age, cultural background, and comfort — for example, using locally familiar colors, patterns, and themes in art activities, and adjusting language and communication to the local context. YAD reports that this flexibility, rather than requiring major redesign, has been one of the approach's core strengths in Hazara Town.

The program fits well within the cultural norms and community values. Both parents and teachers recognize and generally appreciate the positive emotional and behavioral changes when they observe them in the children. (Teacher)

The sessions are organized in a way that keeps children interested and emotionally engaged. Students often look forward to participating because the activities are interactive and different from regular classroom lessons. One important aspect is that the program does not pressure children to speak directly about emotional difficulties. Instead, children communicate naturally through creative activities. (Local Actor)

External education and psychology professionals provided additional support for this assessment. The participants in the local actors FGD— including senior experts from SBK University with no organizational stake in the program's success— described the approach as effective, culturally acceptable, and well-suited to the population. One described it as 'one of the most effective school-based interventions currently available for children's emotional wellbeing' in the context. The use of arts-based methods was specifically validated as contextually appropriate. Several participants noted that children in this population often lack the verbal emotional literacy or cultural permission to discuss feelings directly, making non-verbal creative approaches a good fit.

I consider the YAD program one of the most valuable emotional support initiatives available within the school environment. The combination of creative activities and psychosocial support makes it very effective for children

experiencing emotional distress. Students appear emotionally relaxed during sessions, and this positively affects classroom behavior afterward. (Local Education Actor)

In a context where mental health services are scarce, stigmatized, and poorly integrated into schools and communities, a program that is perceived as culturally acceptable and non-threatening is not only more likely to be used— it is more likely to be sustained. Cultural fit is a critical enabling condition.

3.3.2 Facilitator quality and the group as mechanism

The program works through the session facilitators and the specific ways in which they structured sessions, responded to children, and created conditions in which participation felt safe rather than demanded.

Program staff described a session architecture built around two principles: structure and flexibility. Sessions followed a consistent format which includes warm-up, guided creative activity, group reflection, and a closing ritual. But within that format, facilitators exercised real-time judgment about what children needed and adapted accordingly. Planned activities were sometimes abandoned entirely if children arrived distressed or unsettled. The session was adapted to the group's emotional state on the day. This kind of responsive facilitation requires significant social emotional skill on the part of the facilitator. They must be able to “read” the room, manage group dynamics, and hold the space when children bring difficult emotional content—all while bearing in mind the benefits of consistent structure and the resources of existing curriculum.

I pay close attention to group dynamics because peer interaction can strongly influence emotional comfort. Children often become more confident when they see others participating freely and positively. (YAD implementing staff)

Several learner accounts pointed to specific facilitator behaviors as the mechanism for confidence gains. Children described facilitators praising their drawings, encouraging their participation, and making them feel their contributions mattered. Adult affirmation that was consistent, unconditional, and creative rather than academic appears to have functioned as a repair mechanism for some children whose experience of school had been one of judgment or inadequacy.

The group itself also functioned as a therapeutic mechanism, not just a delivery vehicle. Children described watching their peers participate and feeling it became easier to join. Program staff described peer interaction during group reflection as a source of insight and connection— children learning from one another as much as from the facilitator. One child attributed her shift from outsider to belonging specifically to the fact that 'everyone was encouraged to participate equally.' The equal-participation norm, held by the facilitator, created a group culture that made belonging possible.

Group reflection is another important part of the session. Children often learn from listening to one another, and peer interaction creates a sense of belonging and support. (YAD implementing staff)

3.3.3 Barriers to reach and participation

The school-based delivery model, while enabling the program to reach a significant number of children within a structured and safe environment, also defines the boundaries of who the program serves. Out-of-school children— a population that Balochistan has in particularly large numbers— were consistently identified by program staff and local actors as unreachable under the current model. Children who are out of school are often among the most vulnerable. This includes those who are working, those from families who cannot afford uniforms or materials, and those who have dropped out due to emotional or behavioral difficulties. The program, as currently designed, does not reach these children.

Children with disabilities were similarly identified as a gap. Program staff acknowledged that activities were not systematically adapted for children with different physical or cognitive needs, and that the absence of specialist disability expertise limited the program's inclusivity. The local actors FGD raised this directly; one participant recommended partnerships with disability organizations and home visits as pathways to reach children who could not access the school setting.

Within the program, the absence of art materials for children to take home was raised across all caregiver groups and by teachers. Without materials, the continuation of creative practice between sessions, which several parents described observing and valuing, depended on whatever children could improvise. This is a practical constraint with consequences for the program's ability to support coping beyond the Healing Room.

3.3.4 Community awareness as a sustained activity towards gradual change

Community-level awareness of the program remained limited despite a sustained, multi-channel outreach effort on YAD's part. Beyond the Healing Rooms, YAD ran a sustained program of community-level awareness activity, built around a set of educational mental health videos on trauma-informed art-, play-, and music-based approaches. These were designed as resources intended to be used across platforms and for a range of audiences. They were distributed through multiple, overlapping channels intended to reach well beyond the children directly enrolled in the program. Distribution included intentional dissemination across all eight partner schools, screened within the Healing Rooms, presented at project milestones and exhibitions, shared through parents' and community WhatsApp networks, and disseminated through YAD's broader digital and social media channels. Community members, local stakeholders, artists, and mental health professionals were also engaged directly through exhibitions, learning visits, and advocacy activities.

Despite this, community awareness of the program's purpose was described as limited. Mothers in particular described other families in the community who did not know what the Healing Room was for, or who held some uncertainty about what children were participating in. A few mothers described sharing their own children's positive changes with neighbors, and noted that this was a mechanism by which awareness was spreading. However, this was informal and dependent on individual initiative.

YAD staff acknowledged this gap. In discussion with the YAD team, there was general agreement that this gap may not simply reflect insufficient outreach and engagement activities so much as the underlying difficulty of shifting community-level attitudes on a stigmatized topic within a two-year window. Importantly, this evaluation did not examine the effects of the specific community engagement activities in depth, so it is not possible to say whether the activities were insufficient or if they simply require a longer period of time to be fully realized.

Literature on mental health stigma and awareness

A substantial body of research on mental health stigma reduction treats awareness, attitude change, and behavior change as distinct, sequential stages rather than a single outcome (Funk et al., 2025; Thornicroft et al., 2022). Evidence from low- and middle-income country settings shows that these stages can move unevenly and unpredictably over time (Cruz et al., 2021) but that gains are often of a larger effect size than in high-income countries (Funk et al. 2025). The WHO frames changing attitudes toward mental health as a central, ongoing global priority rather than a one-time achievement (WHO, 2022). This pathway is further complicated in displacement contexts specifically; a systematic review of refugee populations identified mental health stigma, unfamiliarity with dominant mental health frameworks, and competing survival priorities as among the most salient barriers to engagement (Byrow et al., 2020). These barriers closely mirror what YAD, POM's previous research on mental health services in Balochistan, and this evaluation observed. Read together, this literature supports interpreting the community and caregiver engagement findings not as a shortfall in program delivery, but as evidence of the early stages of a pathway towards increasing awareness.

YAD staff noted the following important points: (1) Mental health remains sensitive in this context, so families and communities will require sustained outreach via trusted, relationship-based engagement to raise awareness over a longer period of time, and (2) Hazara Town's wider community is larger and more diverse than the direct project network, so many residents may have had only partial exposure to community engagement activities. Staff reflected on their own efforts to shift towards smaller, repeated, and relationship-based engagement moving forward, noting as well that while the foundation for awareness has been laid, significant and sustained investment to engage with community will be required before more thorough change is documented. Importantly, close tracking of engagement events (including attendance sheets with number and type of community members participating) and follow up with participants (specifically exploring the content of these activities) should be conducted in the future to understand and document change over a longer time period.

