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Exploring Local Coping Strategies and Sources of Resilience in South Sudan

Sandra Björk Olafsdottir Bjerkan
Master of Science in Global Development Studies

Abstract

In South Sudan, relentless conflicts, natural disasters and persistent poverty have had a detrimental effect on children's mental and psychosocial wellbeing. However, researchers have found that some children manage well despite exposure to severe adversities. This study investigates local protective, promotive and risk factors for resilience within Maiwut county, South Sudan. A local research team conducted individual interviews, focus group discussions and a key informant interview with adult local school stakeholders. Five over-arching themes emerged through this research: personal strength, supportive relationships, basic needs, hope and peace. Protective and promotive resources were found on multiple socio-ecological levels, and respondents attributed the immediate environment as having the highest influence on a child's resilience. This study highlights the importance of building on local support systems and sources of resilience, without excluding efforts to reduce risks of adversities. This knowledge can be used to design interventions aiming to promote resilience and mental wellbeing among children and adolescents.

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List of abbreviations

ADRA	Adventist Development and Relief Agency
FGD	Focus Group Discussion
IASC	Inter Agency Standing Committee
MoGEI	Ministry of General Education and Instruction
MHPSS	Mental Health and Psychosocial Support
NSD	Norwegian Centre for Research Data
NMBU	Norwegian University of Life Sciences (Norges Miljø- og Biovitenskapelige Universitet)
PTA	Parent Teacher Association
SDG	Sustainable development goal
WHO	World Health Organization

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1. Introduction

Poverty, conflicts and disasters threaten the development of children and societies worldwide. Children in low-resource settings are at higher risk of exposure to severe adversities, and an added conflict situation only amplifies the risk (Betancourt et al., 2011). Exposure to traumatic events, impoverishment and daily stressors at a young age has negative impacts on mental health and developmental outcomes throughout the course of life (Betancourt et al., 2011; Tol et al., 2013; Vindevogel et al., 2015). Mental ill-health is one of the major causes of lost human capital globally, such as reduced productivity and daily life functioning, high unemployment rates and substantially increased mortality (Ryan et al., 2020)**.** Reducing the effects of serious adversity on children and adolescent's healthy development is therefore fundamental for a society to thrive, function and develop.

Researchers within behavioral sciences emphasize resilience as a key factor in efforts to promote mental health in children and adolescents affected by conflict and daily stressors (Masten, 2014b). Resilience is conceptualized in various ways, but is most commonly described as good mental health outcomes despite exposure to grim adversities (Masten, 2014b; Tol et al., 2013; Ungar, 2011). Good mental health is a state of emotional and social wellbeing, where an individual is able to cope with daily stressors and take an active part in society (World Health Organization, 2012). A better understanding of the underlying factors that determine a person's resilience and mental wellbeing can inform and increase the efficiency of policies and development programs (Betancourt et al., 2011; Eggerman & Panter-Brick, 2010; Miller et al., 2006; Ungar & Liebenberg, 2011)**.**

Research on resilience among war-affected children and adolescents is often implemented through the use of standardized measures, such as resilience indicators developed in the global North (Vindevogel et al., 2015; Wessells, 2017). However, resilience literature highlights how resilience indicators, both risk and protective factors, can vary in different social contexts and cultures. An understanding of how resilience indicators are shaped in different socio-cultural contexts should be at the heart of efforts to promote resilience (Eggerman & Panter-Brick, 2010; Ungar & Liebenberg, 2011). Studies based on locally derived indicators of resilience are still lacking in the literature, especially in war-affected countries, such as South Sudan (Vindevogel et al., 2015). The aim of this study is to examine key indicators for resilience in conflict-affected children and adolescents in South Sudan, as perceived by adult community stakeholders within the school context.

2. Research Questions

This study seeks to explore how adult local stakeholders perceive indicators of resilience among children and adolescents' living in Maiwut County, South Sudan. The focus will be on locally embedded protective and promotive factors, but will also include risk factors. This study will try to answer the following questions:

Main research question:

What do adult local stakeholders within the school-context of selected communities in Maiwut County, South Sudan, perceive as key indicators of resilience among children and adolescents?

Sub-research question:

What are the perceived risk and protective factors to good mental health outcomes?

3. Conceptual and Analytical Framework

3.1 Mental Health

Mental health is an integrate part of humans' health and wellbeing. This is illustrated in World Health Organization's (WHO) definition of *health*; "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1946). When referring to *mental health*, this study adopts the WHO's definition of mental health. Mental health is defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 2012).

Both definitions stress the positive dimensions of human experience, which is also central to positive psychology. *Positive psychology* is a branch of psychology that studies human thoughts, feelings and behavior, with a focus on strengths rather than weaknesses (Peterson, 2008, May). One strength that is embedded in WHO's understanding of mental health is the ability to successfully adapt to or cope with stressors in life, which overlaps with the concept of resilience. Resilience is a prominent concept within positive psychology, as well as important for protection and promotion of mental health (World Health Organization, 2002).

WHO's definition of mental health is also interesting because it connects wellbeing with the physical and social environment. The social, physical and economic environment shapes a child's mental health and wellbeing for better or for worse (Walker et al., 2005). The

impact of social and economic determinants is especially evident in low resource settings. Social inequalities and poverty has shown to increase the risk of mental illness among children (Lund et al., 2011; Ryan et al., 2020). Studies suggest that lack of basic needs, such as food and clothing, should be taken into account in efforts to promote children's mental wellbeing (Heltne et al., 2020; Walker et al., 2005). The importance of basic services and social considerations is also illustrated in the Inter-Agency Standing Committee's (IASC) mental health and psychosocial support[1] (MHPSS) intervention pyramid (Fig.1). In the intervention pyramid, basic services create the very foundation of mental health promotion and protection efforts (IASC, 2006).

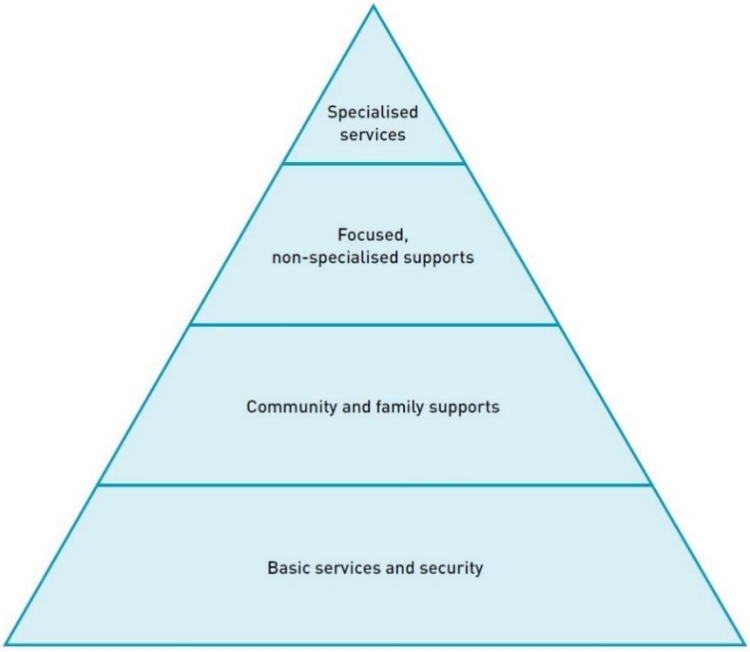

Figure 1: Intervention pyramid, illustrating the multi-layered mental health and psychosocial support services. Taken from in IASC (2006) Guidelines on MHPSS in Emergency Settings

Human wellbeing, and implicitly mental health, has had a growing recognition among development actors for its connection to a nation's health and wealth (Ryan et al., 2020). This is explicitly demonstrated in the third Sustainable Development Goal (SDG): "Ensure healthy lives and wellbeing for all at all ages" (United Nations, 2021). Acknowledging the economic burden of mental disorders, recent methods of measuring poverty have included a subjective measurement of wellbeing as part of a multidimensional approach (Banik, 2006). It is thereby

[1] MHPSS is a crosscutting issue within humanitarian response, as any humanitarian or development intervention has an effect on an individual's mental health and psychosocial wellbeing. MHPSS is defined as "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder" (IASC, 2008, p.16).

apparent that mental health is not only crucial for an individual's wellbeing, but for the society and country at whole.

The understanding of and attitude towards mental health is highly dependent on culture and context (Betancourt & Williams, 2008; Ventevogel et al., 2013). Populations in non-Western and low-resource contexts have shown to have a different way of talking about and referring to mental distress, than western descriptions. Local understandings of mental illness in low-resource contexts, have in many cases focused more on symptoms than syndroms (Miller et al., 2006; Ventevogel et al., 2013). The way local people describe and conceptualize these symptoms varies between contexts.

3.2 Resilience

Resilience within psychology can broadly be understood as good mental health and developmental outcomes despite exposure to severe adversities (Masten, 2014a; Tol et al., 2013; Ungar, 2011). Researchers in the early 70's, such as Emmy Werner, found that some individuals maintain good mental health and well-being although exposed to adversities (Werner et al., 1971). This lead to an increased emphasis on strengths and positive ways to adapt, instead of only risks and negative outcomes (Masten, 2011). Today, resilience is acknowledged as a cornerstone in building and promoting the mental health and well-being of children and adolescents (Masten, 2014b).

The understanding of resilience from Masten (2014b) is commonly accepted. She defines resilience as the capacity to successfully adapt to stresses and major disturbances that threaten adaptation or development. There are two pivotal aspects of resilience in this definition. There is something to recover from as well as the process of recovering, or to *successfully adapt*.

To study resilience you need both a knowledge of what threatens good mental health outcomes and what factors help to reduce the threat or enhance the ability to adapt (Masten & Reed, 2002). Resilience assumes that there is a desirable **state** to be in, here defined as good mental health. There are a number of threats to this **state** of being. The individual needs to adapt to these threats in order to remain in or come back to the desirable state. The factors that work towards a successful adaptation, as well as the threats, can be defined as *resilience indicators*.

The literature (Masten & Reed, 2002; Patel & Goodman, 2007) distinguishes between risk factors, protective factors and promotive factors. A risk factor is *defined* as "a measurable characteristic of a group of individuals or their situation that predicts negative outcome on a specific outcome criterion" (Masten and Reed, 202, p.76) . There are many different well-

established risk factors to individual's positive functioning and development. These include socioeconomic impoverishment, family disruption and mental illness, physical and psychosocial hardships during early childhood, childhood temperamental difficulties, violence and intellectual impairment (Patel et al., 2008).

Protective and promotive factors work toward a positive mental health outcome. These are qualities, of an individual or the environment that, that makes a significant difference for good mental health outcomes (Masten & Reed, 2002). *Protective* factors decrease the probability of suffering mental health problems when exposed to serious threats and adversities, such as sensitive and authoritative parenting, decent educational opportunities, and good physical health. *Promotive* factors on the other hand, actively enhance psychological well-being (Patel & Goodman, 2007), such as social support and prosocial involvement (Zimmerman et al., 2013).

This study included all resilience indicators in its analysis; risk, protective and promotive factors. The analysis did not distinguish between protective and promotive factors, since they can overlap in many aspects, but presents both under protective factors. However, special emphasis was given to the protective and promotive factors, since authors such as Patel and Goodman (2007) highlight the research gap on protective and promotive factors.

A majority of resilience research has been focused on deficits and risk, leaving protective and promotive processes in the shadow (Patel & Goodman, 2007). Identifying risks to mental health and wellbeing are important for risk reduction efforts (Vindevogel et al., 2015)., but this should rather be combined with efforts to strengthen local protective and promotive processes Betancourt et al. (2011) found that it was not just the magnitude of risk factors that predict mental health outcomes among HIV/AIDS-affected youth, but protective processes as well. This highlights the importance of including protective and promoting factors when investigating resilience.

A growing body of research argues that resilience is more than a balance between risk- and protective factors with known impacts on mental health. Early resilience researchers described resilience as a weight scale with risk factors on one side and protective factors on the other (Werner et al., 1971). Although strengthening children's protective factors to counterbalance the negative impact of risk is essential for strengthening children's resilience, recent research on resilience gives a more nuanced perspective on how resilience indicators interact. Prominent resilience researchers (Bonanno, 2004; Masten, 2014a; Panter-Brick & Eggerman, 2012; Ungar, 2011) perceive resilience as an adaptive process with complex interactions across levels of the social and physical ecology of a child. They point to

indicators of resilience at the individual level as well as in the immediate and larger environment.

There is a long tradition in psychology for studying people within, and as part of, their environment. Bronfenbrenner (1977) emphasised that the larger environment, such as cultural laws and values, influence a child's development process, as well as the immediate and most influential setting of family and school. In his *ecological systems theory,* Bronfenbrenner divides a child's environment into five different systems according to their proximity to the child, as illustrated in figure two.

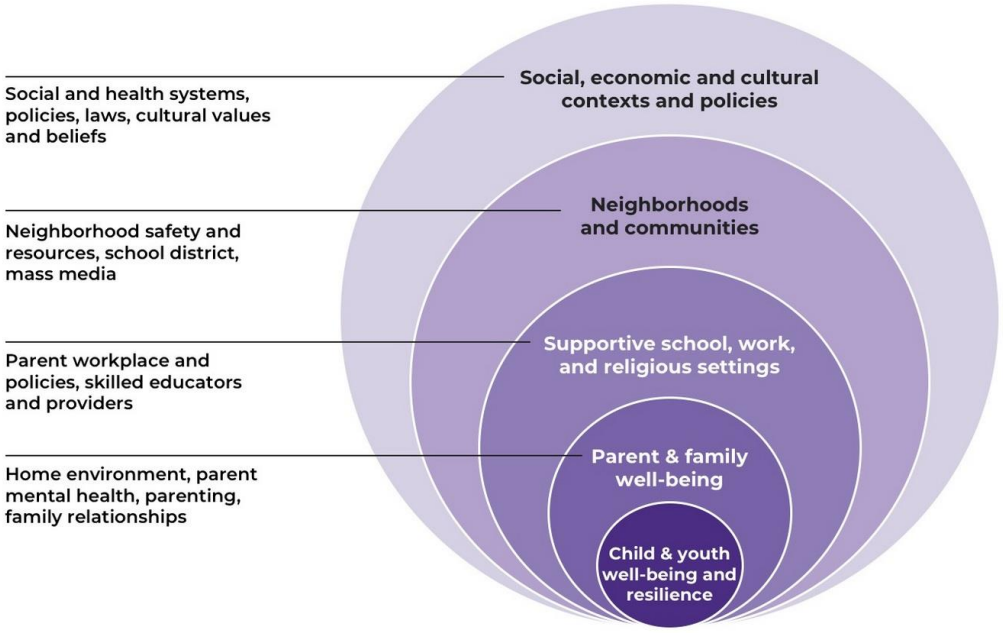

Figure 2: An adapted version of Bronfenbrenner's Ecological Theory, depicting the different layers of influence in a child's environment. Taken from the webpage of Center for Child & Family Well-Being (n.d.), University of Washington.

Super and Harkness (Super & Harkness, 1986) also acknowledged that children are influenced by their environment. They developed a model of *how* to study the child within its cultural context, called the *developmental niche,* by combining a psychological and anthropological view of human development. Similar to Bronfenbrenner, they divide the environment into three major cultural components that shape child development; the physical and social settings of everyday life, customs of child care and child rearing, and the psychology of caretakers. The *developmental niche* and the *ecological systems theory* illustrate the intricate relationship between a child and its immediate and larger environment.

Researchers exploring psychological resilience build on the ecological systems theory and present what they call the socio-ecological model (Masten, 2014b; Ungar, 2011).

Resilience is here viewed to be not only the product of personal traits and agencies, but is affected by a child's social and physical ecology. Children's social and physical ecology includes their surrounding relationships, their communities, as well as the resources made available to them in these communities. Masten (2014a) and Ungar (2011) clarify this relationships by dividing a child's social and physical ecology into socio-ecological levels; the community, family, school and individual level. To understand psychological resilience in children and adolescents, the analysis must therefore include several socio-ecological levels.

An extensive systematic review by Tol, Song and Jordans (2013) on resilience in low- and middle-income countries (LMIC) adopted the socio-ecological levels in their research approach and analysis. Tol et al. (2013) demonstrated how adversities, together with indicators at various socio-ecological levels, affect an individual's mental health outcomes, illustrated in figure one. This study builds on the socio-ecological approach of Tol et al. (2013) as it includes resilience indicators on the community, family and individual level in its investigation of key indicators influencing resilience and mental health outcomes for children and adolescents. The schools level is however merged with the community level in this study.