3.3.5 Caregiver engagement as a sustained activity towards gradual change

Separately from broader community-facing activity, YAD ran a set of activities for caregiver-specific engagement throughout the project lifecycle. This included dedicated parent psychoeducation sessions through the partner schools; a Psychological First Aid (PFA) training track specifically for parents and caregivers (distinct from the PFA training delivered to school staff); regular school-based parent communication (parent meetings, Parent Days, Parent/School Management Committees); home visits by YAD psychologists for children with identified concerns; WhatsApp-based

psychoeducation; informal day-to-day psychoeducation during routine contact with families; and the same educational videos repurposed as home-based learning resources.

Despite this level of activity, caregivers, teachers, program staff, and local actors all described need for more systematic involvement of parents, clearer communication about the program's purpose, and structured opportunities for caregivers to understand and reinforce what children were learning. Across all groups, this was the single most common improvement recommendation in the dataset.

Parent engagement is gradually improving, but communication systems could become stronger. Schools, facilitators, and families need closer coordination. At present, teacher involvement is mostly informal rather than structured, as well. (Local Education Actor)

As described by parents, this gap matters in practical terms. Parents who did not understand the program's purpose could not reinforce it at home. Several mothers described beginning to pay more attention to their children's emotional states as they observed changes, but this awareness grew from observation itself, not the deliberate engagement by the program. Fathers' accounts suggested lower levels of awareness overall; most described behavioral changes in their children without connecting those changes to a framework of emotional wellbeing or psychosocial support. A few fathers noted the need for community sensitizing or outreach to parents to help improve this.

Parent emotional support sessions would be very helpful because families need guidance on supporting children emotionally at home. (Father)

This caregiver engagement gap persisted despite an integrated program of caregiver-specific activity on YAD's part. As was the case with community engagement efforts, it is not possible in this evaluation to state whether this gap was due to insufficient activities (such as not reaching all caregivers or caregivers not understanding the content) or if changes in awareness of mental health needs and programming will increase over a longer time period.

YAD staff reflected on the structural, contextual factors that—similar to raising awareness about MHPSS and the program specifically in communities—may impact parents' awareness. This includes engagement aimed at shifting understanding of children's distress away from framing such as weakness of personality or ordinary misbehavior towards a normalized response to displacement and security. As noted above, such reframing requires sustained, repeated exposure for parents rather than one-off events or outreach. Additionally, many of YAD's outreach activities involved outreach via digital mediums; literacy, language, and uneven digital access may have limited how effectively some caregivers could engage with video- and WhatsApp-based materials. As is true for the community engagement outcome, more detailed tracking of outreach activities (number of participants, specific monitoring of participation of mothers and fathers), as well as a specific effort aimed at understanding the effects of the engagement activities should be integrated in future phases.

Caregiver engagement with the program itself is critical. Structured and sustained parent engagement should include a required on-boarding session, regular briefings, simple psychoeducation, and materials for home. These will ultimately increase the chances that what children learned in the Healing Room is reinforced rather than contradicted at home, and it will begin to build the caregiver capacity that sustainability of the program itself (and its effects) will require.

This finding also has direct implications for the Theory of Change, which articulates increased caregiver awareness of children's wellbeing needs as a short-term outcome. The data suggest this outcome was partially achieved (primarily among mothers), but that additional gains will require continued, dedicated efforts beyond a two-year program cycle. This may include more frequent caregiver dialogue, community-based mental health champions, and greater involvement of trusted local figures.

3.3.6 Teacher engagement and trauma-informed practice

Teacher engagement with trauma-informed practice remained largely informal, and did not extend into the kind of sustained, classroom-level integration the Theory of Change anticipated. This gap likely reflects the structural limits of a single one-day training rather than a lack of individual teacher engagement or program effort.

Inside the partner schools

Staffing and class sizes vary considerably across the eight partner schools. Total school staff ranges from approximately 20 staff persons at smaller schools to 30–40 at larger ones, and average class sizes range from 30 to 45 students. Each school day is organized into 6 to 8 teaching periods of roughly 30 to 40 minutes each, typically running from a 7:30–8:00 AM start to a 1:00–1:30 PM finish. Teacher qualifications vary, with most holding a bachelor's degree in education (a few also hold a Master's degree or other graduate-level qualifications). Each partner school also designates one staff member as a Shadow Art Therapist, who is selected from within the existing school team rather than hired separately.

The evaluation's Theory of Change anticipated that teachers would develop and apply more trauma-informed approaches as an indirect program benefit. The evidence for this is limited. Teachers described what they had observed in students, but did not describe learning new approaches to classroom management, adjusting how they responded to emotionally distressed children, or developing a closer working relationship with Healing Room facilitators. Communication between teachers and facilitators was consistently described (by teachers, parents, and external stakeholders) as limited.

Local actors described teacher involvement as 'mostly informal rather than structured' and emphasized that more formal training and guidance on emotional support strategies was needed. Teachers themselves acknowledged this gap and several recommended stronger coordination between the program and the school.

Communication between teachers and facilitators could become stronger to improve school engagement further. (Teacher)

Some of this reflects structural constraints, not commitment of teachers. In partner schools, class sizes are large and the school day is fully schedule, which limits how much room any individual teacher has to take on additional responsibilities or to integrate new practices.

YAD's support for teachers centered on a one-day Psychological First Aid (PFA) training, delivered to teachers and school staff at each of the eight partner schools and facilitated by YAD's Lead Psychologist. This included using a structured PFA training manual, facilitator agenda, presentations, and locally adapted case studies. The training covered the core Look, Listen, and Link framework;

common emotional and behavioral reactions to trauma; and practical tools — grounding and calming techniques, active listening, safe-space approaches — delivered through role-plays, group discussion, and scenario-based exercises built around situations teachers were likely to encounter, including bullying, grief and loss, family separation, and children showing signs of trauma or emotional withdrawal. It also covered confidentiality, referral pathways, and coordination with YAD psychologists and school-designated Shadow Art Therapists.

Beyond the training itself, teachers had access to informal, ongoing touchpoints through school-based coordination meetings, project discussions, and their school's Shadow Art Therapist, who acted as a day-to-day link between school staff and the YAD team.

Even a well-designed one-day training of this kind is not sufficient to build durable, practitioner-level competence in trauma-informed classroom practice. Skills such as emotional regulation coaching, grounding techniques, and trauma-sensitive classroom management are practice-based competencies that require repetition, feedback, and real-world application to become embedded. They will rarely be consistently or effectively applied after a single exposure. This is consistent with what the evaluation data show: teachers described their engagement with the program as informal rather than structured, and did not describe adopting new classroom management approaches as a result of the training. Teachers themselves recognized this same limitation.

Teachers themselves still require more psychosocial support and training opportunities. (Teacher)

The program serves children within schools but has not yet systematically engaged the adults who work with those children every day beyond the initial PFA training. Closing that gap requires building a longer, scaffolded pathway for teachers; this may include refresher sessions, peer learning, coaching or mentoring from YAD's psychosocial team, and structured opportunities to practice new skills and receive feedback over time.

The PFA training itself was well-designed and covered important, relevant content; further, YAD has the institutional knowledge, staff expertise, and training content needed to deliver this kind of support well. Committing to further trainings with repeated engagement over time will strengthen the foundation established for teachers, and allow them to extend and reinforce the Healing Room's effects.

3.3.7 Unintended consequences

No participant across any FGD described a negative or unintended harmful consequence of the program. Children did not describe distress arising from sessions. Parents did not describe adverse effects. Teachers and external stakeholders did not raise concerns about harm.

The closest thing to an unintended effect in the data was the community awareness gap noted above; namely, that some families felt they were not fully informed about the program's purpose, and held some uncertainty about what their children were participating in. This is a communication gap with potential to undermine trust, though no participant described it as having done so in a concrete way.

The absence of reported negative consequences should be interpreted carefully. Generally, in evaluations, unintended harms may go uncaptured because of social desirability bias or fear of losing support or other negative consequences, given that participants were recruited through program-

affiliated schools and FGDs were conducted in the program context. Therefore, this should be an area that YAD staff and future evaluations should continue to be attentive to.

One positive unintended consequence emerged from the teachers' FGDs. Teachers described their own wellbeing improving as a secondary effect of children's behavioral change. As students became calmer and more regulated through participation in the program, the classroom environment itself shifted in ways that reduced the daily stress teachers experienced. One teacher noted that "Classroom management became easier as students became calmer and more cooperative;" another that "Reduced behavioral problems lowered stress levels for teachers." A third teacher connected this to the broader school environment: "The improved classroom environment positively affected our own wellbeing."