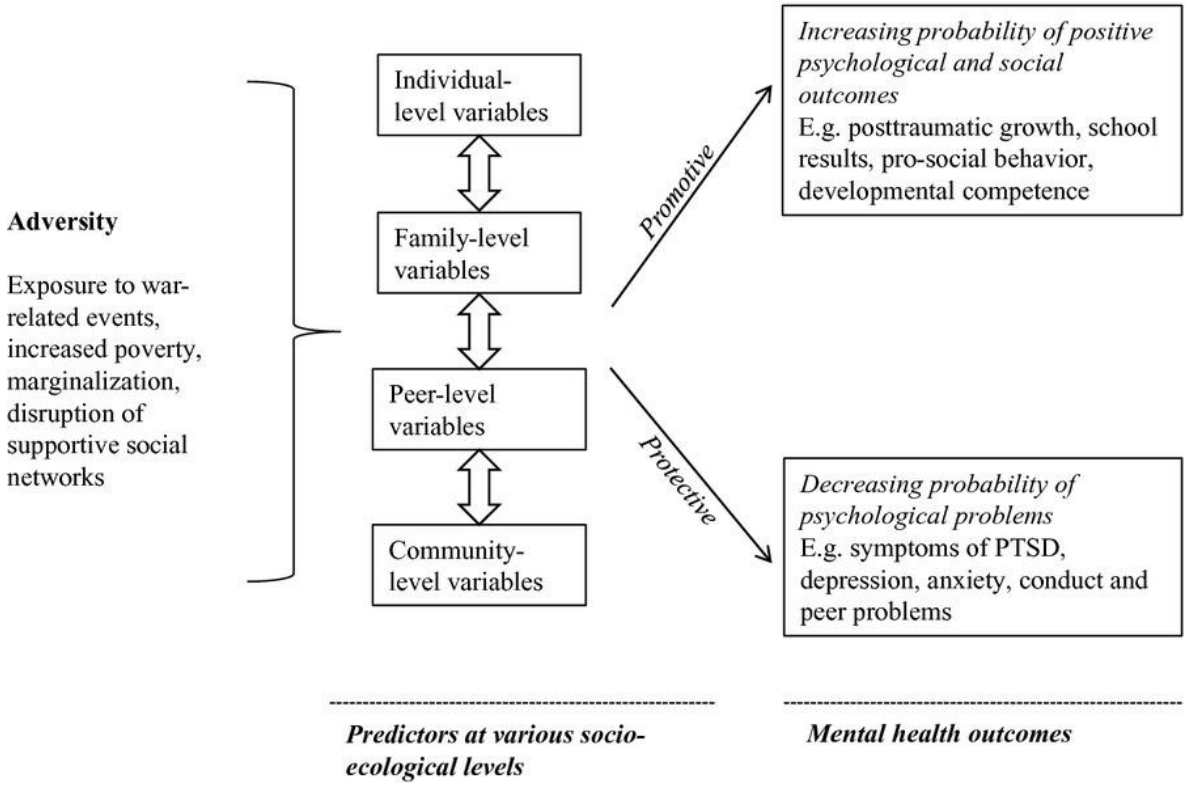

Figure 3: Tol, Song and Jordan's (2013) resilience and mental health model, depicting how adversities, togheter with resilience indicators at various socio-ecological levels, affect mental health outcomes.

Resilience researchers recognize that resilience is both a global phenomenon, and that factors influencing resilience are highly dependent on culture and context (Eggerman & Panter-Brick, 2010; Tol et al., 2013; Ungar et al., 2006; Wessells, 2017) (Tol et al., 2013; Ungar et al., 2006). Tol et al. (2013) observed that the way study participants defined desired mental health outcomes, and the processes that determine these outcomes varied between cultures and contexts. Ager and Metzler (2017) identified local coping mechanisms and pathways to resilience beyond protective and psychosocial interventions, by analyzing comparison groups. Ungar and Liebenberg (2011) explain that resilience indicators have differing amounts of influence on a child and that a child's culture and context affects how these resilience indicators interact. This study aims to identify culturally meaningful resilience indicators from a local point of view, also referred to as an emic approach.

Most universal measures of resilience have however been developed within a high resource setting with limited room for cultural adaptation (Miller et al., 2006; Vindevogel et al., 2015; Wessells, 2017). In efforts to ensure a more cultural and context sensitive measure of resilience, researchers have developed tools and methods that can be adapted to the given context. Ungar and Liebenberg (2011), as well as Miller et al. (2006) present ways of developing locally embedded measures of resilience. Both adopt a two-phased approach. The first phase explores local narratives and understandings to identify risk and protective resilience indicators. In the second phase, these indicators inform the development of a survey for measuring resilience. This study adopts the first phase in both Miller and Ungar's approach in identifying a locally valid measure of resilience.

Panter-Brick et al. (2018) recently adopted the model of Ungar and Liebenberg (2011) to develop a culturally valid measure of resilience within a conflict-affected Jordanian context. They experienced that the interviews in the first phase helped establish a vocabulary for talking about resilience, as well as supported the investigation of differences between refugee and non-refugee groups.

A local understanding of resilience is useful both for measuring resilience, as well as identifying local support systems and sources of resilience. E.g. Eggerman and Panter-Brick (2010) found hope to be the over-arching solution to Afghan participants' most distressing problem. Hope was in this context built on the firm foundation of cultural and religious values that gave meaning and order to life. Vindevogel et al. (2015) on the other hand identified six main themes in his research on war-affected communities in northern Uganda; progress, self-reliance, social connectedness, morality, health and comfort. In addition, Vindevogel et al.

(2015) found that risk factors and protective factors were intricately intertwined, as the study participants presented both protective factors as well as absence of risk factors.

Interestingly, many studies on locally embedded resilience indicators have been conducted within a low-resource and conflict affected context (Betancourt et al., 2011; Eggerman & Panter-Brick, 2010; Panter-Brick et al., 2018; Vindevogel et al., 2015). Children living in low resource settings are already at a higher risk of mental ill-health; an added conflict setting exacerbates the risk of exposure to severe adversities and thereby poorer mental health outcomes (Miller & Rasmussen, 2010; Wessells, 2017; Wessells & Kostelny, 2021). The focus on resilience in conflict settings is in line with current discussions on how to support war-affected children (Wessells, 2017). emphasizes how efforts to promote mental health and resilience should go hand in hand with peacebuilding topics, such as nonviolent conflict resolution, forgiveness and reconciliation, social cohesion and collective healing (Wessells, 2017; Wessells & Kostelny, 2021). Betancourt et al. (2011) reason that since risk factors for good mental health are especially concentrated in low-resource and conflict settings, identifying and strengthening local support systems and sources of resilience should be a natural counter-balancing effort. This study is conducted within a low-resource and conflict affected settings in South Sudan and aims to identify and strengthen local resources and systems.

4. Study context

Limited research has been conducted on mental health within South Sudan after its independence, much less on resilience. Roberts et al. (2009) conducted a post-conflict study on mental health needs in Southern Sudan, before South Sudan gained its independence. They showed that there were high levels of mental health problems in the population, such as post-traumatic stress disorder (PTSD) and depression. Roberts et al. (2009) found that 36 percent of the survey respondents fulfilled the criteria for PTSD, and 50 percent for depression. A similar study, conducted after South Sudan gained its independence, showed that 37.8 per cent of respondents met symptom criteria for PTSD, and vulnerable populations, such as women and those living in poverty, were more at risk for developing PTSD (López & Spears, 2013, as cited in Goldsmith & Cockcroft-McKay, 2019). These studies give an indication of the amount of the mental health needs in the current situation.

Recent research on mental health among South Sudanese populations is in large degree conducted on refugees in neighboring countries. E.g. Adaku et al. (2016) assessed the

needs and resources of South Sudanese refugees in northern Uganda. They asked South Sudanese refugees to identify major mental health concerns in the refugee settlement. The highest ranked mental health concerns were overthinking, ethnic conflict and child abuse. Other big concerns were family separation, drug abuse, poverty and unaccompanied minors. The findings from Adaku et al. (2016), and similar studies of South Sudanese refugees, give valuable insights in possible concerns of South Sudanese returnees.

The sparse research on mental health and wellbeing within the borders of South Sudan focuses on deficits, risks and challenges. Ayazi et al. (2014) investigated community attitudes in South Sudan, and found a high level of stigma towards people with mental health conditions, especially in rural areas. They discovered that their findings were similar to studies conducted in other low resource settings in Asia and Sub-Saharan Africa. Ventevogel et al. (2013), on the other hand, investigated how local people describe and define mental illness across four conflict-affected African communities. Two of the communities were located in South Sudan. They found that sadness and withdrawal was a core way of identifying persons with mental health problems. Identifying mental health concerns and how these are expressed, are important steps for risk-reduction and mental health protection. However, there is sparse research on protective factors that can promote mental health and psychosocial wellbeing within the context of South Sudan, let alone Maiwut county. This study thereby aims to identify protective factors within the Maiwut community, in addition to risk factors.

South Sudan is one of the youngest nations in the world and has suffered from civil conflicts most of its existence. The country gained its independence from Sudan in 2011 after decades of civil war, just to be thrown back into a new civil conflict in 2013. The current population is estimated to be around 11 million. More than two million South Sudanese have however fled the country since the conflict broke out and approximately 1,4 million people are internally displaced (OCHA, 2020). The conflict officially ended when the revitalized peace agreement was signed in late 2018, although there were reports of continued attacks and violations well into 2019. According to the field researchers, communities in Maiwut experienced an attack as late as August 2019.

Maiwut is a county in the Upper Nile district of South Sudan. The main ethnic group in Maiwut, as described by one of the field research assistants, are the Nuer, more specifically the Gajaak Clan of the Nuer people. They occupy approximately 75% of the Maiwut territory, while the Burun people live in 25% of the land on the North Eastern part of Maiwut county, as illustrated in figure 4. Nuer and Burun are the main languages in Maiwut. The main belief

systems for both ethnic groups are Christianity and African Traditional Religion. Study participants from this research are of the Nuer people.

Maiwut has a mixed topography. The northern parts have hills, swamps and streams, while the southern part is a flat grassland characterized with big swamps and scattered bushes. The swamps and streams dry out during dry season, but is a rich source of fish during wet season. The land is fertile and suitable for agro-pastoralists to grow food, as well as for rearing livestock. The Nuer people are main pastoralists, rearing cattle, goats and chicken, but some also grow vegetables such as maize, cassava and groundnuts. People live in *Tukulus*; round huts constructed with mud for walls and floor, and grass for roofing. Branches and reeds are used to reinforce the walls. Rampant conflicts and natural disasters have however disrupted the livelihoods, community structures and families of people living in Maiwut.

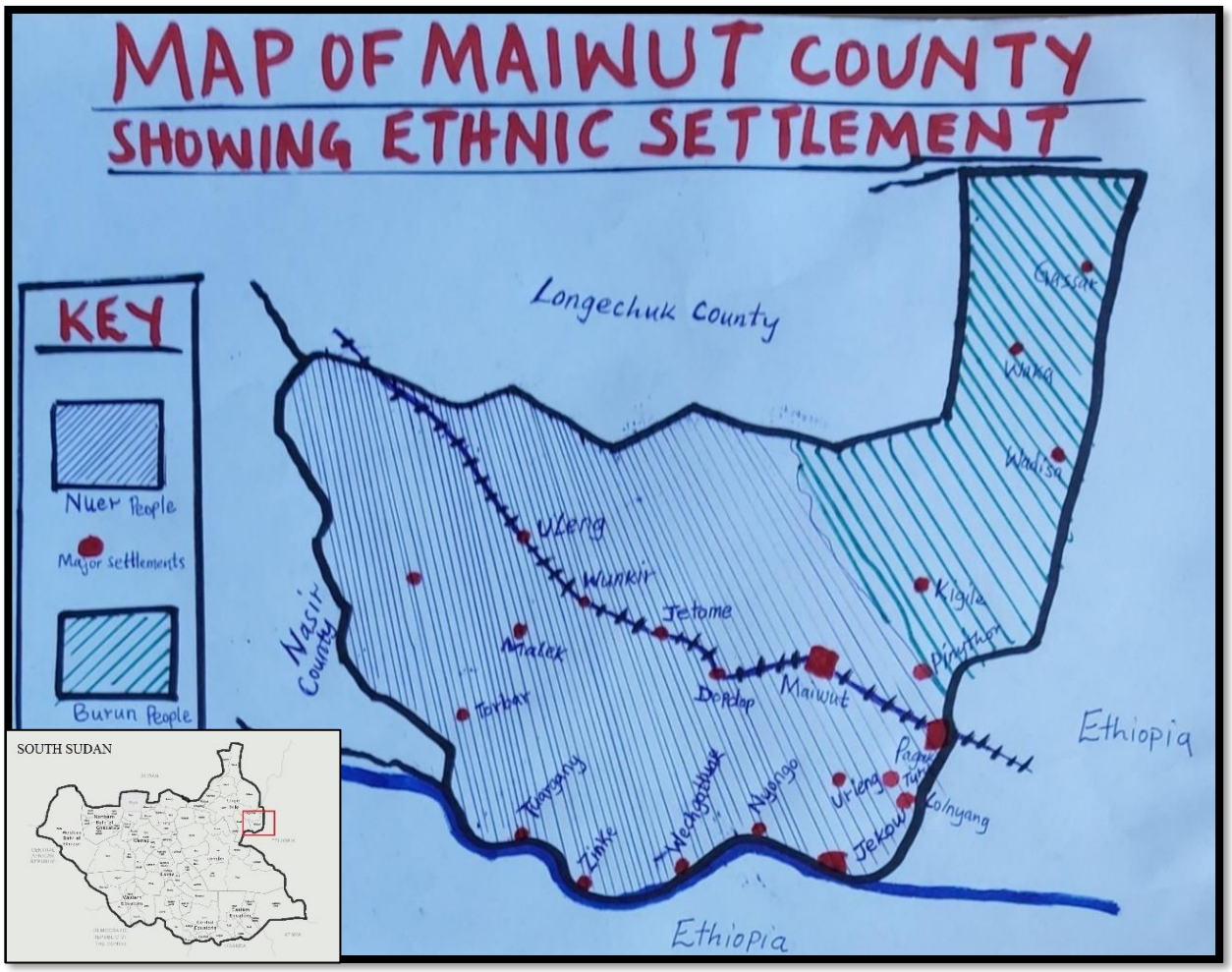

Figure 4: Map of Maiwut county in South Sudan, showing major settlements and Ethnicities. Larger map is hand-sketched by a field research assistant from this study, the inset map of South Sudan is adapted from Sevenants (2018).

The Upper Nile region has been a hotspot for fighting between government military and opposition forces for years since the civil war broke out in 2013 (CFR, 2020). Armed groups from both sides of the conflict have targeted civilians based on ethnicity. Physical and sexual violence, destroyed property and recruitment of children to act as soldiers or otherwise be associated with armed groups are some of the crimes that have been committed (CFR, 2020). Whole families have been forced to flee to the bushes during conflicts, leaving their homes and livestock behind (ADRA Norway, 2020). When the conflict intensified between rival forces in July 2017, the entire population of Maiwut county was forced to flee.

A majority of residents, mainly women and children fled to Ethiopia for refuge. Refuge is however a relative term, as displaced children and adolescents are at high risk of exposure to violence, exploitation, abuse and trafficking (Tidey, 2020, May). Refugees and internally displaced people have been returning to Maiwut since the start of the peace agreement process in 2018. Returnee children may struggle to cope with traumatic experiences and resettle under changed conditions. Broken networks have weakened the community child protection system, including school infrastructures and systems damaged by the devastating conflict (OCHA, 2019).

The stain of conflict and displacement grows darker with the lacking mental health services in South Sudan. There is only one small psychiatric inpatient ward in the capital, serving the entire population (Sevenants, 2018). There are no official mental health services in Maiwut, and even general medical services are lacking. The mental health and psychosocial needs of young returnees remain thereby largely unmet by international actors. In line with current recommendations (Ager & Metzler, 2017; Tol et al., 2013; Wessells, 2017), bolstering local support systems should therefore be an important first step in meeting the psychosocial needs of children and adolescents. This study aims to identify local support systems and resources.

Humanitarian organizations have been returning to Maiwut after the security situation improved in 2018 and have been supporting returnees in resettling and reconstructing facilities. Although returnees are returning to their old way of making a living, communities are still dependent on humanitarian aid. UN's World Food Program is present to provide families with food rations that can cover their basic needs. Access to material resources is also scares, such as "availability of financial, educational, medical and employment assistance, resources, or opportunities, as well as access to food, clothing and shelter." (Ungar & Liebenberg, 2011, p.137).

ADRA[2] is present in Maiwut to help the population rebuild their school buildings and improve the deteriorated educational system. All schools in Maiwut were damaged, and school supplies looted during previous conflicts in the area. The education project aims to meet these needs, as well as increase access to safe learning spaces for returnee children and adolescents. MHPSS for children exposed to violence and lack of protection is an integrate part of the intervention. This study aims to inform these efforts and was conducted within the school context of Maiwut county.