While the program's Theory of Change does not articulate teacher wellbeing as an intended outcome, this finding is consistent with the broader evidence base establishing that student emotional and behavioral difficulties are a primary driver of teacher occupational stress— and that reductions in those difficulties have measurable consequences for teachers' experience of their work (Abramowitz & Doktor, 2023; Bower et al., 2021). It is also worth noting that this point was made alongside the request for teachers to receive more psychosocial support and training opportunities. Importantly, this emphasizes that the indirect wellbeing benefit described above was experienced in the context of an ongoing unmet need for direct support.

3.3.8 Sustainability and local ownership

Participants across several groups reflected on what would need to happen for the program's effects to persist beyond the cohort, and for the program itself to be sustained. Program staff offered the most substantive engagement with this question. Facilitators described sustainability as requiring a shift in where psychosocial support capacity sits— from a program-delivered service to a capacity embedded in schools, families, and communities. The mechanism they described was knowledge and skills transfer. If parents could understand and support children's emotional needs at home, and if teachers could apply basic trauma-sensitive approaches in the classroom, and if community members could recognize signs of distress and point to resources, then the program's effects would be more likely to continue after it ended. This framing is consistent with good practice in MHPSS programming.

The data does not indicate that such a knowledge or skills transfer has yet happened in a systemic way. Parents described observing changes in children; they did not describe having been equipped with new knowledge or tools. Teachers described observing the program's effects in students; while YAD confirms that all partner schools received a one-day Psychological First Aid (PFA) training, teachers themselves did not describe this training as having changed their day-to-day classroom practice, and generally spoke of it as a single, one-off session rather than an ongoing capacity-building process. Community awareness was growing through informal channels, but few evaluation participants described the deliberate capacity-building activities that YAD carried out. These activities included a variety of engagement sessions and outreach efforts, including, as described in Section 3.3.3, educational videos disseminated through schools, Healing Rooms, WhatsApp networks, and social media, plus in-person community events and exhibitions.

This gap, in the evaluation's assessment, reflects the difference between awareness (which the videos and events did generate) and durable shifts in understanding and behavior, which typically require more repeated, relationship-based engagement than one-off or broadcast content can achieve, particularly given the persistent stigma around mental health topics in this context. This

interpretation draws on follow-up consultation with YAD, whose own account of the gap points in the same direction, as well as on local actors' observations of how awareness has spread in practice. They described such change as gradual and informal rather than through a deliberate capacity-building process. Taken together, these perspectives support reading the finding as evidence of how long sustainable change takes, rather than as a shortfall in program delivery.

4. CONCLUSIONS

This section draws together the previous findings to offer an integrated assessment of what the program achieved, where the evidence is strongest, and what the data reveals about how change happened. It returns explicitly to the program Theory of Change— the framework that organizes both the program and this evaluation— and considers how the evidence speaks to each of the outcome pathways the ToC articulates. It closes with a forward-looking synthesis that frames the recommendations that follow.

4.1 The program addressed a real and substantial need and showed impact

One of this evaluation's clearest findings is that the children served by the program carried a real and significant psychosocial burden, and the program responded to a documented gap in available support. Children's pre-program circumstances were consistently described as characterized by emotional distress, social isolation, behavioral difficulties, and school disengagement. The broader contextual details of life in Balochistan, including the specific challenges faced by refugee families and communities, mean navigating the acute anxieties of deportation threats, family separation, and restricted movement. The mental health system serving this population is severely under-resourced, and school-based psychosocial support of any kind is rare. The program occupies a space where there was a notable gap, and provides services that are acutely needed.

The outcome findings reflect this point, as well: An effect size of $d_z = 1.57$ on the total SLEC-26 is large, and children's mean total score moved from below the scale midpoint at baseline to closer to it at endline— a shift that is consistent with what participants described across the qualitative data. The gains are notable and important, but should also be considered within the Balochistan context, where the underlying conditions driving children's distress have not changed, and where continued support is not guaranteed.

Across the data sources, there was breadth and coherence of the changes observed, and improvement was not concentrated in one domain or described by one participant group. Every SLEC-26 domain improved significantly. Every adult participant group independently described changes in children that were consistent with the program's intended outcomes. The changes described by learners, corroborated by parents, confirmed by teachers, and validated by external professionals form a coherent picture of program impact.

4.2 The evidence largely supports and aligns with the program Theory of Change

The program Theory of Change articulates a pathway from program inputs through short-term outcomes to medium and longer-term wellbeing outcomes, with indirect effects on caregivers and

teachers. Table 7 presents an assessment of the evidentiary basis for each outcome in the ToC, drawing on both the qualitative and quantitative findings.

Table 7: Assessment of evidence against key YAD Theory of Change outcomes

ToC outcome	Pathway	Evidence assessment	Summary of evidence
Sense of safety	Short-term	Strongly supported	Strong evidence by learners, implementing staff, and local actors. SLEC-26 safety domain gain of +0.67
Recognizing and expressing emotions	Short-term	Strongly supported	Strongly evidenced across all six participant groups. Children, parents, teachers, program staff, and local actors all described arts-based activities enabling emotional expression that verbal approaches had not. SLEC-26 emotion regulation gain of +0.68
Positive peer relationships	Short-term	Supported	Strong support in qualitative data: Learners described shifts from isolation to belonging; parents and teachers observed reduced peer conflict and new friendships; YAD staff describe group dynamics
Trusting relationships with adults	Short-term	Strongly Supported	Learners, teachers, and parents qualitative data supports improved supportive relationships. SLEC-26 family support domain (as proxy) gain of +0.81
Healthy coping strategies & outlet for stress and difficult emotions	Short-term	Supported	Strong support in qualitative data: Children named specific strategies (drawing, breathing, talking to someone trusted) and described using them outside sessions. Parents observed spontaneous creative practice at home
Caregiver and community awareness of children's wellbeing needs	Short-term	Partially supported	Evidenced primarily through the mothers' FGD; limited in fathers' groups. Awareness grew through behavioral observation rather than deliberate program engagement. Little evidence of community awareness and engagement
Teacher skill application	Short-term	Weakly supported	Qualitative data names this as a gap: Teachers observed changes in children but did not describe changes in their own classroom practice; communication between teachers and facilitators was consistently described as limited; teachers and local actors named this as a gap
Increased confidence and self-esteem	Medium/long-term	Strongly supported	Strongly evidence across all participant groups in qualitative data. SLEC-26 present and future wellbeing (as proxy) gains of +0.90 (though

ToC outcome	Pathway	Evidence assessment	Summary of evidence
			interpreted with care as it is not directly measuring confidence)
Prosocial behavior and cooperation	Medium/long-term	Supported	Strongly supported by all participant groups in qualitative data. Teachers described reduced peer conflict and stronger cooperation; parents described improved family communication and sibling relationships; group session structure described as a direct mechanism of change.
Emotional regulation	Medium/long-term	Supported	Strongly evidenced across qualitative set. SLEC-26 emotion regulation gain of +0.68 (domain reliability is low so qualitative triangulation is particularly important)
Reduced behavioral difficulties	Medium/long-term	Supported	Strongly evidence across qualitative data set; consistent parent and teacher accounts of reduced aggression, conflict, and emotional outbursts
Reduced stress levels	Medium/long-term	Weakly Supported*	Stress was not directly asked about, and was not named in the dataset; this does not indicate that it is an inappropriate outcome, but should be investigated further.
Improved learning readiness	Medium/long-term	Supported (with caveat)	Strongly evidence across qualitative data set; described by learners, parents, and teachers. SLEC-26 school support domain gain of +0.77 (caveat of this representing learners feeling improved support at school not learning engagement)
Continued access to creative expression beyond the classroom	Medium/long term	Supported (with caveat)	Supported by qualitative data (parents, teachers) but lack of access to materials for creative expression named as a barrier to sustainability
School-wide improvements in teacher-student interactions	Medium/long term	Weakly supported*	Not specifically investigated; little emergent data to support
Increased and sustained parent and community engagement with the school and MHPSS programming	Medium/long term	Weakly supported*	Named as a gap by parents, teachers, and local actors

Evidence assessment categories: Strongly supported = consistent evidence across multiple participant groups and quantitative data; Supported = consistent qualitative evidence across at least three participant groups, with or without quantitative

corroboration; Partially supported = present in the data but limited in scope or depth; Weakly supported = minimal direct evidence.