There are 46 schools registered in Maiwut county, but only eleven are operational (OCHA, 2019). ADRA supports education on the primary level in nine of the eleven functional schools. There are no secondary-level schools in the county. Schools in Maiwut have a high student to teacher ratio, with up to 98 students per teacher. There are 1000 to 1600 children enrolled in the two largest schools in Maiwut, distributed between 15-17 teachers. All children go to school at the same time; from seven in the morning until noon. Teachers work full time, five days a week. The field researchers have explained that teachers receive monetary incentives from ADRA for their work, since the national ministry has not been giving teachers their salary since the start of the conflict

Community members are especially engaged in school activities through the Parent Teacher Association (PTA). The PTA consists largely of mothers and fathers of children enrolled in the schools, but also local chiefs, leaders from church groups and county departments. They are e.g. engaged in encouraging other parents in the community to send their children to school, as well as in taking care of the school area.

School buildings have been closed since the COVID-19 pandemic broke out in March 2020. Children have however continued learning in smaller groups with alternative strategies, such as use of lessons on Mp3 players and broadcasting over the radio.

5. Research Design

This study adopts a case study approach to explore in-depth, locally defined indicators for resilience among South Sudanese children and adolescents. Both individual semi-structured interviews and focus group discussions with teachers and parents that are members of the Parent Teacher Association (PTA) are therefore employed for data collection. A key informant interview with a local field researcher and PTA member is also included. This

[2] ADRA is a faith based Non-Government Organization (NGO) established by the Seventh Day Adventist church, and is part of a global ADRA network represented in more than 115 countries.

approach builds on the work of Miller et al. (2006) and Ungar and Liebenberg (2011) for data collection, as well as Tol et al.'s (2013) analytical framework, as they also aimed at finding local indicators of resilience. The resulting data are analyzed through a thematic content analysis approach.

This is a cross-cultural research setting, in a sense that the main researcher is from another culture and context than the study participants. Particular emphasis is therefore given to the study-context by engaging local people in the research and gaining increased insight into the context. Regular conversations with the local research team helped increase the main researcher's knowledge of the context. In addition, the research design and analysis is approved by the local field researchers to ensure the study is based on local needs, is culturally sensitive and represents local meanings.

Three local field research assistants from ADRA South Sudan who are familiar to the study-context are engaged in collecting, transcribing and translating the data. The data was collected in December 2020. All communication has been over the internet; through email correspondence and Skype calls.

5.1 Study Parameters

Two overarching parameters of this study are the limited time frame and the on-going COVID-19 pandemic. The main researcher was given one semester to conduct this study. The research design was selected to provide good quality data despite the limited timeframe. The sample size and data collection methods were handpicked to fit within the scope of the research. The COVID-19 pandemic also set the parameters for this study as it prevailed throughout the research process.

The COVID-19 situation had the potential to place participants and researchers at risk. The chosen data collection process requires an increased social contact, which in turn increases the risk of exposure to the COVID-19 virus. COVID-19 precaution procedures specific for this research were therefore developed and effectuated to ensure that the international and national COVID-19 guidelines were followed. These procedures were made to protect both field researchers and participants from contamination. The data collection was also conducted in conjunction with ADRA's routine visit to the field, as to avoid additional risk-exposure for ADRA South Sudan staff.

The global travel restrictions were also a prevailing factor for this study. The main researcher therefore supervised the data collection and gained insight into the study context

through digital solutions. Telecommunications applications, such as Skype and e-mail enabled good communication opportunities with field researchers throughout the research process.

5.2 Ethical considerations

The processing of personal data in this study was assessed and approved by The Norwegian Centre for Research Data (NSD), as required by NMBU. This study was deemed to be in accordance with data protection legislation. An ethical clearance was obtained from the Ministry of General Education and Instruction (MoGEI) in South Sudan prior to data collection. The education county office in Maiwut and the school management in selected schools also gave their permission to interview school staff and stakeholders.

In order to conduct an ethical research, the main researcher took several ethical considerations specific to the cross-cultural research setting and the sensitive research topic. The ethical considerations for this study were guided by the Inter-Agency Standing Committee (IASC) (2014) *recommendations for conducting ethical mental health and psychosocial research in emergency settings*. The IASC recommendations are internationally renowned and cover a number of practical research principles within these six areas: 1. Research purpose and benefit, 2. Analysis of ethical issues, 3.Participation, 4.Safety, 5. Neutrality and 6.Study design. This study adopted principles from all areas, but gave particular importance to minimizing the potential harm to participants and maximizing their benefit.

This study strived to maximize possible benefits for participants through four main strategies. First, the focus of this study was directed to strengths and resources within the community, rather than focusing on hindrances and negative circumstances, to minimize the risk of harming the participants, e.g. secondary trauma (Guthrie et al., 2017). Second, this research was based on the local education system, to empower existing systems and resources. Third, the local needs were taken into consideration when identifying the research topic and aim. And fourth, a dissemination plan was developed in order for the local community and systems to benefit from the research.

5.3 Participants

The study is based on three methods to collect data – individual interviews, group interviews and a key informant interview. The study population is adult stakeholders with

insight into children's lives and coping mechanisms. Of this population, the sample includes teachers and parents who are members of the Parent Teacher Association (PTA). The sample units are purposely selected from three of the nine ADRA supported schools. The three methods allow for triangulation of data.The focus group discussions enabled participants' perspectives to enfold in ways that differ from individual interviews. The focus group created a safe space for interactive discussions with a broad range of views on the research topic (Hennink, 2013). The data was recorded for the entire group and not by individual. This study conducted two focus group discussions with PTA members. One group with six female participants and one group with six male participants.

Both genders were included to make the study units more relevant for the wider population. The field researchers advised to separate the genders, as the culture in Maiwut is male dominant and female participants are unlikely to speak freely among male participants. The genders were therefore separated to ensure inclusion of female as well as male voices.

Both PTA members and teachers were selected for the individual interviews to gain in-depth insight into their views and perceptions. Six male teachers, two female PTA members and two male PTA members were selected to take part in a semi-structured individual interview, as depicted in table one. The teachers were selected from the three selected schools. This study included only male teachers, as there were no female teachers within the study-area. Field research assistants were asked to select teachers based on their concern for and promoting efforts of student's wellbeing. This was to identify participants who were likely to have reflected on why some children manage well despite adversities.

The field research assistants were asked to select PTA members from the focus group discussions that had thought-through insights regarding why some people manage well despite adversity. Two of the male PTA members that took part in the FGD had the opportunity to partake in an additional individual interview. None of the female FGD participants had the opportunity to partake in an additional individual interview. The two female PTA members were therefore selected from outside the FGD. Table one indicates which PTA members took part in both the FGD and individual interview.

Table 1:
Number of sample units in study, how units are distributed between the different methods and how they are referred to in study.

	Number of sample units	Method	Referred to in study as
Female PTA members	2	Individual interview	p3, p7
	6	FGD	Female FGD
Male PTA members	2*	Individual interview	p4, p5
	6	FGD	Male FGD
	1	Key informant interview	KI
Teachers	6	Individual interview	p1, p2, p6**, p8, p9**, p10
Total of sample units	21		

**Participated in a FGD prior to interview*

***Interview conducted in English*

The unstructured key informant interview allowed for an in-depth insight into personal and community issues related to mental wellbeing and resilience. A local field research assistant was initially selected as a key informant. He was given a theme and asked to audio-record himself while he reflected on the theme. The key informant decided however to have an unstructured interview with a PTA member he, and other community members, look up to and thought would give insightful comments to the topic. This gave a unique dynamic, where the key informant could freely ask the PTA member questions related to the given theme, and thereby share reflections from himself, as well as the selected interviewee. The PTA member is a community elder who has lived in Maiwut for many years. He was described to have endured many hardships and talks openly about challenges within the community. The interview was conducted in Nuer, and simultaneously translated to English by the key informant. This interview was conducted after the initial data was collected to permit a more open discussion around the research topic.

5.4 Data Collection tools

To attain a culturally grounded understanding of key resilience indicators, this study adopted two approaches**.** The *story-telling approach,* where participants are asked to first describe someone they knew who was doing well and another who was doing poorly after being faced with severe adversity. This approach was developed by Miller et al. (2006) within

a conflict-affected context. The second approach is the qualitative pre-implementation stage of the Child and Youth Resilience Measure (CYRM)-28, developed by Ungar and Liebenberg, at the Resilience Research Centre (2009). The first phase of CYRM-28 is modeled to understand locally valid aspects of resilience through a set of prompts, such as "What do you need to grow up well here?". This study combines these two approaches, as did Panter-Brick et al. (2018).

The storytelling approach was adopted for the individual interviews, and the CYRM-28 was used for the focus group discussions. Both approaches were adapted to fit the study aim and context. Existing resilience research related to this study as well as feedback from the field researchers in South Sudan informed the modification of the interview and discussion guide. Some questions were angled to specifically inquire perspectives on the individual, family and community level, as this study aims to investigate resilience indicators within these socio-ecological levels.

The individual semi-structural interview guide (Appendix 1) involved asking respondents to think of two children they knew personally who had been exposed to difficult life experiences; one who had recovered and one who had not yet recovered. The respondent was asked what the difficult life experience was and how the children were affected by it in terms of thoughts, feelings and behavior. The follow-up questions focused on contributing factors to the first person's recovery, as well as what factors contributed to the second person still having difficulties. No personal information regarding the third person that could be traced back to the person was collected or stored.

The focus group discussion guide (Appendix 2) had a more general approach to the topic than the individual interview guide. The group discussion guide sought to clarify concepts such as: what it means to grow up well within the study context, what it means when bad things happen and what being healthy means, as perceived by the participants. The participants were asked to describe people who grow up well despite the many problems they faced, what strategies they would advise to stay healthy physically, emotionally and spiritually, as well as what they do when faced with difficult life experiences.

The semi-structural interview guide and focus group discussion guide was translated into the local language, and then back-translated to ensure congruence of meaning between the languages (Tyupa, 2011). *Back-translation* is a quality control method widely used in international research settings and means that the interview guides and information letter is first translated to the desired language, and then translated back to the original language.

(Tyupa, 2011). After this process a pilot study was conducted. The pilot study enabled the rephrasing of questions as well as helped the field research assistants to practice using the interview guides.

The key informant interview guide was unstructured and open-ended. The initial key informant was asked via email to make an audio-recording sharing whatever he felt was relevant to a given theme. The theme he received was: factors that promote or hinder psychological resilience within the context of Maiwut. He was given the following examples of community domains to focus his answers to local and cultural aspects: cultural traditions and customs, community support systems and community concerns.

5.5 Field research assistants

Local field researchers were engaged in the research process to increase the cultural validity of the study approach and findings as well as reduce participant reactivity. Employing local people to engage with the study participants, diminished cultural and language barriers, as well as participant's reactivity degree. *Participant reactivity,* also known as the observer effect, can occur when the research approach changes the behavior of participants (Corbin & Strauss, 2014). A high level of participant reactivity could make the research findings subject to error.

Two field research assistants and one field research coordinator from ADRA South Sudan were recruited to conduct the data collection. Since mental health is a sensitive topic and needs to be approached in a delicate manner, the field researchers were selected based on their empathic communication skills, research experience and familiarity with the research topic and context. The program advisor at ADRA Norway, who collaborates with and is familiar to the ADRA staff in South Sudan, recommended a female field research coordinator based on the criteria presented. Her eligibility was confirmed through Skype discussions and e-mail correspondence with the main researcher early on in the research process.

The field research coordinator is from Kenya and plays an administrative and coordinating role in ADRA South Sudan and is well familiar with conducting and leading out in research projects. She is a teacher with a master's degree in psychology and has worked with leading out in psychosocial support efforts in humanitarian settings. She works at the main ADRA office in Juba, the capital of South Sudan, but travels regularly out to the field, such as Maiwut county.

The field research coordinator recommended two ADRA staff located in Maiwut as field research assistants. The field researchers are familiar to the local context and have experience with structured interviews and focus group discussions. Both research assistants have previously been trained on topics related to mental health and psychosocial support. The research assistants are from South Sudan; one grew up in Maiwut and is fluent in the local language, Nuer, and the other has lived in Maiwut for a couple of years and can understand much of the Nuer language. Both research assistants and the research coordinator are proficient in English.

The field research team was engaged in the design, execution and analysis of this study. They gave contextual and cultural guidance for the research design and analysis and conducted the data collection. The main researcher supervised and guided the practical execution of the data collection, with help from the field research coordinator. The main researcher communicated with the field research team through correspondence over email and skype.

To minimize language barriers, one field researcher and a local humanitarian aid worker were selected to transcribe and translate the data. Both translators grew up in Maiwut, but only the field researcher had taken part in collecting the data. Having two translators reduced the potential for translation mistakes, since translators could quality check each other's work. The translators speak the same dialect of Nuer as the study participants, which ensured proper comprehension of words and cultural idioms. Both field researchers were adequately proficient in English and had experience with project related translation, but were not familiar to verbatim transcription. The field researchers received support from the main researcher on verbatim transcription and translation.

The transcription and translation process was guided by verbal and written guidelines (Appendix 3) from the main researcher, to safeguard data richness and accuracy. This included transcription and translation guidelines, a transcript template, as well as a skype meeting with the main researcher. The transcript template illustrated how to best structure the transcript document. The transcription and translation guidelines explained and defined verbatim transcription, described the desired translation and transcription approach, gave specific guidelines, such as what to do with cultural expressions, and provided a research topic and aim summary for the translator who had not previously been a part of the research. The field researchers received the guidelines via email, before meeting with the main researcher over Skype to discuss the process in detail.

This study attempted to recruit an external professional to transcribe and translate raw data, to increase translation quality, as well as reduce chances of bias from local translators and researchers. An accurate transcription and translation process was important to reflect perspectives of the participants correctly, as well as to identify nuances in the language (Lincoln et al., 2011). The main researcher was actively engaged in the recruitment process, by communicating recruitment requirements, partake in the interviews, as well as review tests. The tests involved transcribing and translating parts of the information letter from Nuer to English. However, the interview and test rounds proved the two candidates to be both unreliable, as well as insufficiently skilled in English or the relevant Nuer dialect. The local field researchers were therefore deemed more equipped for the job than the external candidates were.

To increase the accuracy of data translation, this study adopted a two-step transcription and translation process. The first step involved a verbatim transcription of the Nuer interviews from the audio recordings. Having the raw data in audio recordings also enabled the possibility of quality checking translated transcripts later in the research process. The second step was to translate the transcribed data into English.

The data was largely transcribed in South Sudan and partly in Norway. Eight interviews and two FGDs, conducted in Nuer, were transcribed and translated in South Sudan. Translated transcripts were successively transferred to the main researcher as they were finalized. The main researcher transcribed two interviews conducted in English, as well as the key informant interview. Table one on page 22 shows which interviews were conducted in English. Having interviews in a language that the main researcher understood gave an added advantage in being able to compare their remarks with translated scripts. This also enabled the main researcher to gain insight into the data before the translation process was completed

5.5 Data collection procedures

The main researcher arranged a data collection training for the field research team over skype. The field researchers were asked to answer an online survey to map the training needs within each topic prior to the training. The study aim, purpose and key concepts were communicated in the training to ensure a common understanding. In addition, the field researchers were given the opportunity to comment and suggest amendments to improve the common understandings. The training topics included a discussion and orientation around the *research topic*, such as concepts, purpose and aim, refreshment of *research methods*,

including data safety and management, research ethics and interviewing techniques (e.g probing).

The training also helped to familiarize the research team with the data collection tools, such as the interview guide, information letter, work plan, and the data collection and management protocol. The work plan (Appendix 4) outlined in detail the different tasks needing to be done prior to, during and after the data collection, as well as who was responsible and when it was to be done. The data collection and management protocol (Appendix 5) described the sample design, data management plan and data collection strategy and procedures, such as COVID-19 precaution measures, protection of participants and other practical guidelines.

The COVID-19 precaution measures included specific procedures regarding handwashing and sanitizing, disinfecting surfaces, physical distancing, minimizing contact with others, as well as other concerns. The COVID-19 procedures were based on national and international recommendations as well as routines for fieldwork developed by Faculty of Environmental Sciences and Natural Resource Management at NMBU.

A pilot study was conducted in conjunction with the data collection training. The pilot study helped correct some minor errors in the interview guides, as to give it a better a flow, as well as guided the field researchers in how to convey the information letter to the participants without major misunderstandings. Two focus group discussions and two individual interviews were piloted one week prior to data collection. The pilots were not conducted within the selected communities, yet within the school context of Maiwut.

In recognition of IASC (2014) recommendations, field researchers were informed of the special considerations that need to be taken when conducting research on mental health. Field researcher received written guidelines on how to give basic psychosocial support to participants, as well as how to protect participants from harm. Most of the participants are likely to have been through serious adversities themselves and bringing up stories similar to their own might result in vicarious trauma, that is a form of secondary trauma (Guthrie et al., 2017). Field researchers were also at risk of becoming emotionally affected by the topic. Topics of self-care were therefore included in the guidelines

The field research team signed a code of conduct describing the professional, legal and ethical responsibilities they have as research assistants prior to data collection. The data collection was conducted alongside a scheduled field visit. This conjunction reduced the risk

of the research process interfering with regular work tasks. Reducing travel also reduced the safety risks, as well as the risk of being contaminated by COVID-19.