**Indicates an outcome that was not explicitly examined. Thus, evidence assessment is not relevant for understanding program impact but could be useful in determining future lines of inquiry.*

The overall picture from the ToC assessment is notably positive. Relevant medium and longer-term outcome domains showed significant improvement on the SLEC-26, and the qualitative evidence corroborates these gains with specificity and coherence. The short-term outcomes— the mechanisms through which the program was expected to produce change— were also broadly evidenced, with two important exceptions.

Caregiver awareness of children's wellbeing needs was partially achieved. The mothers' FGD provided evidence of growing awareness, and the SLEC-26 family support domain gain of +0.81 points is consistent with improved home relationships. But the pathway was informal rather than designed; mothers became more aware of their children's needs by observing changes, not because the program engaged them deliberately. Fathers' groups showed less of this shift.

Teacher skill application showed the weakest evidentiary support of all ToC outcomes. Teachers observed program effects in children; they did not describe changes in their own practice. This is partly a design gap— the program delivers to children within schools but has not yet built a structured channel for engaging the teachers who share those children's days. The ToC's aspiration that teachers would develop and apply trauma-informed approaches has not yet been realized in Cohort 3.

In terms of long-term outcomes, three were not directly investigated in this evaluation (as noted in the table above). All relate to engagement with non-learner actors (teachers and other school staff; caregivers; community), which has been noted as a gap and opportunity previously.

4.3 The mechanisms of change and how the program worked are supported by data

The findings point to three mechanisms that appear to account for explaining much of what the program achieved in terms of learner outcomes.

The first is the use of arts-based, non-verbal modalities in a context where verbal emotional expression was constrained. Children in this population often lacked either the language, the cultural or gendered permission/norms, or both to talk directly about what they felt. Drawing, painting, music, and storytelling provided an alternative medium that was effective because it facilitated expression despite those skill/norm gaps. This mechanism was described consistently across participant groups, and was validated by external psychology and social work professionals. The evidence therefore supports the appropriateness of this modality for this population.

The second mechanism is the quality and approach of the facilitation. The Healing Room's effectiveness was not simply a function of activities, but also of how those activities were held. This includes the non-coercive participation norm, the real-time adaptation of sessions to children's emotional state, the deliberate warm-up and closing rituals, the consistent affirmation of children's contributions, amongst others. These are practices that required skilled and reflective facilitators, who were well supported by YAD. Several learner accounts traced their confidence gains directly to the experience of being noticed and praised by a facilitator. This is a relationship-based mechanism,

which aligns with the broader MHPSS literature related to what works to support children's mental health and psychosocial wellbeing.

The third mechanism is the group. The program worked not only through what individual children experienced but through what they experienced together. Equal participation, peer learning, shared creative practice, and group reflection produced a sense of belonging that many children described as new. Peer belonging itself then functioned as a pathway to further outcomes such as reduced loneliness, improved motivation, and greater hope. This social dimension of the program's effectiveness has implications for how it is described and scaled, and this mechanism and outcomes within the ToC should be emphasized.

4.4 There are some key gaps which represent real opportunities moving forward

Four areas emerge from the evidence as priorities for program development, each connected to something the ToC anticipated but the current program has not yet fully realized.

First, parent and caregiver engagement is the most consistent gap identified across all adult participant groups — teachers, both caregiver groups, program staff, and local actors. The ToC places caregiver awareness as a short-term outcome because it is understood as a mechanism for sustaining children's gains. The data suggest this mechanism is present but under-developed. Children's wellbeing improvements were visible to parents, but parents still lacked a framework for understanding what they were seeing and tools for supporting it at home. Structured parent engagement via regular communication, basic psychoeducation, and materials for home use, is a high-leverage investment towards longer-term outcomes and sustainability of the program and its impacts.

Secondly, teacher integration and support was a named gap. Teachers observe effects of the program but are not yet part of the program's ecosystem in a structured way. Teachers apply varying levels of trauma-sensitive approaches in the classroom, such as noticing a distressed child, adjusting how they respond, and not inadvertently undermining what the Healing Room is building. Stronger integration of these approaches would help to sustain their impact beyond the Healing Rooms. This does not require major investment in upskilling teachers (a burden that would fall on trainers, schools, and teachers themselves), but basic support with actionable items and activities would be beneficial. It also means building stronger relationships between facilitators and YAD, and classroom teachers themselves.

Thirdly, there is a gap related to community engagement as both a short- and longer-term outcome pathway. The Theory of Change names community engagement, distinct from caregiver or parental engagement, at two points: increased community understanding of MHPSS and school programming as a short-term outcome, and increased and sustained community engagement with the school and MHPSS programming as a longer-term one. The evidence speaks only to the earliest edge of this pathway. A handful of mothers described sharing their children's progress with neighbors, prompting some interest from other families, but this was incidental rather than program-led, and broader community awareness remained limited, with several caregivers describing neighbors who did not know what the Healing Room was for. The longer-term outcome— sustained engagement— cannot be assessed in the context of the evaluation but should be followed up on during cohort reviews by YAD and via intentional monitoring (see Recommendations). Closing this gap requires both a deliberate, program-led community engagement strategy beyond organic word-of-mouth, and longitudinal,

multi-cohort monitoring capable of detecting whether engagement is genuinely increasing and sustaining rather than assumed from a single point-in-time evaluation.

Finally, there are notable gaps in terms of program reach and inclusivity. The program currently serves children who are enrolled in partner schools and able to attend. Out-of-school children— often the most vulnerable— are largely unreached. Children with disabilities lack adapted programming. These are structural constraints that cannot be solved within the existing school-based model without deliberate design work, but they represent a meaningful gap between the children the program serves and the full population of children who carry the burden the program is designed to address.

4.5 The evidence support a positive overall assessment of the program

This evaluation set out to assess whether YAD's arts-based MHPSS program made a meaningful difference to the psychosocial wellbeing of the children it served in Cohort 3. **The evidence supports a positive overall assessment.**

The program reached children who genuinely needed it, in a context where alternative support was largely absent. It worked through mechanisms that are coherent with its Theory of Change and that participants described with specificity and consistency. It produced significant and broad-based improvements in children's self-reported psychosocial wellbeing, corroborated by qualitative evidence from multiple participant groups and validated by external professionals. The changes described— in how children managed their emotions, related to peers, engaged with school, and felt about themselves and their futures— were observable and meaningful in the lives of the children and families involved.

The program did not achieve everything its Theory of Change envisioned, though the shortfalls may be largely read as evidence of how long durable change takes than as gaps in program delivery. Caregiver and community awareness remained largely dependent on direct observation of learners rather than deliberate engagement, despite a considerable volume of outreach activity YAD undertook. This pattern is consistent with the wider evidence base on mental health stigma and behavior change, which treats awareness, attitude change, and behavior change as distinct, sequential stages that a two-year project can meaningfully advance without necessarily completing. Teacher integration of MHPSS into classroom practices followed a similar trajectory. Namely, YAD's one-day PFA training was well-designed and covered the right content, but a single session is not equivalent to the sustained, scaffolded support teachers would need to embed trauma-informed practice into everyday classroom routines. Still, the evidence supports notable accomplishment across the majority of outcomes identified in the ToC, and a program design and delivery model that closely reflects the mechanisms of change the ToC articulates.

The child-level effects produced within six months were substantial; whether they persist without continued reinforcement is unknown. This sustainability of impact represents the next stages of work—including investments in community embedding, caregiver engagement, teacher capacity, and sustainability that would allow a strong program to become a durable one. The recommendations that follow are grounded in this assessment. They build on what the evidence shows is working, addressing the gaps the evidence has made visible, and investing in the conditions that would allow the program's effects to outlast the cohort.