Regular debrief sessions were scheduled to support the field research team. The debriefs opened the possibility to correct the course amid unforeseen challenges (McMahon & Winch, 2018) and provided a space of shared experiences. The main researcher was also able to follow the process and gain immediate insights into the content of data through the debriefs. The debrief sessions were held after the pilot study, after the first and second day of data collection, as well as four days after they had completed collecting the data.

A precaution plan was in place to guide the way in case risks of harm would occur or special needs identified. The precaution plan included a referral system with the use of local resources. There are few referral system in place and limited structures to support participants that might be in need of specialized mental health care. This study benefitted from ADRA staff, at the field office in Maiwut, qualified in providing mental health and psychosocial support for mild to moderate cases. In addition, there was an opportunity to refer cases with extreme needs to specialized care over the boarder to Ethiopia.

This study also had an internal referral system in place, in case a special need was presented. A special need included mental health needs, as well as legal needs and basic needs, such as food and clothing. If a need for referral would arise, the research assistant was to report to the field research coordinator. The field research team and the main researcher would together come to a consensus on how to best support the participant's needs. A qualified counsellor stood ready to provide basic mental health support if needed.

Due to the many risks related to research, such as loss of confidentiality, all study participants were well informed before giving their consent. The information letter and consent form (Appendix 6) informed the participants of what the study involved, the purpose and duration of the participation, before asked to give oral or written consent. They were also informed that the conversations would be audio recorded.

Oral consents were recorded on a separate audio recording, to ensure confidentiality. The recording included an oral orientation of the information letter and an encouragement to ask questions for clarification before giving an oral consent. This consent procedure was to ensure that participants knew exactly what they were giving consent to. Literate participants signed the consent letter after having read the information letter or received an oral orientation

of the content of the information letter. Participants were given the opportunity to withdraw from the study at any time.

A data processor agreement was signed between the Norwegian University of Life Sciences (NMBU) and ADRA South Sudan. The agreement was intended to ensure that personal data was not processed in ways that result in alteration, erasure, damage, loss, or unavailability, according to Norwegian personal data legislations.

Data management procedures were developed to secure participants' confidentiality and anonymity. Safe storage and transfer procedures were important to ensure that only authorized persons were able to access the participants' personal data, as well as safe guard the data from being lost. The field research team were therefore given specific instructions through the data collection and management protocol. The protocol gave a detailed description of the management process, requirements and responsibilities. The field research coordinator was given the responsibility to ensure that these procedures were followed in South Sudan.

Soft and hard copies of the data were stored in a locked cabinet at the ADRA field office in Maiwut during and after data collection. Only the field research team had access to this cabinet. Procedures were in place to transfer the data and personal information separately, in further efforts to ensure confidentiality. The data and personal information was transferred to the main researcher through the cloud storage provider Google Drive. The main researcher then stored the files on an encrypted and protected folder on OneDrive from February to May 2021. All personal data and audio recordings stored in Norway or South Sudan were deleted at the end of the project in May 2021.

Special emphasis was given to safeguard participants' personal information during storage and transfer. The following personal data was collected: names, community of origin, age, gender, education level, livelihood, years lived in Maiwut and how many children they have. Information that could be traced back to the participant, such as names and community of origin, was kept separate from other personal information and was not included in processing or analyzing the data.

The participants' names were switched out with a code to safeguard their anonymity. The participant records, listing the participants' names, community of origin and respective codes, were stored and transferred separately from the rest of the collected data to ensure confidentiality. This system enabled participants to be identified and thereby also withdraw

from the study if desired. Participants had the opportunity to get in touch with ADRA staff working in their area for inquiries regarding the research after the data was collected.

5.7 Data Analysis

This study bases its analysis on data from individual interviews, focus group discussions and a key informant interview. The analytical structure and approach of this study is based on Tol et al. (2013) and recent studies on locally embedded indicators of resilience (Betancourt et al., 2011; Eggerman & Panter-Brick, 2010; Vindevogel et al., 2015). This study adopts the analytical structure of Tol et al. (2013), supported by central resilience researchers exploring resilience (Betancourt et al., 2011; Masten, 2014b; Ungar, 2011), which highlights the importance of investigating resilience at multiple socio-ecological levels**.** This study includes the individual, family and community level.

Following the approach of recent studies on locally valid resilience indicators (Betancourt et al., 2011; Eggerman & Panter-Brick, 2010; Vindevogel et al., 2015), this study adopts an inductive approach together with thematic content analysis. Such a systematic examination of themes, patterns and meanings helped identify meanings that were both plainly stated and hidden between the lines. The inductive nature allowed for local themes to emerge from the data without interference from conventional resilience indicators, largely developed in a western context. The thematic content analysis was elevated by the use of NVivo, a qualitative data analysis software.

The coding process included a combination of bottom-up and top-down coding. A top-down coding was initially implemented, by developing a coding table to ensure that the research questions would be answered (Appendix 7). The coding table broke the main and sub research questions into points of information that were relevant for answering the questions. The different points were; local understanding of good mental health, poor mental health, risk factors and protective factors. This study only includes the risk and protective factors in its analysis.

Following Tol et al.'s (2013) approach, the risk and protective factors were set as separate sub-codes under each socio-ecological level. Each level represented a main code, together with the code *adversity.* Adversity was added as a main code separate from the socio-ecological levels to get a better overview of the severe adversities children had been exposed

to. The adversity code had the following sub-codes: type, time scale, gender and effect. These main and sub-codes were the starting point for coding the data in NVivo.

The first stage of analysis involved reading through all transcripts and identifying manifest content main categories under each code. This process involved two steps. The first step was sorting plainly stated remarks, also referred to as manifest content, according to a suitable pre-code. This gave a good overview of risk and protective factors on each level. The second step involved a bottom up-coding; creating categories under risk and protective factors at each socio-ecological level. These categories, or sub-codes were based on labelled statements and comments. E.g. statements describing children as being isolated, reserved or not wanting to talk about their problems, went under the label "withdrawn". NVivo facilitated the first stage of analysis.

The aim of the second stage was to identify major or crosscutting themes. A major theme was identified based on how often participants would refer to it or to what degree participants emphasized the theme or category. The first step was identifying common themes across socio-ecological levels. The second step involved identifying categories that could be merged under a common theme. E.g. child neglect, abuse, exploitation were grouped under the theme *child maltreatment.*

As themes emerged, this study found that both risk and protective factors could be placed under the same theme. Grouped protective factors seemed to correlate with the grouped risk factors and vice versa. E.g. Supportive care giver corresponded with the opposite risk factors, such as loss of parent or child maltreatment. Another example is *peace* with *conflict* as a corresponding risk factor. Protective and risk factors were thereby grouped under the same theme. A color map was used to facilitate finding the themes across levels and risk/protective factors (Appendix 8).

The third and last stage of analysis was to quality check the final themes and findings. The transcripts were re-read in part or at whole in an iterative process to see if themes or codes needed to be modified. During this process, being *entangled and overwhelmed by life* was for instance merged with *bad feelings and thoughts*. All coded and labelled statements were double-checked, to make sure they were not taken out of context. This last stage helped to ensure that the themes emerging from the data could be traced to the original data.

Together, the thematic content analysis and systematic coding helped form the main themes. A majority of themes crossed over several socio-ecological levels. *Personal strength*

was a major theme and covered only the individual level. The rest of the emerging themes were identified on more than one socio-ecological level. The crosscutting themes were: *supportive relationships, basic needs, hope and peace*.

The key informant interview was conducted and analyzed after the main themes of this study had emerged. The findings did not add any new aspects to the data, but supported two of the merged main themes (hope and peace) and was therefore included.

The main researcher, situated in Norway, conducted the analysis with guidance from the field research team. Field researchers received the first draft of the analysis to give feedback and contextual guidance.

It was crucial for the main researcher to get a better understanding of study-context in order to elevate the analysis. In this study, the main researcher is crossing into an unfamiliar culture and social setting. This increases the risk of misconception, as well as missing interesting details in the data. The main researcher took three strategies to gain insight to the study context. First, continual communication and consultation with local field researcher for insights into the cultural context. Second, studying a project based video describing the local context in Maiwut. And third, the main researchers conducted three test interviews with local school counselors trained and hired by ADRA South Sudan.

The main researcher has gained increased knowledge about the context through continual communication with the local field researchers. The field researchers provided contextual and cultural information when planning the research design, as well as when developing the data collection tools and protocol. The main researcher received this information through written responses to specific questions, as well as through regular Skype meetings. These answers also informed the analysis of this study.

To gain a more visual understanding of the context, the main researcher studied a video depicting the everyday life of children in Maiwut (ADRA Norway, 2020). The video is produced by ADRA Norway to shine light on their education project in the study area. However, the video also gives a good visual and verbal description of the living conditions, such as everyday chores, social customs and physical environment as well as some main challenges. The content of this video has been validated by local representatives.

To get a first-hand experience of interviewing representatives from the local community the main researcher interviewed local counselors hired by ADRA South Sudan. The interviews were conducted via skype and coordinated by a local field researcher.

6. Findings and Discussion

This study will present key local resilience indicators, including both risk and protective factors for resilience, under over-arching themes. These themes emerged from the data analysis. This study found that protective factors could be grouped with corresponding risk factors. For example, personal strength and personal weakness. They are therefore presented together under respective themes. Leaning on the analytical framework by Tol et al. (2013), each socio-ecological level will be addressed under each theme. There were no major differences between sample units that were central for interpreting the data. Differences between units that were identified will be mentioned at their respective place.

6.1 Risk and Protective Factors

From the analysis of the data, there emerged five over-arching themes. The themes were personal strength, supportive relationships, having your basic needs met, hope and peace. Personal strength was the only theme that did not span across several socio-ecological levels, but was found to be a key indicator on the individual level. The corresponding risk factors under each theme were either the lack of the protective factors or the opposite characteristic, such as peace and conflict. There were some over-all findings in addition to the themes.

This study found that participants in the individual interviews largely told the story of adolescent boys and girls (10-20 years of age). The main adversities children had been exposed to in the narratives were having a physical disability or having lost their parent. Seven of the 16 different narratives told by the participants were of children with a disability and seven narratives were of children that had lost their parents. These adversities were often coupled with either lack of basic needs or child maltreatment.

Not all participants in the individual interviews could think of both a child that *had* recovered and one that had *not* recovered. Only six out of ten participants could think of a child that had recovered from exposure to severe adversities. Participants P1, P7, P4 and P5 were unable to think of a child that had recovered during the individual interviews. PTA members seemed to have a harder time thinking of children that had recovered, as only one out of four PTA members could think of such a child. There was however only one out of six teachers (P1) that could not think of a child that had recovered.

6.1.1 Personal Strength

Personal strength, or the lack of it, emerged as a main theme in this study, both in regards to protective factors and corresponding risk factors. Personal strength was the most frequently mentioned factor within the individual level and had strong relations to other emerging themes, i.e. supportive relationships and hope. Six out of ten participants (p2, p3, p7, p8, p9, p10) mentioned personal strength, or the lack of it, as a contributing factor for resilience. Having inner strength meant that you had coping strategies such as having a positive attitude and being open towards others. Inner strength was made visible by describing personal attributes, attitudes and behaviors of a child or adolescent.

- Inner strength -

Participants described personal strengths mainly as a personal asset and attitude, such as having zeal, confidence, or strong will. A teacher expresses it in the following way, when being asked what contributed to a female student's recovery:

> "She has determination towards her future… Then she has the natural resilience in her. You can see her very weak and distant and then immediately she forgets and becomes very strong. (p9)"

Answering to the same question, a female PTA member (p3) responds:

> "she has a strong will, good adaptation to new life, her grandmother was caring, the community is encouraging her and she is forward working."

Children that lacked inner strength were viewed as being at risk for not recovering after adversities. Children at risk of not recovering were described as either vulnerable or lacking of personal strengths. All six previously mentioned participants described lack of confidence, self-esteem or strength as negatively contributing factors. Comparatively, only three out of the ten participants (p3, p9, p10) mentioned the positive aspects of personal strength. Lack of personal strength was also in different ways described as being vulnerable.

A child was described as vulnerable largely based on their behavior and demeanor. Behaviors viewed as risk factors were; crying easily, being sensitive to talk about difficult life experiences and not speaking up for themselves. A male PTA member was asked what hindered a child he knew to recover, and said that "She keeps crying whenever the situation worsens. (p5)" Some more examples of the statements made of participants:

> "She is very soft and she rarely talks about her rights even though they are being abused or she is being insulted." (p10, Teacher)

> "She isolates herself, doesn't answer questions and cries when asked touching questions." "He felt pity for himself, lost confidences and no happy in the company of others. " (p8, Teacher)

- *Positive Attitude* -

A positive attitude to life was closely associated to personal strength. The ability to acknowledge own abilities as well as have a positive outlook on life, was identified as protective factors for resilience. A teacher said: "He concentrates on what is positive in his life. His motivation is that he wants to achieve his goal of becoming a doctor in order to treat people of his caliber. (p8)" Another teacher was asked why one child recovered and the other did not, and answered:

> "the second child has known that his physical inability does not mean that his life is worthless instead he capitalized on his abilities meanwhile the first child lacks support and has a weak spirit. (p10)"

A positive attitude was closely connected to the themes hope and supportive relationships. Local and hope-centered coping strategies were encouraged by family and community members. Children who were motivated by success stories and positive role models were viewed as being resilient, as well as able to adapt to new circumstances. The following was expressed in the female FGD: "If parents talk to children about those who made it they end up inspiring them to do the same."

An interesting finding was that participants described children who had recovered from an adversity, as forgetting past difficulties. A teacher (p6) tells of a child who's life was completely changed when a relative took over the caregiver role from her stepmother:

> "That is where they changed their lives completely. They play with others and then they changed, they forget the, the, the experience. They, they, they face"

However, there are statements that suggest that forgetting does not mean that you do not remember it, but that you do not think or focus on it. This is suggested by the following statements, when speaking of a child that has recovered:

> "She has determination towards her future. Then she has the natural resilience in her. You can see her very weak and distant and then immediately she forgets and becomes very strong." (p9, Teacher)
>
> "He is now social and talks freely and does not think of past difficulties and wears good clothes." (p2, Teacher)

A negative disposition to life was described as a risk factor. A negative outlook on life was described in terms of thoughts and feelings, such as feeling that none cares, fear of stigma and self-pity. These descriptions were at times coupled with lack of supportive relationships. Here are examples of ways teachers described this:

> "he is a clever child but because he is entangled and overwhelmed by life conditions he has lost concentration in school. (p1)"
>
> "She lacks basic needs such as clothes. She also has constant bad thoughts and lives as an orphan. (p10)"
>
> "The child shows lack of interest with people and feels no one cares because they assume that they can get nothing good from the child. (p4)"

- *Openness* –

Being open towards others and open to listen to advice was closely associated to personal strength. This category overlaps with supportive relationships, as participants include the social aspects of openness. A teacher talks about a child who has recovered saying: "he is a free spirited child; he is outward and shares his problems with trusted friends." Being open towards others about their problems, as well as sharing their experiences to encourage others, was viewed as a protective factor and referred to by six out of ten participants. Female PTA members agreed in the FGD that: "people who have been able to grow up well listen to advices, encourage others and share their experiences." The opposite attribute to being open was viewed as a risk factor for recovery.

Children who were withdrawn and not wanting to listen to advice, were seen as less able to recover. Being withdrawn meant to isolate oneself from others, not playing with other kids and not talking about their problems. A male PTA (p4) is asked what hindered a child from recovering, and points to the child's reserved nature:

> "I think what is hindering this child from recovery could be the extent of his medical health, this is contributed by the way of living in their home and the reserved nature of the child who does not disclose his problem."

A teacher (p6) describes it in this way: "he could no longer play with friends, he stopped going to school and needed to be pushed to get out."

Being withdrawn and not listening to advice was also connected to bad behaviors. Participants described how some children could be rude, violent and even addicted to drugs. A female PTA member explains why an adolescent with drinking problems is still having

difficulties: “it is because he has dropped out of school, doesn’t want to reform despite advice and continues to drink up to date. (p7)” She continues to describe the adolescent later in the interview: “he became an alcohol addict who doesn’t want to be social with his peers. He has neglected family responsibilities and dropped out of school. (p7)” Other participants made statements such as:

> “he used to be very aggressive and often cries when he request for something.” (p10, Teacher)
>
> “she was distressed. That is why she was forced to fight if somebody want to converse with her, even a simpleton that you may not fight with.” (p6, Teacher)

Personal strength played an important role in the narrative of two children with disabilities, told by two teachers p8 and p10. P10 tells the story of a boy who had polio at young age, which made him unable to walk and had to be carried around. He used to cry a lot, was hot tempered and was bullied by other children at school. “His friends called him poor lame boy when they try to ridicule him” the teacher told. However, a change occurred when family and community members started encouraging him and capitalizing his strengths. When asked what contributed to the child’s recovery, the teacher says that the child “has known that his physical inability does not mean that his life is worthless instead he capitalized on his abilities”. The teacher explains: “He used to be very aggressive and often cries when he request for something. However, now it is fine with him whatever he get the shares and if he has not been given he knows another time is there.” He continues to describe the change in the boy’s life:

> “He attends school, he is social with friends and no longer rude to friends”.
>
> “He is a very good speaker and speaks with confidence. He tell many stories which are often funny, thus people like staying around him”
>
> “He is very jolly and he is always getting help from friends who like his stories”.

This story is an interesting example where a child recovered, despite being at risk of persistent mental ill-health due to his physical disability. A combination of personal strength and family and community support, brought a positive change in the life of the child. Future studies could be inspired from this story, as to explore resilience specifically among children with disabilities with emphasis on the role of social support.

Interestingly, personal strength was never mentioned as a standalone criterion for recovery of any child. In this study personal strength was always coupled with different kinds

of social support. Love and care from parents, as well as instructions from both parents and community, seemed to be a condition for nurturing personal strength. The quality of personal strength, self-confidence, positive focus an open mindedness, were encouraged by family and community members. Although personal strength was important for recovery, it was never presented separate from other types of social support. The seemingly strong connection between personal strength and social support could be interesting for future studies to investigate.

This study revealed that signs of distress and risk factors were overlapping. Participants would mention signs that told them that a child was still suffering after adversities, and later mention the same factors as hindrances to recovery. This was especially relevant for risk factors such as being withdrawn or lacking self-esteem. There were similar tendencies for protection factors. Openness, personal strength and a positive disposition were both signs of recovery as well as reasons for recovery. Why there was an overlap between signs and reasons for distress or recovery was not examined in this study, but could be an interesting topic for future studies.

Personal strength and coping mechanisms, such as a positive attitude and openness, are interestingly similar to other studies on local resilience indicators in conflict-affected communities. This study found personal strength, a positive focus and openness to be the key protective factors on the individual level. This is in line with previous studies on resilience in similar contexts (Betancourt et al., 2011; Tol et al., 2013). Betancourt et al. (2011) found that perseverance and self-esteem, or confidence, to be the core protective factors on the individual level among HIV/AIDS and conflict affected children. Tol et al. (2013) had a longer list of protective factors taken from studies on resilience in low-resource contexts. Personal strength and agency, extraversion and coping were three of the factors on the list of seven protective factors. These findings also go well in line with what the resilience researcher Bonanno (2004) describes a hardiness. The resemblance between these studies together with the emphasis the theme was given in this study might indicate that personal strength is a common denominator across contexts.

6.1.2 Supportive relationships

Supportive relationships was a common protective factor on the family and community level. Supportive caregivers and community support played an important role for children's mental wellbeing. There were however several indications that the importance of loving caregivers, that communicated family and community standards, were more important

than support from community members, such as visits, words of advice and physical support. The lack of support from family and community had a substantial negative impact on children's wellbeing.

- *Family level –*

A supportive caregiver was the most frequently mentioned and emphasized protective factor across all levels. A supportive caregiver, or the lack of it is referred to by eight out of ten participants (p1, p2, p3, p6, p7, p8, p9, p10) as well as in the all-female FGD. A supportive caregiver was someone who made the child feel loved, cared for, protected and belonging, as well as communicated clear boundaries and standards. Multiple participants mentioned a supportive caregiver when being asked why a child recovered or what contributed to the child's recovery:

> "he is shown love and care by family members." (p10, Teacher)
>
> "the family started responding positively and supports him. He is provided with basic needs that make him feel equal with others." (p2, Teacher)
>
> "she receives support from her grandmother." (p3, Female PTA)
>
> "Mostly it's the support and care that she's given." "Love, support and care. And she feels under protection now." (p9, Teacher)

A teacher told a story of a girl who had been mistreated by her caregiver, but her life changed after getting a new caregiver.

> "Those educated people, they know, one day, that child will be ok, so they, they encourage the, the woman who is the caregiver that "aah, you treat her…" yeah, she just go to school, without any preventing. Because of this, the child feel that she was one of the family, they treated her as real family to them." He continued later with: "The caregiver made it to forget their behavior and treated them equally with their children. Yeah, so the child felt, felt at home, the child felt at home."

Having at least one person who cared about them made a big difference when compared to children who had not recovered.

A supportive caregiver was also someone who communicated boundaries and upheld standards for a child. The importance of listening to advice was mentioned several times in both interviews and FGDs. When female PTA members in the FGD were asked what one would need to grow up well in Maiwut, part of the reply was that "children need to follow up with their studies and their needs given to them. Good parenting is necessary to teach children good moral ethics. Children need to be brought up with integrity." Caregivers were expected

to motivate the child to go to school and to help control bad habits and behaviors, such as drinking. A female PTA member told the story of a boy with drinking problems and said that one of the reasons that the boy had not recovered was that "he is living alone without parents who can help him to control himself." A boy with a disability "could no longer play with friends, he stopped going to school and needed to be pushed to get out." (p6, Teacher)

Loss of caregiver or being maltreated by a caregiver was the most frequently mentioned risk factor within the family level. Six out of 10 participants (p1, p3, p6, p8, p9, p10) referred to loss of parent as a main adversity a child had been exposed to in the individual interview narratives. P3 and p10 explained that the loss of parents was directly related to a previous conflict. The other four participants did not describe whether the children's parents had died of natural causes or as a result of conflict. Loss of a parent was in three out of the six cases (p9, p6, p10) combined with maltreatment of new caregiver

Maltreatment included neglect, abuse and exploitation, and was mentioned as a risk factor by p2, p3, p7, p10. Neglect encompassed lack of basic needs and being hindered from attending school, abuse was both verbal and physical, as well as exploitation, in form of child labor. A teacher (p6) tells the story of a girl who was both neglected and exploited:

> "So one day, she was… eeh… called. "what is problem?" she said "ah no problem" " but where is your mother? Mother is at home?" she said "my mother died". And she told her, she said "We are two and our mother, we stayed with our stepmother… soo… she's…" because we took it as a confidential in, in a separate place she said "she's mistreating us. She does not confer us with her children. Mistreat us, she don't buy clothes for us, and uhh… She don't allow us to go to school, we are the ones collecting firewood." I am doing home activities, while I'm thinking for my small sister… so I'm really worried."

Children living with their parents could also be subject to maltreatment as well as exposed to conflict within the family. A teacher (p2) tells the story of a child who was being abused at home by his parents:

> "the child is suffering from Physical disability of being lame, he has also been neglected and suffers from discrimination. His mother divorced from the father and got married to another man, she always insults the child."

When asked what hindered the child from recovering, he states: "bad parental guidance from his mother who still insults him and beats him whenever he is wrong." In the same interview, the teacher presents a story of another mistreated child: "his parents divorced and the child lived with a step father who mistreated him. They did not provide him with basic things he

needed like clothes and school fee (p2)". Later the teacher states that: "his step father reminds him that he is not his biological father". The situation changed however to the better when "the family started responding positively and supports him. He is provided with basic needs that make him feel equal with others. He became religious and attends bible study". "The family apologized for what had happened in the past and took a new turn of supporting him (p2)".

This study also presents stories of children who had lost their parents, were being maltreated by their new caregiver, but had their life changed to the positive. A teacher (p6) tells that a positive changed happened after a child received a new caregiver that cared for them and made them feel they belonged. He says:

> "No, She was not changed completely, she was not changed … yeah… aaah… unless after she, the child and her sister, was taken … by the … sister of the dead father. That is where they changed their lives completely. They play with others and then they changed, they forget the, the, the experience. They, they, they face»

Answering to why the child recovered, he explains: "Yeah… ehm… because the caregiver made it to forget their behavior and treated them equally with their children. Yeah, so the child felt, felt at home, the child felt at home". Although having gone through severe adversities, these children were able to manage better because of a supportive caregiver.

Findings show that having a supportive and loving caregiver was the most frequently mentioned and emphasized protective factor for children and adolescents across levels. The literature agrees with the importance of close relationships and good parental guidance and support (Betancourt et al., 2011; Tol et al., 2013; Ungar & Liebenberg, 2011). Close relationships is one of seven aspects of resilience in Ungar and Liebenberg (2011). Parental support is also at the top of the list in Tol et al. (2013) literature review, and Betancourt et al. (2011) also emphasize the importance of good parenting. In addition, these findings align with academic discussions on the importance of taking daily stressors, such as child maltreatment and poverty, into account when investigating mental health in war-affected populations (Miller & Rasmussen, 2010). This indicates that a supportive caregiver is a common and important protective factor across conflict-affected settings.

This study revealed that the main risk factors on the family level was the loss of parents. Children who had lost their parents seemed to be more at risk of maltreatment by the new caregiver and increased suffering from poverty. These findings go well in line with Adaku et al.'s (2016) needs assessment. They listed child abuse, family separation, poverty

and unaccompanied minors as prominent risk factors. Loss of parents and maltreatment is strongly related to its corresponding protective factor; the presence of a supportive caregiver.

- *Community support* -

Supportive relationships within the community level, presented itself as encouragement and acceptance from community members. Five out of ten participants (p3, p6, p8, p9, p10) referred to the importance of social support from the community. Community members supported children by visiting families and giving encouragement and advice to children who were struggling. Answering to what in the community contributed to a child's recovery, a teacher (p8) states, "Community members and other concern neighbors visit him and share word of encouragement with him." Talking about a child with a physical disability that had his life changed for the positive, another teacher (p10) reasons: "the community members have capitalized on encouraging him and recognizing his abilities." A child, who was described to be physically challenged, received the following support: "community members and other concern neighbors visit him and share word of encouragement with him" (p8, Teacher).

Community members also supported children in the community actively through keeping the vulnerable children in mind when NGOs provided extra resources, such as books and hygiene and sanitary items especially for children. A teacher (p2) mentions that "whenever there is aid or assistance, he is often considered thus it encouraged him as the gap created by needs was covered". Another teacher mentions the same phenomena and explains "if any NGOs come to interview, they (*referring to vulnerable children*) are always given that priority… then they receive those. If there is anything to be received, they are given that." Community members, especially PTA members, also actively went out in the community to encourage children to go to school. Despite clear signs of community support systems, there were also indication of discrimination and lack of support, especially towards *certain* children.

There were indications of discrimination against orphaned children and children with disabilities in the data. Telling the story of a child with physical disabilities and speech impairments, a male PTA member (p4) says: "The child shows lack of interest with people and feels no one cares because they assume that they can get nothing good from the child." "sometimes he speaks out his heart however he also has speech impairment; to my view I do not think he can attend school". A teacher (p8) identified the lack of community support as one of the factors hindering a girl with disability from recovering: "she lacks support from

family members, no people visit to encourage her and she has no access to proper medication." Statements about children with disabilities such as "the community members have capitalized on encouraging him and recognizing his abilities" (p10, Teacher), also indicate that there was a time where they did not recognize his abilities.

Orphaned children seemed to be viewed differently, as well as felt different from other children. How orphaned children deal with the fact that they are orphaned gives an indication of this: "And she's, she's been very stressful from the time she realized that everyone knows that she is orphan (p9, Teacher)". "The word *orphan*, she just, she starts crying when she hear the word orphan. She just starts crying like this (p6, Teacher)". In what degree community members supported orphaned children also gave an indication of some type of discrimination towards children who had lost their parents.

An narrative about a girl who had been separated from her family, gives an interesting insights into possible stigma related to being an orphan. A female PTA member (p3) explains the reasons for why a child was suffering: "Separation of the family, loss of father who was breadwinner and lack of basic needs like clothes. She was different from her peers who have both parents." Later, the same participant explains that "she is being discriminated in school and community. She is also being treated unfairly no one accepted her." Interestingly, the community seemed to treat the girl differently when she received the news that her mother was alive. The participant explains that "she get encouraging messages from members of the community and neighbors", indicating that community support and acceptance also aided the recovery process of this child. The contrast of not accepting an orphan at first, and then accepting the child when the community knew that the mother was alive, could suggest a certain stigma towards orphaned children.

There were examples of stigma and discrimination within the school context through bullying. There were three direct references in the data to children being bullied in school. A teacher (p3) tells of a girl that had been sexually exploited by a soldier during the last conflict and was being bullied in school. The teachers described the situation in the following way:

> "she cries and runs away when friends remind her of what happened to her. She is very soft and she rarely talks about her rights even though they are being abused or she is being insulted."
>
> "she cries when friends joke about her and often withdrawn from other children."
>
> "her attention is withdrawn at times or one could call her and she could not respond because her mind is in other thoughts. She is being bullied by some anti-social friends.

A child with paralyzed legs was also being bullied for having a disability: “his friends called him poor lame boy when they try to ridicule him (p10, Teacher)”.

The lack of community support and acceptance was a central risk factor in this study.

These findings are similar to that of other studies, such as Betancourt et al. (2011) and Tol et al. (2013), who focus on the corresponding protective factor. Tol et al. (2013) listed community acceptance and belonging, as well as support to self-esteem and emotional social support, as main protective factors. Similarly, Betancourt et al. (2011) found collective support to be the most important protective factor within the community. Although not explicitly stated, the emphasis on community support in these studies as a protective factor, indicates that the lack of it poses a risk for children’s wellbeing. In addition, this study found indications of stigma and discrimination towards orphaned children, children with disabilities and children who had been sexually exploited, but did not identify the presence of stigma towards individuals with mental health issues, as was found in Ayazi et al. (2014). Stigma was however not the focus of this study, but is a relevant topic for future studies.

This study revealed some interesting similarities between resilience indicators on the family and community level. Both family and community support seemed to play an important role for children’s wellbeing. Participants attributed most influence to family support, but their emphasis on support from community members was noteworthy. Support from community members might play a bigger role for promoting and protecting the mental wellbeing of children in this context than in more individualistic societies. The importance of community support and acceptance might be related to collective moral rules and systems within the culture. How family and community support overlap, as protective and promotive factors for children’s resilience, is a relevant topic for future studies.

Interestingly there were no references to cultural traditions or ceremonies playing an important role for resilience, as found in other studies (Tol et al., 2013). This could be related to the fact that this study did not have the opportunity to collect data until one reached data saturation. Participants might also have assumed that such answers would not be interesting to the interviewer, based on how the questions were phrased or the interviewer’s affiliations. Other important aspects related to cultural tradition might therefore have been left out. This would be interesting to follow up on in future studies.

6.1.3 Basic needs

Basic needs emerged as a main theme crossing all socio-ecological levels. Having your basic needs covered was frequently mentioned as an important factor for both physical and mental wellbeing. Seven out of ten participants (p1, p2, p3, p5, p6, p8, p10) in the individual interviews and both FGDs referred to the lack of basic needs in relation to mental ill-health. Lack of basic needs, such as food and clothing, was largely related to poverty or as the result of child mistreatment. The lack of basic needs overlapped with categories under the supportive relationships theme. Community structures, such as education and humanitarian assistance were highlighted as important sources to provide children their basic needs. Naturally, the lack of medical services was brought up as a risk factor for children's physical and mental wellbeing.

- *Community Level* -

Lack of material resources to provide for basic needs, such as food and clothing, was described as an over-arching problem in the community. The lack of adequate food is clearly communicated and agreed upon in the two FGD's. To illustrate; when the all-female FGD was asked what the biggest challenges for growing up well in Maiwut is, they answered: "lack of adequate food due to man-made and natural factors (…)". A participant in the all-male FGD states that "There are times when our children and spouses die because of famine. These are some of problems we face here". Humanitarian organizations seemed however to play a big role in providing material resources to cover basic needs in the community.

Humanitarian organizations provided the community with resources, both through safe food and water, as well as education opportunities for children. One of the reasons refugees started returning to Maiwut, was the presence of humanitarian organizations. There seemed to be an agreeance on this in the all-male FGD:

> "Nowadays presence of ADRA and other humanitarian organizations has encouraged return of many women and children to Maiwut however there are many people who remained in the refugee camps than those that have returned to back."

Humanitarian organizations providing children with education opportunities also had a positive influence on the monetary resources in the community. Male PTA members agreed in the FGD saying:

> "We will continue to tell other people about how ADRA has constantly remained with vulnerable community of Maiwut during hard times. The monetary incentives ADRA gives to teachers in schools it supports, has helped community a lot for instance one

> shares with a brother, nephew, friend. Thus these money circulates in the community whose members are poor."

Monetary increase was however not the only benefit the all-male FGD saw from the education projects: "Since your coming as ADRA we can say the orphaned children now are getting support to pursue their studies they have settled that's why you can see them studying."

School was viewed as an important resource in the community by providing education and materials to children. The view of education as a protective factor was especially apparent through the way PTA member participants spoke of and actively supported the schools. The all-male FGD members agreed that "school is the back bone of the country because many people that are working are school products such as doctors, pilots and engineers." PTA member would both actively go out in the community to encourage parents to send their children to school, as well as help with keeping the school area safe. This is illustrated through the following statement in the FGD: "After some times ADRA started supporting students in schools and entrusted us PTAs to clear bushes around school compound because snakes could bite children so we clear every vegetation around". These statements indicate that participants viewed education as a basic need for children's wellbeing.