5. RECOMMENDATIONS

The following recommendations are grounded in the findings and conclusions of this evaluation. They are organized into six categories: program design and delivery; caregiver and community engagement; teacher integration and school embedding; reach, inclusion, and access; monitoring, evaluation, and learning; and donor and policy-level action. Recommendations are specific and actionable with relevant resources indicated where available. They are addressed primarily to YAD as implementing partner, to Peace of Mind Foundation as funder and program steward, and where indicated to broader stakeholders.

5.1 Program Design and Delivery

- **Develop differentiated activity approaches for the 6–8 and 9–12 age ranges, with particular emphasis on movement-based activities for younger children.** The program serves children aged 6–12 as a single group in all schools. Broadly consistent outcomes were observed across age groups in both the qualitative and quantitative data, but practitioner accounts note that younger children respond better to play-based and interactive activities while older children engage more deeply in reflective storytelling and discussion. Formalizing age-differentiated session plans within the existing 22-week curriculum would strengthen the developmental appropriateness of delivery without requiring significant additional resources.
- **Extend program activity options to include movement, play, and sports-based activities alongside existing arts-based modalities.** Physical and play-based activities offer an additional, complementary channel for children to process stress and build confidence—particularly for children who may engage less readily with drawing, music, or storytelling—while also supporting peer connection and group cohesion. Piloting a small set of structured movement or team-based games within the existing session structure would allow facilitators to gauge engagement before considering broader integration into the curriculum.
- **Systematically document and share session adaptations across the TATG.** Facilitators described adapting sessions in real time based on children's emotional state— sometimes changing planned activities entirely. This kind of responsive facilitation is a clear program strength, but the knowledge driving it currently sits with individual facilitators rather than being shared systematically across the team. The TATG should introduce a brief structured reflection at the end of each session cycle to capture what was adapted, why, and with what effect. Over time, this builds a practical library of tested adaptations that strengthens program fidelity, supports onboarding of new facilitators, and reduces the risk of institutional knowledge loss.
- **Formalize the before/after drawing activity as a recurring wellbeing check-in tool** used at regular intervals throughout program delivery, rather than only at evaluation endpoints. Children's demonstrated ability to communicate emotional states non-verbally through this method makes it a low-burden way for facilitators to track shifts in individual wellbeing over time and adjust support accordingly.
- **Establish a structured annual feedback process that includes children's and caregivers' voices in program review.** Participants — including children — described specific aspects of the program they found most valuable and offered concrete suggestions for improvement. This kind of direct input could be used by YAD systematically. YAD should introduce a brief,

structured feedback process at the close of each cohort that includes a simple facilitated activity with learner groups and a short verbal or pictorial survey with caregivers. Findings should be reviewed by the TATG and feed directly into the following cohort's planning. This ensures the program remains responsive to the people it serves, not only to its original design.

5.2 Caregiver and Community Engagement

Several features of the current program design already function implicitly as stigma-reduction mechanisms. This includes school-based delivery which normalizes participation as part of the school day rather than a separate clinical service, and the program's psychosocial rather than clinical framing which lowers the barrier to caregiver and community acceptance. The recommendations below aim to build on the caregiver and community engagement activities that are already occurring, and in doing so also emphasize this existing stigma-reduction function.

- **Establish a structured caregiver and community orientation at the start of each cohort, paired with a simple recurring engagement touchpoint through the program cycle.** YAD already runs a substantial ongoing awareness effort (educational videos distributed through schools, Healing Rooms, and WhatsApp; community events and exhibitions; and informal coordination with school staff), but this activity is distributed across channels and unfolds gradually, rather than anchored to a single, deliberate onboarding moment when a new cohort of children begins. As a result, some caregivers reported uncertainty about the program's purpose even well into their child's participation. A short, structured orientation session at intake— covering what the Healing Room is, what children will be doing, how progress will be communicated, and how caregivers can ask questions— would give every family a consistent baseline understanding from day one, rather than relying on awareness accumulating unevenly over time. This should be paired with a lightweight recurring touchpoint (e.g., a brief update at key program milestones) so understanding is reinforced. The Operational Guidance for Child Friendly Spaces in Humanitarian Settings includes a dedicated chapter on working with caregivers and community members and offers a useful model for structuring this kind of orientation.
 - **Relevant resource:** IFRC Reference Centre for Psychosocial Support and World Vision International. (2018). Operational Guidance for Child Friendly Spaces in Humanitarian Settings. <https://www.mhpss.net/toolkit/children-and-families-mhpss-resource-collection/resource/the-toolkit-for-child-friendly-spaces-in-humanitarian-settings-cf>
- **Provide caregivers with simple psychoeducation tools and home materials.** Multiple caregiver groups described children using drawing and music at home as a result of the program, but noted that without materials this was limited to what children could improvise. YAD should develop a simple take-home pack— a small set of art materials, an illustrated guide with two or three activities caregivers can do with their children, and a brief psychoeducation sheet on recognizing children's emotional distress. These do not need to be expensive but should be practical and in local languages. The UNICEF Common Signs of Psychosocial Distress in Children advice sheet provides a useful model for the psychoeducation component.
 - **Relevant resource:** UNICEF (2022). Common signs of psychosocial distress in children. <https://www.mhpss.net/toolkit/children-and-families-mhpss-resource-collection/resource/common-signs-of-psychosocial-distress-in-children-cf>

- **Conduct dedicated caregiver sessions— separately for mothers and fathers— with space for participant-led discussion.** The evaluation found that mothers and fathers had meaningfully different levels of awareness and engagement with the program. A structured session for each group (rather than a combined session that may replicate gender dynamics) would more effectively reach both. Sessions should be facilitated in a non-clinical way, using accessible language and concrete examples from the program. Sessions should not be entirely facilitator-driven, and should allocate time for caregivers to raise topics they consider timely and relevant. This may include concerns about their children, questions about what they are observing, things they do not understand, which would make sessions more responsive to evolving family needs and more likely to generate genuine engagement. The I Support My Friends resource kit (MHPSS Collaborative, Save the Children, UNICEF, WHO) provides structured facilitation guidance for supporting adults to recognize and respond to children's emotional needs.
- **Relevant resource:** MHPSS Collaborative, Save the Children, UNICEF & WHO. I Support My Friends resource kit. <https://resourcecentre.savethechildren.net/document/i-support-my-friends-training-children-and-adolescents-how-support-friend-distress>
- Extend programming to address caregiver wellbeing alongside child-focused support. Findings from this evaluation, together with recent regional evidence, point to the significant psychological toll of displacement and repatriation-related fear not only on children but on the caregivers responsible for their protection. Caregiver stress— driven by poverty, insecure legal status, and the constant threat of detention or deportation— can compromise caregivers' capacity to provide the consistent emotional support that is central to positive child outcomes. Future phases of programming should incorporate a caregiver wellbeing component alongside the existing child-focused programming, rather than treating caregiver and child support as separate tracks.
- **Relevant resource:** War Child. (n.d.). Our care system – BeThere. <https://www.warchild.net/intervention-bethere/>
- **Build peer-to-peer community awareness through parent networks.** The evaluation found that informal peer communication, via mothers sharing observations with neighbors, was already functioning as a pathway for community awareness. YAD should formalize this by identifying willing parent ambassadors in each school community who can speak to the program's purpose and outcomes with other families. This is a low-cost, high-trust mechanism for broadening reach and reducing the stigma that limits engagement with psychosocial support programs.
- **Incorporate structured social contact with individuals with lived experience of mental health conditions as a stigma-reduction strategy, particularly for children identified as requiring specialized support.** Social contact, which means direct or indirect engagement with people who have lived experience of the condition being stigmatized, is an evidence-based approach to stigma reduction. YAD should explore low-risk ways of incorporating this approach, such as inviting community members with relevant lived experience to speak at caregiver or community sessions, or sharing anonymized recovery narratives in awareness materials. This could extend the focus beyond psychoeducation and orientation activities to address broader community attitudes towards mental health, including attitudes affecting children who require more specialized support.

5.3 Teacher Integration and School Embedding

- **Build on YAD's existing PFA training to introduce a fuller, ongoing trauma-informed practice programme for teachers in partner schools.** YAD currently provides teachers with Psychological First Aid (PFA)-centered training, which offers a valuable foundation for recognizing and responding to acute distress. However, PFA alone is designed for immediate, short-term response rather than the sustained, everyday classroom demands of supporting children affected by chronic trauma and displacement-related stress. YAD should build on this existing training by introducing a fuller trauma-informed practice curriculum for all teachers in partner schools, complemented by ongoing support and scaffolding rather than a single one-off session. The MHPSS Collaborative's Thriving Through Play programme offers a structured, field-tested teacher training approach developed for crisis-affected contexts. A forthcoming modular teachers' guide on MHPSS for learners, developed jointly by UNESCO, UNICEF, and WHO, will provide a further practical resource organized around four action areas: promoting wellbeing, recognizing and responding to distress, teacher self-care, and family and community engagement. When published, YAD should consider adapting this guide for use with partner school teachers.
 - **Relevant resources:** MHPSS Collaborative. Thriving Through Play. <https://mhpscollaborative.org/thriving-through-play/>; UNESCO, UNICEF & WHO (forthcoming). Teachers' guide on supporting learner mental health and psychosocial wellbeing [modular toolkit, in preparation].
- **Establish a structured communication channel between Healing Room facilitators and classroom teachers.** Currently, coordination between facilitators and teachers was described by multiple participant groups as informal and insufficient. YAD should establish a simple, regular coordination mechanism— a brief check-in between each school's facilitator and a designated teacher liaison— in which facilitators can flag children who may need additional classroom support, and teachers can flag children whose distress has become visible in the classroom, alongside the formal recommendation forms used.

5.4 Access and inclusion

- **Establish a partnership with disability organizations to develop adapted programming for children with disabilities.** Children with disabilities were identified by program staff and external stakeholders as a group the current program model does not adequately serve. Arts-based and play-based approaches are often well suited to children with a range of disabilities but require deliberate adaptation. YAD should identify and partner with a local or national disability organization to develop adapted session materials and to train facilitators in inclusive facilitation. SBK University's Faculty of Social Work and the Special Education sector represented in the local actors FGD are natural starting points for this collaboration.
- **Address gender-specific barriers to girls' access and participation.** Female-specific barriers— such as family responsibilities, cultural restrictions on girls' movement, and limited caregiver permission— were identified by program staff as constraints on girls' access and full participation. YAD should work with school and community leadership to address these barriers proactively through caregiver sessions that explain the program's purpose and safety to families, through scheduling that accommodates girls' household obligations, and through

deliberate attention to whether the program's activities and norms are creating an equally welcoming environment for girls and boys.

- **Pursue formalized partnerships with education, MHPSS, and refugee support coordination bodies to expand reach.** YAD currently operates across eight schools. The local actors FGD identified significant interest from the education and social work community for wider scaling. PoM and YAD should document and share the program model and this evaluation's findings through MHPSS coordination forums in Pakistan, the INEE network, and relevant UNHCR and government coordination bodies. The program's demonstrated effectiveness and cultural fit position it well for advocacy toward incorporation into provincial education and child protection structures. The INEE Minimum Standards for Education in Emergencies provide a policy framework against which to situate advocacy efforts.
 - **Relevant resource:** INEE (2024). Minimum Standards for Education: Preparedness, Response, Recovery. <https://inee.org/minimum-standards>

5.5 Monitoring, Evaluation, and Learning

- **Maintain matched pre-post measurement with one single tool (such as the SLEC-26) across future cohorts.** The SLEC-26 pre-post design used in this evaluation produced clear, interpretable results with strong effect sizes that was within YAD's capacity to use effectively. However, other options do exist that may be equally relevant in the Quetta context. These include: the Strengths and Difficulties Questionnaire (SDQ) which YAD has used, and the Child and Youth Resilience Measure (CYRM). Both of these additional tools have more explicit measure of confidence, which would be an important addition based on the strong qualitative evidence of impact on this outcome. YAD should determine a single tool to use as pre-post measure; this should then be piloted with a small sample, check for comprehension and response distribution issues, and verify internal consistency before committing to full rollout. A brief piloting phase at the start of an upcoming cohort, involving 10–15 children, would identify problems before they affect the full dataset. Consistent measurement across cohorts would allow cumulative evidence to build and would support comparisons over time.
- **Develop a simple monitoring tool to track teacher skill application.** The two ToC outcomes with the weakest evidentiary base in this evaluation — caregiver awareness and teacher skill application — were difficult to measure because no specific monitoring mechanism existed for them. YAD should develop brief, structured check-in instruments for each. This could include a structured observation for teachers assessing their awareness of trauma-informed practices.
- **Establish routine participation and feedback tracking across all caregiver and community engagement activities, with a next-phase focus on linking this data to the ToC's awareness outcomes.** YAD undertakes a substantial volume of caregiver and community engagement activity but currently has no systematic record of who these activities reach or how they are received. YAD should introduce a simple, consistent tracking template applied across all engagement activities, capturing at minimum: participation counts disaggregated by activity type and, where feasible, by caregiver role (mother/father) and community versus caregiver audience; and a brief content-feedback component (e.g., a short structured debrief with facilitators after community events, or a two- to three-item verbal check with caregivers after orientation and psychoeducation sessions) assessing whether content was understood, useful, and relevant. This distinguishes reach (who attended) from

effect (what participants took away), neither of which this evaluation was able to assess. In the next program phase, this participation and feedback data should be explicitly structured to speak to the ToC's caregiver and community awareness outcomes so that progress along this pathway can be assessed cumulatively across cohorts.

- **Assess longer-term outcomes in a follow-up study.** This evaluation measured children's wellbeing at the close of the program cycle. It cannot speak to whether gains persisted six or twelve months later. A follow-up study— even a modest qualitative one, re-engaging a subset of children and caregivers six months post-program— would provide critical evidence on sustainability of effects and would significantly strengthen the program's evidence base.
- **Incorporate participatory evaluation approaches in future cohorts.** Future evaluations should involve children and caregivers not only as data sources but as active participants in evaluation design. This could include child-friendly workshops to validate emerging findings, caregiver focus groups that feed into interpretation of what changes have been observed, and youth-led data collection activities. Participatory approaches strengthen the validity and relevance of evaluation findings, and are particularly important in contexts where the gap between adult analytical frameworks and children's lived experience is substantial.
- **Treat the Theory of Change as a living document to be revisited and updated across cohorts; full ownership of this process must sit with YAD, who will lead in all future revisions.** The Theory of Change was developed collaboratively and has provided a strong organizing framework for this evaluation, but it should not be treated as fixed. The evidence from Cohort 3 — and from each successive cohort — will reveal where the theory holds, where it needs strengthening, and where the program is producing change that the ToC does not yet capture. YAD should commit to a formal ToC review at the end of each two-cohort cycle, drawing on evaluation findings, TATG reflective practice, and participant feedback. The ToC revision process should be participatory, involving facilitators, school staff, and where possible caregivers and community members, so that it remains grounded in the realities of implementation rather than becoming a static planning artifact.

5.6 Donor and Policy-Level Action

- **Continue and formalize PoM's commitment to multi-year, flexible funding that supports program continuity across cohorts and space for adaptation within each cycle.** Flexibility here refers primarily to YAD's ability to adjust programming in response to participant and community feedback (for example, adding movement- and sports-based activities alongside existing arts-based modalities; see recommendation above), rather than a specific claim about budget-line structures, which this evaluation did not examine. This is not a critique of PoM's current flexibility, which has already supported YAD's ability to learn and adapt across cohorts; the recommendation is to continue that flexibility and extend it explicitly to within-cycle adaptation so that YAD can respond to emerging feedback mid-program.