Absence from school and poor performance was closely associated with mental ill-health among children. As many as eight out of ten participants (p1, p2, p3, p6, p7, p8, p9, p10) associated school performance and/or participation with children who were struggling mentally. Participants would describe it in the following way:

> "her participation and performance was poor" (p3, Female PTA)
>
> "he is a clever child but because he is entangled and overwhelmed by life conditions he has lost concentration in school." (p1, Teacher)
>
> "his constant absence from school makes me thing that he has not recovered." "he was not performing well and did not get good marks." (p2, Teacher)
>
> "She is not so much participating, she, yeah, she can participate but eehh… she just keep quiet" (p6, Teacher)

Children who had recovered after severe adversity, were described to participate and have an increased performance in school This is illustrated by the following statements:

> "Now he comes to school, socialize freely with friends, answers questions in class and his performance has improved." (p8, Teacher)
>
> "It's now better, her performance improved. Her relationship with friends and teachers also improved." (p9, Teacher)

"He attends school, he is social with friends and no longer rude to friends." (p10, Teacher)

Education and food rations can however not fill the gap in regards to medical services. The lack of medical services for children's physical needs were mentioned in four interviews and both FGD as a hindrance for physical and mental wellbeing. Children with physical illnesses or disabilities were described to be more likely to suffer from mental ill-health. When asked what was hindering a child from recovering, one teacher (p8) answered: "She lacks support from family members, no people visit to encourage her and she has no access to proper medication". The lack of medical services in the area seems to be an over-arching hindrance for meeting the basic needs of children.

- Family Level -

Having sufficient personal wealth to cater for immediate needs was viewed as important for wellbeing and to avoid "insanity" that could lead to insecurity in the community. Here are some examples from the all-male FGD:

> "Being contented with personal wealth is also one way of living healthy because when thinking of big plans which are unachievable one tends to become depressed thus become sick. This is the suggestion that I can add as part of personal health emotionally.
>
> "When food is enough at home happiness will be attained thus good health will be at home. If one has property than that will also influence his or her health due to happiness that is going to attain. Money is another factor for health with saving from bank one can quickly get access to proper medication."
>
> "some people the mere fact that they have money normalize their life and mental stability because they can cater for their immediate needs. When some people live in abject poverty they tend to lose their sanity and these are the same people that instigate insecurity."

Families failing to provide basic needs for children, such as adequate food and clothing, was frequently mentioned as a risk factor. Lack of basic needs was largely due to neglect and unfair treatment at home, but also because of extreme poverty. There were several examples of children being neglected by their caregiver, such as this boy: "His parents divorced and the child lived with a stepfather who mistreated him. They did not provide him

with basic things he needed like clothes and school fee." There were also stories of children living in extreme poverty. A teacher (p8) tells:

> "I know a girl whose father died Five years ago and now lives with her mother. She doesn't have basic needs because they are in abject poverty, her mother is not able to feed the family meanwhile the girl is mentally challenged."

It was apparent that the lack of basic needs was a perceived risk factor for recovery. A teacher (P10) plainly states that it was "the level of poverty at their home and her reactive nature" that hindered a girl from recovering after a sexual assault by a soldier.

- Individual Level -

Lack of basic needs had clear implications on the individual level. Children that lacked basic needs, such as proper clothes, were also described as feeling unequal to others and having self-image issues. A female PTA member (p3) tells the story of a girl who had lost her father, the breadwinner in the family, and lacked basic needs, and states that "She was different from her peers who have both parents". She continues and explains how this affects her self-esteem: "she has low self esteem in school and in the community. She was unhappy about seeing her peers with things that she cannot afford." The connection between lack of basic needs and self-esteem is further supported by statements from a teacher (p10): "She doesn't have proper clothes and her self-esteem is very low". Lacking basic needs and thereby being different from others, seems thereby to be a risk factor for mental wellbeing.

Findings indicate that lack of proper clothing was possibly just be the top of the iceberg in regards to risk factors for resilience. Lack of basic needs was often interlinked with other risk factors within the family level. Children that lacked basic needs, were in a large degree children who were orphaned or had lost one of their parents. These children were also more prone to abuse, exploitation and neglect by the new caregiver, as presented earlier. This highlights how vulnerable groups, such as orphaned children, face additional risk factors as a result of their changed position in life.

The importance of having your basic needs met spanned across all levels and was frequently referred to, which might indicate that it is one of the key protective factors within the context of Maiwut. Ungar and Liebenberg (2011) support the importance of having your basic needs met to foster resilience in low-resource and conflict affected settings. One of their seven aspects of resilience was defined as access to material resources, including "availability of financial, educational, medical and employment assistance, resources, or opportunities, as well as access to food, clothing and shelter" (Ungar & Liebenberg, 2011, p.137). Heltne et al.

(2020) expand on this and suggests that basic needs should be taken into account in interventions promoting children's mental wellbeing. These findings also fit well with current discussions on how poverty reduction programs can have a positive effect on mental health (Bauer et al., 2021; Zimmerman et al., 2021). Participants in this study focused mostly on fundamental basic needs, such as lack of food, water, proper clothing and medical assistance, but included financial resources and educational opportunities as well.

The lack of basic material resources is a common issue within the context of Maiwut, yet inequalities within this context interestingly emerged as a risk factor. Although the community is living on the margins of material resources as a whole, the findings seems to indicate that children in the lowest range of access to resources, were more easily pray for discrimination in the community. This inequality, made visible through lack of proper clothing, also effected the children's self-esteem when comparing themselves to children with access to more material goods. This highlights inequality and relative poverty as prominent risk factors within low-resource settings.

6.1.4 Hope

Hope was an over-arching theme for local coping strategies across socio-ecological levels. Communicating these coping strategies was encouraged on the family and community level. Children and individuals who lived by these principles were seen to be more likely to recover.

Local coping strategies involved local expressions that were meant to help children and community members through tough times, as well as religious belief and practice. Religious beliefs involved trusting that God would provide for their needs and take care of them, as well as prayers to God. A frequently mentioned expression of encouragement was to in different ways say that problems come and pass, meaning that the situation might change for the better. Family and community members would also encourage and instruct children by directing them to focus on positive narratives and role models. These coping strategies were closely connected, and directed children's thoughts to something that gave hope for a better future.

Categories under hope could easily fit under other themes, such as personal strength and supportive relationships. Hope-centered coping strategies overlap with positive attitudes, under the personal strength theme, as they focus on possible positive outcomes and are forward minded. Family and community members utilized these local coping strategies to support and encourage children. However, hope emerged as a separate theme because specific

local coping strategies seemed centered on the idea of hopefulness and positive expectations. Participants also emphasized these hope-oriented coping strategies as central for protecting and promoting the mental wellbeing of children.

Participants emphasized hope-oriented local expressions as important for coping with difficulties in life. A local expressions frequently referred to was that problems come and go. Female PTA members expressed it in the following way during the FGD; "We understand that problems come and pass, this has been happening in Maiwut during past times." Male PTA members in the FGD also referred to this expression, while talking about the previous conflict in Maiwut:

> " For that case, it gives us deep thinking for our people who were deceased however we still understand that there is beginning and end because many problems were faced before. I within myself that problems are always there and time come when they disappear. Now these current days prove to be better that those days of war."

A male PTA member in the FGD went so far as to urge that this principle should be actively communicated within the community to help build resilience in community members:

> "It is import for awareness to be done within the community. This can help in building resilience amongst and self help initiatives. Many days and many years are not the same today is today and tomorrow will be tomorrow."

An English speaking teacher (P6) refers to a similar saying called "Baretic" (*B`r5-tek*) in Nuer language, that focuses on that the future will be better. In the context of a child that is receiving advice, he says:

> "They use to say it "baretic" in Nuer language, they use "baretic". That means, when you stay long, you will forget all this, you will be good in the future. So that word, she said it. One day it was an old lady who is close to her: "Ah don't worry, but in the future you will not be like this, you will be a good people, you will have something." That is all this thing. That is why I land actually, the reasoning, you know what she has advised, she has."

The key informant further supports these sayings to be key expressions for coping with adversities. He says:

> "The people that have been here in Maiwut have faced several conflicts that have taken over here. But they have taken resilience because they know that if war is there today, tomorrow there might be a better day. So people live on daily basis that when it is a time of war, better days are coming, when it is a time of hardship, better days are

> coming. So this is what has been their perspective of life. Those who are alive know that today is different from tomorrow."

Parents and community members also encourage children to focus on positive narratives and role models. In the all-female FGD a PTA member expresses that "If parents talk to children about those who made it they end up inspiring them to do the same." This was also viewed as an important personal attribute for recovery, illustrated by the story of a disabled boy:

> "He is free spirited; he shares his experience with friends. He concentrates on what is positive in his life. His motivation is that he wants to achieve his goal of becoming a doctor in order to treat people of his caliber." (Teacher P8)

In addition, community members thought it was important that adults acted as role models for children. To stay emotionally healthy, female PTA members in the FGD expressed that you need to be "having a peaceful relationship with spouses and neighbors and being a role model to other as well as not listening to gossips."

Having the right coping skills in place *during* an adversity seemed to indicate how well an individual would cope *after* an adversity. Findings showed that directing your thoughts to things that gave hope seemed to be especially important during life and death situations. PTA members tell of how praying to God was coupled with encouraging each other that this adversity would not end their life. "Life is what we value and we run from danger to save it if things get worse (FGD, Female PTA)." Hope could in that sense not only be important for recovering, but also for survival. This is especially interesting considering the study context, where community members have had to flee for their lives at several occasions.

The importance of trusting in and praying to God was mainly emphasized in the two FGDs. Religious belief and practice was referred to in four different statements during the all-male FGD. Some examples are:

> "(…)When problem comes it is sure that it will someday end, many things are painful but they all become normal at the end. Let's keep praying to God to provide wisdom in sad times because things comes and goes. God is the sustained amidst all problems if we put trust in Him all our difficulties we end."
>
> "In term of spiritual living when one thinks of very bad things and depressing thoughts like lack of money, the feeling changes for worse. Therefore, asking God to provide

> anything that lacking and when situation worsen God to show the way forward rather than to lose by faith."

Religious belief and practice was referred to in three different statements during the all-female FGD. Female PTA members explained what they do when they face difficulties in life in the following way:

> "Share thoughts with neighbors and pray to God. We encourage ourselves knowing that it is not the end to life. Life is what we value and we run from danger to save it if things get worse."
>
> "We pray and ask God to intervene and before we take any decision. When fighting broke out in Maiwut we encouraged and comfort one another. We understand that problems come and pass, this has been happening in Maiwut during past times.

Religious belief and practice was also referred to in the individual interviews, but more indirectly. Having someone in your life that was religious seemed to be a strength, and being religiously active seemed to be considered a personal strength. This is illustrated by the following statements, when participants are asked what contributed to a person's recovery: "support from his brother who is very open to him. The brother is also religious and participants in church related activities (Teacher P8)". "The family started responding positively and supports him. He is provided with basic needs that make him feel equal with others. He became religious and attends bible study (Teacher P2)".

Directing your thoughts to something that gave hope and inspired inner strength was an over-arching theme for local coping strategies. Hope was also the key for making sense of and coping with adversities within a conflict-affected and low resource setting in Afghanistan (Eggerman & Panter-Brick, 2010). Eggerman and Panter-Brick (2010) found that resilience and personal strength rested on hope. Hope was gained through believing that adversities would ultimately be overcome and religious faith was the very foundation of hope. This study also found hope to be a key factor for resilience, but religious faith did not seem to be the very foundation of hope, as in Eggerman and Panter-Brick (2010) study. However, these common findings still indicate that hope plays a big role in conflict affected communities, such as Maiwut.

Although hopeful coping strategies played a role on all socio-ecological level, the main goal was for hope to influence the personal, or individual, processes. The local expressions seemed to feed a strong and optimistic attitude combined with perseverance.

Seeing how these expressions were encouraged at all levels, highlights the importance of a right attitude. And a right attitude rests at the end of the line with the individual. One could thereby argue that the individual was viewed to have an important responsibility in being resilient.

6.1.5 Peace

- Community level -

Participants emphasized peace as a central protective factor, but mentioned a lack of peace more frequently. This was most apparent in the FGDs, where participants referred to peace nine times and conflict, fighting or war 15 times. Although the importance of peace was seldom plainly stated in the individual interviews; conflict was tied up with other adversities and risk factors. Nearly all participants had fled Maiwut due to conflict in their lives; some had previously lived in refugee camps in neighboring countries. Adversities, such as loss of parents, family separation, sexual exploitation and even disability, were also directly connected to the conflict. The emphasis on peace and conflict is therefore likely related to the conflict-affected study context.

Conflict could contribute more to adversities than this study was able to determine. E.g. participants did not always describe the cause of death. The cause of death could therefore be related to natural causes or conflict. Peace or the lack of it could thereby play a bigger role for children's mental wellbeing than these findings can anticipate.

Although participants recognized that there was peace in the area at the time when the data was collected, it seemed to be a relative term for them. They acknowledged that the past conflicts was over, but did not express that they felt safe in the community. Participants in the all-female FGD even expressed that: "There is also need for peace in Maiwut". Perceptions of peace in settings with reoccurring conflicts would be an interesting topic for future studies.

Participants refer to peace as being important for children's wellbeing. Participants in the all-male FGD state that: "Being healthy means living in a peaceful environment, drinking safe water as well as eating safe food, living in a clean house where this is no rumors of insecurity". Peace was also one of two main themes in the key informant interview.

The key informant supported peace as a central protective factor on all socio-ecological levels. Individuals needed to have peace in mind and one needed to cultivate peace in the family and community for mental wellbeing. The following statements by the key informant makes this clearer:

> "For one to grow up mentally well here in Maiwut, the first thing one needs to have is peace of mind and a general peace context in the environment, because when the environment does not have peace, one is forced to flee away or move to another safer place where by one can go and sit down and enjoy the privileges of safety and peace."
>
> "And mainly peace is the major condition for other aspects of mental growth"
>
> "When you are in good relationships with everyone and whatever you are hearing is favorable or saying is favorable for everyone, then you will also be embracing peace, and embracing peace creates a calm spirit where you grow up in a good mental state"

- Family level -

The wellbeing of caregivers seemed important for the wellbeing of children. Having peace in the family was emphasized as an important protective factor for children's wellbeing, especially in the FGDs. Conflict within the family could on the other hand "spoil even a healthy child", according to a male PTA member (p5). He explains this in his interview:

> "if life is good because husband and wife live well without arguments at home even children are taught in peace mental wellbeing becomes order. Children have a tendency of looking towards their fathers or mother if they always quarrel even the home become very divided. That is why children life became miserable even a healthy child get spoiled."

In discussions around what it means to be healthy, the following was mentioned in the all-male PTA FGD:

> "Being healthy in your family means that I am is happy living with my children and spouse. If my spouse treats me good then I will be happy and if I ask my spouse for something and gives it to me it also means happiness. If a man asks a woman and she replies in good attitude, the man will be happy and healthy while at home."

Female PTA members were asked what is needed to stay emotionally healthy, and answered: "having a peaceful relationship with spouses and neighbors and being a role model to other as well as not listening to gossips."

Peace is connected with categories under the supportive relationships theme. In addition, the lack of peace within the family may overlap with lack of peace within the community level. Domestic violence and abuse have been identified as main hindrance for peace within the family, as well as the extended community (Wessells & Kostelny, 2021). It is challenging to build peace in settings where children are exposed to violence on a regular

basis at home. Wessells & Kostelny (2021) explain how children who are victims of violence are themselves at risk of becoming perpetrators of violence.

Peace and unity was found as a protective factor in studies within a similar context. Tol et al.'s (2013) literature review highlights the importance of a good family environment. Findings from Betancourt et al. (2011) also emphasize the importance of family unity, as well as good parenting. One could thereby assume that peaceful family environment is a common protective factor across settings.

Peace within the community was a key factor for community members in this study. The participants' focus on peace in this study is likely related to the history of recent and reoccurring conflicts within the study area, as well as the seemingly persistent feeling of insecurity. This might indicate that a sense of peace plays a more important role on all socio-ecological levels in populations who have recently or repeatedly been affected by conflict. Interestingly, none of the included studies on local resilience indicators in conflict-affected settings mentioned peace as an important protective factor on the community level (E.g. Betancourt et al., 2011; Eggerman & Panter-Brick, 2010; Tol et al., 2013; Vindevogel, 2015). The importance of peace and safety for mental wellbeing is well established in the literature (Wessells & Kostelny, 2021).

6.2 General discussion

This study revealed that protective and risk factors are interconnected and largely found across socio-ecological levels. These findings support what Super and Harkness (1986) argued; that although a child follows certain psychological developmental steps in growing up, their patterns of thought and behavior are shaped by culture. This idea of a mutually interactive system between a child and its environment is also present in Bronfenbrenner's (1977) ecological systems theory and the socio-ecological model (Masten, 2014b; Ungar, 2011). One could thereby argue that by promoting individual resilience, one can promote the resilience and mental wellbeing of a family and a community.