The evaluation found that for Cohort 3, six months was sufficient to produce meaningful change in children's outcomes. The community and caregiver engagement findings (Sections 3.3.4 and 3.3.5) point to a longer timescale. Shifting community-level awareness and caregiver behavior, and building teachers' sustained capacity for trauma-informed practice, are processes that plausibly take longer than the current two-year program phase to be fully

realized. Multi-year funding models, committing to at least four consecutive cohorts in each partner school, allow the program to build on what it has already established rather than restarting trust-building and orientation with each new cycle. This model also directly enables the caregiver and teacher engagement investments recommended above, both of which require sustained relationship-building rather than one-off sessions to take hold.

The current phase already spans four consecutive cohorts (September 2024–August 2026); the recommendation here is to extend this same multi-year, flexible commitment into a further phase beyond August 2026, with explicit room for within-cycle programmatic adaptation, rather than to establish multi-year or flexible funding for the first time.

- **Fund further documentation and dissemination of the program model for wider uptake.** This evaluation provides strong evidence of positive outcomes associated with the YAD arts-based model in this context. That evidence is currently contained within an evaluation report and a more accessibly learning brief that is also translated into local languages. Beyond the scope of this evaluation, there should be a push to disseminate the findings more widely in the local context. This should include sharing with peer organizations, MHPSS coordination bodies, and government counterparts.
- **Advocate for incorporation of school-based MHPSS into provincial education policy in Balochistan.** The five local actors who participated in this evaluation included the Director of Education for the region, two heads of department from SBK University, and a representative from the Afghan Refugee Office. Their participation reflects genuine interest in and support for the program at an institutional level. PoM and YAD should leverage these relationships to advocate for the inclusion of school-based psychosocial support within Balochistan's education policy framework — drawing on the INEE Minimum Standards and the WHO/UNESCO (2021) Making Every School a Health-Promoting School standards.
 - **Relevant resource:** WHO & UNESCO (2021). Making every school a health-promoting school: Global standards and indicators.
<https://www.who.int/publications/i/item/9789240025073>
- **Expand partnerships with universities and academic institutions to strengthen the local MHPSS knowledge base.** SBK University's Departments of Social Work and Psychology were represented in the local actors FGD and described the program in strongly positive terms. A formal partnership between YAD and SBK University could serve multiple functions: providing practicum placements for psychology and social work students within the Healing Rooms; enabling local academic engagement in program monitoring and evaluation; and contributing to the development of a locally rooted evidence base for arts-based MHPSS in Balochistan. This would also begin to address the near-total absence of local MHPSS research capacity that the draft research brief identified as a structural gap in the region.
- **Invest in developing local facilitator capacity and a sustainable training pipeline.** The program's effectiveness is substantially dependent on the quality of individual facilitators. Currently, that expertise sits with a small number of trained TATs. YAD and PoM should consider the development of a structured training pathway that could be delivered locally to train additional facilitators and refresh existing ones. Partnering with SBK University to host this training would contribute to long-term local ownership of the approach.

- **Relevant resource:** MHPSS Collaborative. Thriving Through Play.
<https://mhpsscollaborative.org/thriving-through-play/>
- **Work toward sustainable local resource mobilization and provincial budget inclusion.**
External donor funding is currently essential for program continuity and will remain so in the near term, given the limited local resource base in Balochistan. However, the long-term goal should be to build toward the program— or elements of it— being funded through provincial education or health budgets. This requires a deliberate advocacy strategy, including engaging the Secretary of Health Balochistan (who has publicly identified the MHPSS capacity gap and announced initial public funding for 2025–26), the Director of Education (already engaged as a local actor in this evaluation), and other provincial counterparts.

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ANNEX 1: SLEC-26



Student Learning in Emergency Checklist (26) SLEC-26

Children living in war conditions frequently experience stressful conditions and multiple trauma, which can severely challenge their development, mental health, and academic functioning. Feeling a sense of chaos, loss of concentration and reduced memory are frequent reactions among children, which can reduce the ability to keep up in the classroom, do homework and graduate from school. It is a complex challenge to design education in emergencies responses that meet local needs, are sensitive to local culture and context, build on international guidelines for best practice, and use research-based methods. The Student Learning in Emergency Checklist (SLEC-26) is a tool that is developed for informing the work of planning, designing and evaluating school based psychosocial interventions for education in emergencies. The SLEC-26 helps measure promoters and barriers for learning before and after interventions to establish indicators for students' academic functioning and school well-being.

Administration

SLEC-26 is self-completed and can be administered in groups. A staff member reads the items out loud to the students in groups and the students ticks the box that most applies to them.

Scoring

All items, **except from item 21**,
are scored on a 1-5 Likert scale:

Never = 1

Rarely = 2

Sometimes = 3

Most of the time = 4

Always = 5

Item 21 is scored in the opposite direction,
also on a 1-5 Likert scale:

Never = 5

Rarely = 4

Sometimes = 3

Most of the time = 2

Always = 1

The tool measures five different factors:

Safety and adaptability = Items 1+3+4+5+7+8+12+15+16

Emotion regulation = Items 2+6+9+21

School support = Items 10+13+22

Family support = Items 11+14+23

Current and future hope and well-being = Items 17+18+19+20+24+25+26

06.09.19: *This version of SLEC-26 is made for monitoring purposes of the Better Learning Program in the Middle East region. More research is needed before SLEC-26 can be sufficiently validated and standardized.*

1. I feel that the teachers and school staff respect me.

Always	Most of the time	Sometimes	Rarely	Never

2. I can control my temper.

Always	Most of the time	Sometimes	Rarely	Never

3. I feel safe at home.

Always	Most of the time	Sometimes	Rarely	Never

4. It is easy for me to stick to my aims.

Always	Most of the time	Sometimes	Rarely	Never

5. I feel safe at school.

Always	Most of the time	Sometimes	Rarely	Never

6. When I am scared, I can calm myself down.

Always	Most of the time	Sometimes	Rarely	Never

7. It is easy for me to accomplish my goals.

Always	Most of the time	Sometimes	Rarely	Never

8. If I am in trouble, I can think of a solution.

Always	Most of the time	Sometimes	Rarely	Never

9. When I feel angry, I can calm myself down.

Always	Most of the time	Sometimes	Rarely	Never

10. Someone in the school staff (a teacher, the principal, a counselor) ask me how I am doing.

Always	Most of the time	Sometimes	Rarely	Never

11. I can talk to my parents about my worries.

Always	Most of the time	Sometimes	Rarely	Never

12. I can handle whatever comes my way.

Always	Most of the time	Sometimes	Rarely	Never

13. Someone in the school staff (a teacher, the principal, a counselor) support me when I feel scared.

Always	Most of the time	Sometimes	Rarely	Never

14. When I feel scared, I can tell my parents.

Always	Most of the time	Sometimes	Rarely	Never

15. I am confident that I can adapt to events I had not predicted.

Always	Most of the time	Sometimes	Rarely	Never

16. I can easily concentrate when doing schoolwork.

Always	Most of the time	Sometimes	Rarely	Never

17. I am able to do my best in school.

Always	Most of the time	Sometimes	Rarely	Never

18. I will get a job when I grow up.

Always	Most of the time	Sometimes	Rarely	Never

19. I like being at school.

Always	Most of the time	Sometimes	Rarely	Never

20. I will live a meaningful life when I grow up.

Always	Most of the time	Sometimes	Rarely	Never

21. When I feel angry, I hit other people or things.

Always	Most of the time	Sometimes	Rarely	Never

22. I can talk to someone in the school staff (a teacher, the principal, a counselor) about my worries.

Always	Most of the time	Sometimes	Rarely	Never

23. My parents ask me how I am doing.

Always	Most of the time	Sometimes	Rarely	Never

24. I am satisfied with my life.

Always	Most of the time	Sometimes	Rarely	Never

25. I will graduate school.

Always	Most of the time	Sometimes	Rarely	Never

26. Things will turn out great in the future.

Always	Most of the time	Sometimes	Rarely	Never

Please fill in the blanks below.

Gender: _____

Age: _____

Grade: _____

Area: _____

ID-number: _____

Name of
school: _____

Thank you so much for participating!