Findings from this study support a holistic approach to understanding, utilizing and strengthening resilience. In this particular case, a holistic approach means aligning with central resilience researchers (Bonanno, 2004; Masten, 2014b; Panter-Brick & Eggerman, 2012; Ungar, 2011) in including all socio-ecological levels with its interlinked influence on each other. This includes interlinkages between levels as well as protective and risk factors, with cultural and contextual nuances. Since resilience is found to be a complex and dynamic

process, researchers and development actors are advised to take a holistic and culturally sensitive approach as well.

Resilience indicators affecting psychological resilience were found both in the immediate and larger environment. Community support was a core indicator under supportive relationships. Access to material resources on the larger level, had a big impact on children on the individual level. Peace, or rather the lack of it, had major ripple effects on other levels of a child's social and physical ecology. These findings support recommendations by authors, such as Betancourt et al. (2011) and (Ungar et al., 2006), to include multiple socio-ecological levels when measuring resilience.

Findings indicate that personal agency and the immediate social and physical environment played a more influential role than the larger community did. Personal strength emerged as a main theme on the individual level, separate from other socio-ecological levels. Indicators such as inner strength, a positive attitude and openness towards others were emphasized in the data as central for resilience and mental wellbeing. In a similar degree, a child's immediate environment stood out as the most important indicators under the themes supportive relationships and basic needs. A supportive caregiver that provided a child with its basic needs, such as clothes, food, as well as love and support, was one of the main protective factors for the mental wellbeing of a child. The opposing risk factors on the individual or family level seemed to have an equally negative effect on resilience and mental wellbeing. These findings support research arguing that personal agency as well as the immediate environment has most influence on a child's mental wellbeing compared to higher socio-ecological levels (Bronfenbrenner, 1977; Super & Harkness, 1986).

The findings of influential resilience indicators on all socio-ecological levels, have implications for planned interventions within the study context. Interventions aimed at promoting the mental health and resilience of conflict affected communities in Maiwut should include a variety of stakeholders on different socio-ecological levels. Community members and religious leaders can be important stakeholders to engage, as they are key persons in communicating hope and local coping strategies to children. Caregivers are even more central in caring for and guiding the child as it grows. Engaging these stakeholders could also help fight stigma and discrimination towards vulnerable groups, such as orphans, children with disabilities and children who have been sexually abused. This study thereby aligns itself with recommendations to bolster and strengthen local support systems (Ager & Metzler, 2017) and especially recommendations to reinforce factors on the family level, such as parental support (Tol et al., 2013).

Resilience indicators were linked across levels and had elements of mutual benefits or negative influence. For example, the lack of basic needs spanned across all levels as a risk factor for children's wellbeing. The lack of material resources to cover a child's basic need was an over-arching risk factor in the community, but depended also on the family situation and how children were treated at home. Although the lack of basic needs was frequently referred to as a risk factors, this risk factor would in large degree be coupled with risk factors under other themes, such as lack of supportive relationships or lack of personal strength. Protective factors would be interconnected in a similar degree. These findings supports views of resilience as an intrinsic and interconnected process (Betancourt et al., 2011; Vindevogel et al., 2015).

Protective and risk factors were also largely coupled together. If there was a positively valued factor, there would be a corresponding negatively valued factor. This is clearly illustrated in the emerging themes. For example, opposite to supportive relationships, were either child maltreatment or loss of parent. Personal strength was described as possessing an inner strength, having a positive attitude and being open. The corresponding risk factor to personal strength was to be vulnerable, having a negative disposition to life and being withdrawn. Due to this interconnectedness, this study aligns itself with Vindevogel et al. (2015) arguing that both protective and risk factors should be included when strengthening, measuring or conducting research on resilience.

This study found local ways of responding to adversity, but also a high degree of risk and adversity. Socio-economic insecurity was prominent in the findings, demonstrated by the emphasis on basic needs, various examples of domestic abuse and disrupted family bonds, as well as fear of future conflicts. In addition, four out of ten interview participants were not able to think of a child that had recovered after adversity. The existence of local protective or promotive factors should therefore not be used to argue that risk reduction in such settings is less urgent (Patel & Goodman, 2007). However, strengthening local protective and promotive processes might be a strategic way of counterweighing risk factors that are difficult to modify, such as poverty or reoccurring conflicts (Betancourt et al., 2011).

This study found resilience indicators that were both common to and distinct from other conflict affected contexts and cultures. The themes personal strength, supportive relationships, basic needs and hope had many similarities with other studies. These are however broad terms, and the type of indicators within each theme, as well as the degree of importance varied across contexts. These findings supports Ungar et al.'s (2006) propositions that resilience is a global phenomenon, as well as formed by cultural and contextual aspects.

This study agrees with Miller et al. (2006) to not necessarily replace conventional measures of resilience, but urges development actors and researchers to include local perspectives for increased efficiency and relevancy.

7. Study limitations

The extenuating circumstance of the COVID-19 pandemic imposed many limitations in terms of travel and safety. As the main researcher could not travel, she did not have the opportunity to experience or gain in-depth insight about the study context increasing the possibility of misrepresenting meanings (Corbin & Strauss, 2014). The main researcher compensated through conversations with local representatives over Skype, receiving detailed information about the context from the field researchers, as well as studied an existing video describing the physical and social environment. A follow-up attempt to both gain deeper insight to the physical location and open for local people to control the camera in an unstructured interview (Photo Voice) proved limited in success. Another issue was that someone else than the main researcher collected and translated the data.

Translating from the local language to English may have introduced a lack of precision and good practice. The understanding of words and their meanings may have been lost in translation as their meaning can differ across cultures and languages, as well as be warped based on the translator's stand point and perceptions (Temple & Young, 2004). In addition, the translation was not verbatim, as instructed. When comparing translated transcripts with interviews conducted in English, it was evident that part of the data had been interpreted instead of translated word by word. Translated transcripts were up to half as short as the all-English transcripts. Responses by participants seemed to have been "tidied up" and sometimes summarized by the translator. The main researcher was thereby unable to determine if significant data was lost. The translators' interpretations limits in large degree the opportunity to identify nuances in the language and thereby compromises the richness of the data. In addition, time constraint hindered the main researcher from quality checking the translated transcripts with the audio recordings. To compensate for these limitations, the main researcher coded for general meanings and associations in the data analysis.

A merit of the study approach is that it is likely to have reduced cultural and practical barriers. As the main researcher is an outsider, employing a local person familiar to the context reduced participant reactivity. Prior experience from the field research team showed that even South Sudanese people from other parts of the country would be considered an

outsider by the study-population and would likely receive less information than a local person. This reaction was confirmed during interviews the main researcher conducted over Skype with school counsellors. The school counsellors responded to interview questions as if reporting on project progress, rather than sharing insights on the research topic, e.g. talking about how they do their job and what kind of support they or the project is in need of. These interviews were also negatively affected by poor internet connection, such as poor sound and video quality, and increased social distance compared to face-to-face interviews. Using a digital medium seemed to create a barrier for good flow of conversation and a trusting relationship in the interview. Employing a local person to collect the data thereby enabled a higher quality of research data.

This study was not able to represent study participant's voice and meaning in full extent due to several practical issues. A main issues is that the field researchers did not record or distinguish between who was speaking or describe the interactions between group participants in the FGDs. It was not possible to follow dynamics of how topics emerged and which participants were active or quiet. In addition, it was impossible to identify the participants who took part in an individual interviews and FGD, and therefore not possible to compare responses. Lastly, participants did not have the chance to validate interpretations, meaning that researchers did not contact the participants at any later point in time to see if they agreed with what was recorded. Together, these issues disrupt one of the tenets of qualitative research; to honor the participants' own words and their underlying meaning (Lincoln et al., 2011).

As for most social research, the potential presence of participant or researcher bias limits the findings of this study (Corbin & Strauss, 2014). Researchers' worldview and position in relation to the topic leaves a particular room for bias in this study. ADRA Norway financed this research project and is involved in monitoring and evaluating the local school project. All research team members are also employed by ADRA, a Christian humanitarian organization, including the main researcher. The main researcher's understanding of the world differs from the participants' view, which might have influenced the study analysis as well.

Participants are likely to have reacted to the presence of the researchers, based on their affiliations and financial position, during their interview. Examples could be saying what was expected, as well as feeding possible agendas, such as change in project or increased support. All study participants have close ties to the school, making room for additional bias. Findings related to humanitarian organizations, schools and religion must therefore be understood in

the light of the above mentioned possible reactivity effects.

8. Conclusion

This study identified locally perceived indicators of resilience among conflict-affected children and adolescents on the individual, family and community level. The local protective and risk factors were clustered into five themes based on the rationale behind the indicator. The five themes that emerged were personal strength, supportive relationships, basic needs, hope and peace. These themes were interconnected, cutting across several socio-ecological levels and seemed in some cases to be interdependent on each other.

Personal agency and the immediate social and physical environment was especially emphasized in the findings of this study. Personal agency involved indicators under personal strength, but also local coping strategies focused on hope and forward-mindedness. These local coping strategies were a central way of dealing with adversities and seemed to feed the desired personal agencies. Personal agency also seemed to be highly dependent on close supportive relationships. A supportive caregiver was a main protective factor under supportive relationships, although community support was emphasized as a key element as well. The corresponding risk factors, such as lack of personal strength and supportive relationships, seemed to be equally emphasized as harmful for children's resilience and mental wellbeing.

The emphasis of having your basic needs met, as well as peace in the family and community, possibly reflects the insecure socio-economical situation in the study area. Basic needs was a theme that spanned across all levels, while peace was a main theme in the FGDs and key informant interview. The emphasis on basic needs together with descriptions of severe adversities highlighted the continual importance of identifying risk factors in addition to local protective systems in similar settings. This study suggests however that identifying and strengthening local protective and promotive resources has the potential to counter-balance some of the risks and adversities that are present in the community.

The findings from this study have the potential to inform future studies on how to measure resilience within the given or a similar context. There is still a great need of research on protective and risk factors for resilience, especially in low-resource and conflict affected settings. Future research is recommended to explore the relation between family and community support, as these seemed to have a competing importance in this study.

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Appendix 1 – Individual interview guide

Individual Interview Guide

Teachers and selected Parent Teacher Association (PTA) members

Checklist:

- Have you gone through the information letter with the participant and made sure they understand?
- Has the participant had sufficient time to decide if he/she wants to take part?
- Do you have a signed consent by participant?
- Have you written down the participant's real name and codename in the *individual interview record*?
- Note the participant's code name:_____
- Circle the participant's gender: female / male
- Are the COVID-19 precaution measures are followed?
    - Physical distance of 2 meters between researchers and research participant
    - Have you disinfected common-touch surfaces?
    - Are all hands washed?
- Have you turned on the audio recorder?

Facilitator's welcome, introduction and instructions to the participant

Welcome and thank you for taking part in this interview. We have asked you to participate in this discussion, as your point of view is important. We realize that you have many things to tend to and appreciate that you have taken the time to be here.

Introduction: In this interview, we are hoping to hear your thoughts and insights on why some people manage well despite difficult life experiences, while others do not. The focus in our discussion will be on school-aged children. The interview will take no more than an hour. The conversation will be recorded to make sure we catch everything that is being said (if needed, demonstrate how the recorder works) and my colleague will take notes regarding what is discussed. The recordings will be erased before the project ends. I ask that you try to answer and comment as accurately and truthfully as possible. If there are any questions or topics that you do not wish to answer or participate in, you do not have to do so; however please try to answer and be as involved as possible.

Anonymity: I would like to assure you that the conversation will be anonymous. The notes from this conversation will contain no information that would allow you to be linked to specific statements. Your answers will not be shared with the school staff or anyone else that could link your statements to you.

Ground rules

- You do not have to speak in any particular way or order and there are no right or wrong answers, so I hope you will feel open to share.
- If you do not want to participate you can leave at any time. If there is a question that you do not want to answer you can say 'I prefer not to answer'.
- Do you have any questions before we start? (answers) OK, let's begin

Background questions:

We'll start with some brief background questions: (circle the right age-group)

What is your age?

18-20 21-25 26-30 31-40 41-50 51-60 61-70 71-80

Do you have any children?

Yes / No

By what means does your family make a living?

_____

How long have you and your family lived in Maiwut?

_____

How many years of education have you completed?

_____

Main questions

1Can you think of a child or adolescent you know personally who has suffered emotionally because of difficult life experiences they went through and who has not yet recovered despite the passing of time? Please do not mention the persons name, your relation to him/her or any information that might help identify the person.

2Can you tell me about the difficult life events this child has experienced?

- How much time has passed since he/she experienced these things?
- What is the child's gender and approximate age (6-11 / 12-14 / 15-18 / other)?

3How was he/she affected?

- Was his/her *behavior toward friends* changed by the experiences? was their behavior at home or in school changed by this experience?
    - If yes, how did it change their behavior?

- Did the difficult life events change *the way she/he expressed his/her feelings or thoughts*?
    - If yes, how did the difficult life events change the way he/she expressed their feelings or thoughts?

- Were there any changes in *school participation or performance*?
    - If yes, in what way?

4What are the signs that he/she has not recovered?

5Why do you think he/she is still having difficulties?

- What more has hindered this person from recovering?

6Now, can you think of a child or adolescent who has suffered emotionally to the same degree as the first person because of difficult life experiences, but who *has recovered* and is now functioning well despite the hardships he or she has endured? Again, please do not mention the persons name, your relation to him/her or any information that might help identify the person.

7Can you tell me about the difficult life events this child experienced?

- How much time has passed since he/she had these difficult experiences?
- What is the child's gender and approximate age (6-11 / 12-14 / 15-18 / other)?

8How was he/she affected?

- Was her/his behavior toward friends changed by the experiences? Was her/his behavior at home or in school changed by the difficult experiences?
    - If yes, how did it change their behavior?

- Did the difficult life events change the way she/he expressed her/his feelings or thoughts?
    - If yes, how effected the difficult life events their thoughts and feelings?

- Were there any changes in school *participation or performance*?
    - If yes, in what way?

What are the signs that he/she has recovered?

Why do you think this person recovered, while the first person (child you identified) is still having difficulties?

What do you think contributed to his/her recovery, compared to the first person (child you identified)?

- Do you think the child had some personal characteristics that contributed to his/her recovery?
    - If yes, what personal characteristics do you think contributed to his/her recovery?

- Do you think something within the *family circle* contributed to his/her recovery?
    - If yes, what do you think contributed to his/her recovery within the *family circle*?

- Do you think there was something in the *community* that contributed to his/her recovery?
    - If yes, what things in the *community* do you think contributed to his/her recovery?

Conclusion

- Thank you for participating and sharing your insights
- Your opinions will be a valuable asset to the research report
- We hope you have found the interview interesting

- If there is anything you are unhappy with or wish to complain about, please contact the ADRA South Sudan office or speak to me later
- I would like to remind you that any comments featured in this report will be anonymous
- We will share the results from the different discussions and interviews when the report is ready

Note to research assistants:

- *Hand the Interview notes, participant consent forms and recorder to your team leader at the end of the day. Do not take any confidential information home.*
- *If you are concerned that the participant might hurt himself/herself or others, report this to the FRS.*
- *If you are concerned for the participant for any other reason report this to the FRS.*

Appendix 2 – Focus Group Discussion Guide

Focus Group Discussion Guide

Parent Teach Association (PTA) members

Checklist:

- Do you have signed consent form from each participant?
- Have you filled out a FGD record for each participant in the group?
- Are the COVID-19 precaution measures are followed?
    - Physical distance of 1 meter between FGD members
    - Physical distance of 2 meters between researchers and FGD members
    - Have hands been washed?
    - Have surfaces and been disinfected?
- Have you turned on the audio recorder?

Facilitator's welcome, introduction and instructions to participants

Welcome and thank you for taking part in this focus group. We have asked you to participate in this discussion, as your point of view is important. We realize that you have many things to tend to and appreciate that you have taken the time to be here.

Introduction: In this group discussion, we are hoping to hear your thoughts and insights on why some people manage well despite difficult life experiences, while others do not. The focus in our discussion will be on school-aged children, since we want to know how best to support them through our education program. The focus group discussion will take no more than one and a half hours. The discussion will be recorded to make sure we catch everyone's opinions (if needed, demonstrate how the recorded works) and my colleague will take notes regarding what is discussed. The recordings will be erased at the end of the project. You should try to answer and comment as accurately and truthfully as possible. I and the other focus group participants would appreciate it if you would not discuss the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so; however please try to answer and be as involved as possible.

Anonymity: I would like to assure you that the discussion will be anonymous. The notes from this conversation will contain no information that would allow you to be linked to specific statements. Your answers will not be shared with the school staff or anyone else that could link your statements to you.