ANNEX 2: QUALITATIVE CODING FRAMEWORK

The following coding framework was developed prior to analysis using a deductive approach anchored to the Theory of Change and the evaluation's ten research questions. It comprises 21 codes organized into four sections (A–D) plus an emergent category. The framework was applied to all 13 focus group discussion transcripts. Codes were applied at the passage level, and a passage could receive multiple codes. Frequency of coding reflects the structure and focus of each FGD guide as much as the significance of any theme and was interpreted accordingly.

A — Context and Challenges

Codes in this section capture the psychosocial challenges and adverse contextual conditions that children faced before or alongside program participation.

Code	Code name	Definition and coding guidance
A1	Emotional distress	Expressions of sadness, fear, anxiety, loneliness, worry, low self-worth, or emotional overwhelm. Includes suppression of emotion (keeping feelings inside, staying silent about distress)
A2	Behavioral difficulties	Aggressive behavior, peer conflict, reactive anger, emotional outbursts, impulsivity, or conduct difficulties that affect relationships or functioning
A3	Social isolation and withdrawal	Avoidance of peers or social interaction, preference for isolation, difficulty making or maintaining friendships, feeling excluded or like an outsider
A4	School disengagement	Low motivation toward learning, poor concentration, avoidance of classroom participation, irregular attendance, or negative attitudes toward school
A5	Adverse context details	References to displacement, family instability, financial hardship, deportation fears, interrupted education, or other external adversities shaping the child's environment

B — Short-Term Program Outcomes

Codes in this section capture outcomes expected to emerge during or shortly after program participation, as seen in the Theory of Change. B-codes reflect early-stage changes that enable longer-term outcomes.

Code	Code name	Definition and coding guidance
B1	Sense of safety and psychological safety	Feeling safe, comfortable, or free from judgment within the program space (Healing Rooms), with facilitators, or in the school environment

B2	Recognizing and expressing emotions	Improved ability to identify, name, or communicate emotions—particularly through creative means (drawing, music, storytelling, other creative outlets). Includes increased emotional openness both in school and at home
B3	Positive peer relationships	Formation or improvement of friendships; sense of belonging in the group, school community, or classroom; improved cooperation with peers; reduced peer conflict
B4	Trusting relationships with adults	Increased trust in or comfort with teachers, facilitators, or other adults. Includes feeling cared for, encouraged, or valued by program and school staff
B5	Coping strategies	Development or use of specific strategies for managing emotional distress—drawing, breathing, music, talking to a trusted person, asking for help. Strategies are named or described explicitly
B6	Caregiver awareness	Increased awareness among parents or caregivers of children's emotional and psychosocial needs, or of the purpose and value of psychosocial support. Includes accounts of caregivers noticing or responding differently to children's emotional states
B7	Teacher skill application	Evidence that teachers have applied trauma-informed or emotionally supportive practices as a result of the program, or that they have observed and responded to changes in children's wellbeing.

C — Medium and Longer-Term Outcomes

Codes in this section capture outcomes expected to consolidate over the medium to longer term, as the short-term changes described in Section B become embedded. C-codes reflect more durable changes in children's functioning, wellbeing, and orientation.

Code	Code name	Definition and coding guidance
C1	Increased confidence and self-esteem	Stronger belief in one's own abilities, willingness to speak up, try new things, or participate; reduction in self-doubt or avoidance
C2	Prosocial behavior and cooperation	Cooperative behavior, patience, respect for others, sharing, helping, or resolving conflict peacefully. Includes improved family and peer relationships
C3	Emotional regulation	Improved ability to manage emotional reactions, including calmer responses, less reactivity, ability to pause before acting, or reduction in frequency or intensity of emotional outbursts
C4	Reduced behavioral difficulties	Observed or reported reduction in the behavioral difficulties coded under A2, including less aggression, fewer peer conflicts, less disruptive behavior at school or home

C5	Learning readiness and concentration	Improved attention, motivation for school, classroom participation, completion of schoolwork, or academic engagement. Includes reduced emotional interference with learning
C6	Hope and future orientation	Expressed optimism about the future, positive future aspirations, sense of agency or possibility
C7	Creative expression beyond the program space	Evidence that children engage in drawing, music, painting, or other creative activities outside of program sessions, mainly at home

D — Implementation and Program Quality

Codes in this section capture data relating to how the program was delivered, the quality of implementation, what enabled or constrained effectiveness, and participant recommendations.

Code	Code name	Definition and coding guidance
D1	Activity type and delivery	References to specific program activities (drawing, painting, storytelling, music, group games, role-play), how they were delivered, or participant preferences among activities.
D2	Facilitator quality and approach	Descriptions of how facilitators conducted sessions, including their warmth, responsiveness, skill, non-coercive approach, ability to adapt, or the trust they built with children
D3	Group dynamics	References to the group nature of sessions, including peer learning, equal participation, group belonging, or the value of the collective experience
D4	Perceived program relevance and appropriateness	Participant or stakeholder assessments of whether the program is relevant to children's needs, appropriate to the cultural context, or well-suited to the population served
D5	Barriers to participation	Factors that limited children's access to or full engagement with the program, including out-of-school children, disability, transport, limited home resources, low community awareness, or cultural restrictions/norms
D6	Enablers and facilitating factors	Factors that supported program implementation or effectiveness, including school integration, community acceptance, facilitator training, cultural fit, or stakeholder relationships
D7	Suggestions for improvement	Recommendations from participants or stakeholders for how the program could be strengthened including duration, reach, parent engagement, materials, coordination, follow-up support.

D8	Program fidelity and consistency	References to the structured curriculum, consistency of session delivery across schools, or the balance between structured design and flexible adaptation.
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EMERGENT — Emergent Themes

Used to flag passages that do not fit within Sections A–D but appear analytically significant. Emergent codes were reviewed after the initial coding pass to determine whether they warrant a new code, can be subsumed under an existing code, or should be noted as a limitation of the framework.

Code	Code name	Definition and coding guidance
EMERGENT	Emergent theme	Applied to any passage that raises a theme not anticipated by the ToC framework or research questions. These can be positive or negative, expected or unexpected.

ANNEX 3: EXPLORATORY ANALYSES

The following quantitative survey analyses are exploratory and hypothesis-generating; they are not confirmatory tests of programme effect and should be read as descriptive.

Improvement across subgroups

Improvement in the total score was examined descriptively within gender and age subgroups. Gains were positive and of similar magnitude across all subgroups, suggesting the programme was associated with improvement broadly rather than only for particular groups. No between-group significance testing was performed, consistent with the analysis plan and the sample sizes involved.

Table 8: Total-score improvement by subgroup (descriptive)

Subgroup	Level	n	Mean change	95% CI
Gender	female	74	+0.71	0.60 – 0.82
Gender	male	61	+0.81	0.69 – 0.94
Age band	11-13	62	+0.78	0.67 – 0.89
Age band	5-7	28	+0.68	0.49 – 0.87
Age band	8-10	45	+0.78	0.63 – 0.94

Characteristics associated with degree of change

An exploratory regression examined which child characteristics were associated with the size of total-score improvement. Predictors were fixed in advance: baseline score, age, gender, family income, and education level. Coefficients describe associations within this sample and are not causal. Collinearity was negligible (all variance inflation factors below 1.3), and the model explained a modest share of variance (adjusted $R^2 = 0.36$).

Table 9: Exploratory predictors of total-score change (OLS regression)

Predictor	Estimate	95% CI	p
Intercept	3.11	2.43 – 3.79	< .001
Baseline score	-1.04	-1.29 – -0.79	< .001
Age (years)	-0.03	-0.06 – 0.01	.153

Predictor	Estimate	95% CI	p
Gender (male vs female)	0.13	-0.01 – 0.26	.063
Income: middle vs low	0.22	0.03 – 0.41	.023
Education: secondary vs primary	0.15	-0.01 – 0.31	.064

The main pattern is that children with lower baseline scores tended to improve more (baseline coefficient -1.04). This partly reflects regression to the mean as children scoring low at baseline have more room to rise. Hence, should not be over-interpreted. Associations with age, gender, income, and education were weak. In substantive terms, improvement was fairly even across children rather than concentrated among any particular group.