Ground rules

- The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.
- There are no right or wrong answers
- You do not have to speak in any particular order
- When you do have something to say, please do so. There are many of you in the group and it is important that I obtain the views of each of you

- You do not have to agree with the views of other people in the group
- If you do not want to participate you can leave at any time.
- If there is a question that you do not want to answer you can say 'I prefer not to answer'.
- Does anyone have any questions? (answers).
- Ok, let's start

Main questions

1. What would I need to know to grow up well here?

2. How do you describe people who grow up well here despite the many problems they face?

3. What does it mean to you when bad things happen?

    a. What does it mean to your family or to your community when bad things happen?

4. What kinds of things are most challenging for you growing up here?

5. What do you do when you face difficulties in your life?

6. What does being healthy mean to you?

    a. What does being healthy mean to others in your family and community?

7. What do you do to keep healthy; physically, emotionally and spiritually?

    a. What do others you know do to keep healthy; physically, emotionally and spiritually?

Conclusion

- Thank you for participating. This has been a very successful discussion
- Your opinions will be a valuable asset to the research report.
- We hope you have found the discussion interesting
- If there is anything you are unhappy with or wish to complain about, please contact the ADRA South Sudan office or speak to me later
- I would like to remind you that any comments featured in this report will be anonymous

- We will share the results from the different discussions when the report is ready

Note to research assistants:

- *hand the FGD notes, participant consent forms and the audio recorder to your team leader at the end of the day. Do not take any confidential information home.*
- *If you are concerned that the participant might hurt himself/herself or others, report this to the FRS.*
- *If you are concerned for the participant for any other reason report this to the FRS.*

Appendix 3 – Transcription and translation guidelines

Transcription and translation Guidelines

Process outline

- *Step one:* Transcribe audio files (from audio to written form) in Nuer language
- *Step two*: Translate transcription files from Nuer to English.

Transcription

Transcription is the action of providing a written account of spoken words. In qualitative research, transcription is conducted of individual or group interviews and generally written verbatim (exactly word-for-word).

Specific guidelines for transcriber:

- Incomprehensible text should be noted with symbols such as ###
- Silence and pauses should be noted as: ….
- Note fill in words or sounds, such as; ehm… well… hmm…
- Note emotionally laden text with a bracket at the end, such as “laughing”, ”sad” or other feelings.
- If the transcriber is uncertain about the precise wording (e.g., if speech is slightly muffled), this should be marked with red text, and the transcriber should follow up with the interviewer for clarification.

Translation guidelines

- DO NOT modify answers based on what the translator thinks the researcher wants to hear
- What to do when words do not have an exact equivalent translation, such as cultural expressions and idioms?
    - Maintain the original word in quotes with the closest description in brackets or footnotes. It may be a good idea to discuss the meanings of particular words amongst the study team.

Briefing about research with external translator/transcriber.

- Main points to touch on
    - Specific instructions about the research purposes
    - Inform of the sensitive topic (trigger warning)
    - Stressing confidentiality
        - Confidentiality agreement
    - Transcription requirements
        - See attached template with expected structure
        - See attached document on "transcription and translation".

Briefing about the research

Are you familiar with the concept of Psychosocial support? What would you associate to Mental Health?

The topic of this research is psychosocial support and mental health within the school context

Mental health is defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO)

This research focuses on Resilience. Have you heard of the concept before?

Resilience, within mental health, can be defined as good mental health and developmental outcomes despite exposure to severe adversities.

We are looking at factors influencing resilience of individuals. There are however many levels within a **social setting** that impacts the individual; it can be on the community level, family level, peer and individual level.

Background

Children in South Sudan are exposed to traumatic events due to the conflict, not to mention impoverishment and daily stressors. This threatens their mental health and developmental outcomes.

Resilience has been found as a key factor in efforts to promote mental health in children and adolescents affected by hardships (A. Masten, 2014). **A better understanding of the underlying factors that determine a person's resilience can both inform and increase the efficiency of development programs**

Objective

The things that help individuals to cope and deal with life has shown to vary between contexts and cultures. This study aims to explore factors that promote or hinder resilience among children and adolescents within the school-context of Maiwut county. These factors may include local resources, strategies and systems within the community, family, peers or individual level.

Purpose

Identifying the strengths and resources of a community is a solid starting point in efforts to promote the wellbeing of children, as we can build on existing protective systems and resources.

This study could therefore inform efforts to promote the psychosocial wellbeing of children and adolescents attending school. It has also the potential to inform future studies on how to measure resilience; within the specific context.

Transcript Template and Example

Fill in the following:

- Participant's codename: _____
- Gender:_____
- Mark the correct alternative:
  - PTA member / Teacher
  - Individual interview / Focus Group Discussion

Transcription guidelines

- Incomprehensible text should be noted with ###
- Small pauses (1-3 seconds) should be noted as: ....
- A longer silence should be noted as (silence)
- Note fill in words or sounds, such as; ehm... well... hmm...
- Note emotionally laden text with a bracket at the end, such as (laughing), (sad) or other obvious feelings.
- If the transcriber is uncertain about the precise wording (e.g., if speech is slightly muffled), this should be marked with red text, and the transcriber should follow up with the interviewer for clarification.
- Interviewer = A
- Interviewee = B

Interview

Example transcription of an interview conducted over Skype

A: Could you tilt your screen abit, cause I can only see you from.. I can only see your mouth
B: Okey, yeah
A: Okey good.. eeehm
B: Now you see?
A: Now I see you (both laugh)

A: So I'm just going to go right ahead and ask you if you can think of a child or an adolescent, that you know personally.. ok? That has suffered emotionally because of difficult life experiences that they went through and who has not yet recovered despite the passing of time. Was the question clear?

B: Yah, the question is clear…
(Silence)
A: Can you…. Can you think of a child or adolescent that has been through a difficult life experience and that you know personally?

B: Yes….. one's problems is not yet completed and one is recovered. And the the problem is not recover, eh, separated with his family, You know that South Sudan is now conflict that occur.. and it separated with their father. So that child, when she went to school she is really feard

Appendix 4 - Workplan

Research Work Plan

Main researcher: Sandra	MR
Main research coordinator: A	MRC
Field research supervisor: A	FRS
Field researchers: B and C	FR

Task	Responsible	Date	Task completed
Preparation			
All research members sign Non Disclosure Agreement and ADRA SSu code of conduct	FRS		
Send copy of formal papers signed by FR+FRS to MR	FRS		
Arrange meeting with the MRC and FRS	MR		
Identify referral pathways and service providers (MHPSS)	MRC, FRS		
Translate Tools	FR		
External person quality checks translation	ADRA staff		
Select Practice Day Village and notify			
Select school for data collection	MR, with help from FR		
Conduct community visit of selected communities			
Select and notify teachers for individual interviews	FRS, FR		
Select and notify participants for FGDs	FRS, FR		
Draft a Data Collection Schedule	MR		
Complete Data Collection Schedule	FRS		
Prepare COVID-19 kit for data collectors	FRS, FR		
Training			
Organize training venue/meals	FR (Alex)		
Print Data Collection Tools (including information letter, participant records and tools)			
Print Data Collection and management protocol			
Print authorization letter for data collectors	FRS		
Conduct Training	MR		
Conduct practice day and pilot in Nuer and English	FR		
Conduct Supervisor Orientation	FRS, FR ?		
Data Collection and Management		**Date**	
Data Collection	FR, FRS		
Transcribe data in Nuer	External		
Translation of transcribed data to English	External		
Sned transcribed data for quality check of FR	MRC		

Quality check translated data	FR, FRS		
Notify MR when data is finalized	MRC, FRS		
Upload final data and records to OneDrive	MRC, FRS		
Store data in a locked cabinet in the ADRA office	FRS		
Keep all digital data on a USB in a locked cabinet	MRC		
Delete or destroy all other digital data documents	MRC, FRS, FR		
Delete all data at the end of the project	MRC, FRS, FR		
Analysis and Reporting			
Data Analysis	MR		
Report Writing	MR		
Review analysis	FR, FRS		
Review Report	MRC, FRS		
Share report with the MoGEal			
Disseminate Findings			

Appendix 5 - Data Collection and Management Protocol

Data Collection and Management Protocol

Research project:

Resilience among children and adolescents in Maiwut County

Content

Abbreviations

FGD – Focus group discussion
PTA – Parent Teacher Association
MR – Main Researcher
FRS - Field Research Supervisor

Roles of research team

Main researcher: Sandra Bjerkan, ADRA Norway
Main research coordinator: A
Field research supervisor: A
Reserve Field research Supervisor: D
Field Researchers/data collectors: B and C

Sampling design

Population	Adult stakeholders who are closely connected to the school-context	
Sample context	2-3 Selected primary education schools	
Selection phase	1st selection phase	2nd selection phase[1]
Units	6 *male* PTA members - **FGD**	2 male PTA members - **Individual interview**
	6 *female* PTA OR *mothers groups*[2] members - **FGD**	2 female PTA OR *mothers groups*[2] members - **Individual interview**
	6 Teachers - **Individual interview**	

[1] Select PTA members for the individual interviews from the group that took part in the focus group discussions.
[2] Only select mothers group members in case there is a lack of access to female PTA members.
[3] If there is a lack of participants in one school, we can find participants in another school

Sample criteria:

General sample criteria

- **Adult** stakeholders:
  - Teachers: 19-75 years of age
  - PTA members: 19-85 years of age
- **Especially concerned for student's wellbeing** and **puts in efforts to promote student's wellbeing**.
- Try to include members of all clans represented in the school

Specific selection criteria

Individual interview with PTA members
Pick individuals from the FGDs that you think had interesting and thought through insights regarding why some people manage well despite adversity, while others do not. Do not do a random selection.

Be aware!

- Make sure that none of the local ADRA staff are from the sampled villages
- Do not select individuals that
  - Seem extra vulnerable

- That can be emotionally damaged by participating
- Cannot give a genuine consent

Data collection

COVID-19 precaution measures

The authorities' rules and guidelines as well as ADRA South Sudan's guidelines must be followed at all times.

Handwashing, Hand Sanitizing, and Disinfecting surfaces

- Researchers carry a personal hand-sanitizer with them
- Have surface disinfectants available for disinfecting common-touch surfaces including vehicles, data collection venue and field equipment.
- Have handwashing facilities and hand sanitizing equipment available, such as handwashing soap (for when water will be available) and hand sanitizer
- Researchers must wash their hands and disinfect common-touch surfaces between each interview or FGD.
- Have participants wash their hands before and after registration, as well as after the data collection.

Physical distancing and minimizing contact with others

- Care should be taken to ensure physical distancing on travel and in the field
- Select a venue where social distancing can be maintained and where there are handwashing facilities in place; bring a soap in case.
- Keep a minimum of 1 meter between each FGD participant
- Keep a minimum of 2 meters between Data collector and participants.
- If physical distancing cannot be maintained, the research team must wear a face-mask covering mouth and nose; e.g during registration.
- Do not use the same mask for more than one day.

Other concerns

- No researcher who feels ill or has reasonable cause to believe they have been exposed to COVID-19 should participate in the field research or field visit.
- If a fieldwork team member believes that they are at a higher risk for severe illness from COVID-19 and is concerned about participating in fieldwork, they should contact the main research coordinator to discuss further.
- In cases of disease outbreak at the ADRA office in Maiwut or in the field, all research activity in the field must be stopped temporarily.

The FRS is responsible for ensuring that the research team follows the listed COVID-19 precaution measures.

Data collection timeframe and schedule

Anticipated timeframe for data collection

Activity	**Anticipated duration**
Fieldwork	3-4* days
Individual interviews	1 hour

Focus group discussions	1 hour 30 minutes

* Depends on how many schools that are selected, as well as unforeseen challenges

Data collection schedule

DAY 1

1. Conduct two Focus group discussions
2. Digital debrief with the whole research team
3. Individual interviews if time allows

DAY 2

1. Conduct as many interviews as time and energy allows
2. Digital debrief with the whole research team

DAY 3

1. Conduct the remaining interviews
3. Final digital debrief with the whole research team

Checklist for data collection

Formal requirements for the research team

- All research members must sign a *Non Disclosure Agreement* and *ADRA South Sudan's code of conduct*.
    - These documents must be signed prior to data collection
    - The FRS sends a copy of the documents to the main researcher.

Informed consent

- Inform the participant of the purpose, aim and scope of the study, as well as their rights. *See information letter* .
- Give the participants sufficient time to decide whether they would like to take part.
- All participants should receive a copy of the information letter in Nuer or English
- Make sure to have the consent form(s) signed before starting the interview or focus group discussion.
    - For participants who <u>can</u> read and write well: Give an oral orientation of the information letter and let them read it before signing the consent form. Make it clear that they can ask questions for clarification.
    - For participants who <u>cannot</u> read or write: Make a separate audio recording, where you give an oral orientation of the information letter and get an oral consent. Stop the recorder when the participant has given their consent. Make it clear that they can ask questions for clarification.

Practical points

- Offer participants a soda drink as a token of appreciation
- Follow the Covid-19 specific guidelines (page 3)
- Make sure to register all participants in either the individual interview record or the FGD record.
- *Audio recorder*

- Explain and illustrate how the audio recorder works, emphasize that the recording of their voices will be deleted.
- Let the participant(s) know when you put the audio recorder on and when you turn the audio recorder off.
    - Start every recording with saying the participant's codename (not for FGD)
    - Avoid using the participant's real name during the recording.

Guidelines during Interviews and FGDs

- There should always be two field researchers conducting the interviews/FGD.
    - One field researcher will take notes while the other moderates the conversations.
- During the interview
    - If the participant shares their own difficult life experiences, this is fine, but avoid digging more in that and try to lead conversations away from personal experiences. This is to reduce the risk of exposing the participants to harm.

Debriefs

Debriefs will be scheduled at set times during data collection (see data collection schedule) .

Why debriefs?

- To address unforeseen challenges
- Open the possibility to correct the course amid unforeseen challenges
- To share experiences
- To get an insights into the content of data

Protection of Participants

Note to FR:

- If you are concerned that the participant might hurt himself/herself or others, report this to the FRS.
- If you are concerned for the participant for any other reason report this to the FRS.

Note to FRS:
When necessary and depending on the nature of the concern, refer participants to Health, MHPSS or legal service providers.

Data management

The following steps must be followed to ensure that no unauthorized persons are able to access the participants' personal data.

During data collection

1. Both FR review the hand written notes when they come back from the field and add any corrections content that was not covered.
2. FR hand the audio recorders, handwritten notes, participant records and consent form to the FRS at the end of each day. *Do not take any confidential information home.*
3. The FRS is responsible for storing the audio recordings, handwritten notes and participant records in a locked cabinet.

After data collection

1. When data collection is completed the handwritten notes, participant records and consent form is kept in a locked cabinet at the ADRA office in Maiwut.
2. The recordings are transferred to three external USBs:
    a. One USB containing the recorded consents, and locked in a cabinet.
    b. Two USB containing the collected data
        i. One to be stored in a locked cabinet at the ADRA office in Maiwut.
        ii. One to be brought to Juba for transcription (must also be stored in a locked cabinet)
    c. All other recordings are then deleted.
3. The MR and MRC/FRS agree on an external consultant to translate and transcribe the data.
    a. The external consultant must sign the non-disclosure agreement prior to accessing the anonymized data.
4. The transcribed data is reviewed by the FRs and FRS to check if the data is accurately translated.
5. MRC/FRS notifies the MR when the data is finalized
6. MR sends a link to two a protected online folder on OneDrive.
    a. One folder for anonymized data
    b. One folder with a copy of consent forms and participant records.
7. MRC/FRS uploads the anonymized data, consent forms and participant records to the designated folders.
8. MR sends an email to confirm that all relevant files have been successfully uploaded
9. Only original recordings, records and consent forms are stored in a locked cabinet until the end of the project, all other data is deleted.
10. MR sends an email to the FR at the end of the project (aprox. June 2021) asking them to delete and destroy all remaining data and personal information, including recordings and documents.

Note to the field research supervisor

- Please inform the MR if any of the points in this data collection and management protocol could not be followed, and provide I reason for this. Either during the data collection process or at the end of the data collection process.
- Feel free to contact Sandra, the main researcher via WhatsApp: +47 41 10 68 17

Appendix 6 – Information letter and consent form

Are you interested in taking part in the research project

Resilience among children and adolescents in Maiwut County?

This is an inquiry about participation in a research project: The main purpose is to explore locally defined indicators for resilience in South Sudanese children and adolescents, as perceived by adult stakeholders. In this letter, we will give you information about the purpose of the project and what your participation will involve.

Purpose of the project
This research project is a collaboration between ADRA South Sudan and the Norwegian University of Life Sciences through ADRA Norway. It is conducted as part of a graduate student's master's degree. The topic of this study is psychosocial support and mental health within the school context with a focus on resilience. Resilience, within mental health, can be defined as good mental health and developmental outcomes despite exposure to severe adversities. The things that help individuals to cope and deal with life varies between contexts and cultures. This study will explore what factors promote or hinder children and adolescents' resilience within the school-context of Maiwut county. The research will focus on protective factors. The project will last from December 2020 to June 2021. The study will try to answer the following question:

Within the school-context of selected communities in Maiwut County, South Sudan; what are some key indicators of resilience among children and adolescents, as perceived by adult local stakeholders?

1. What is the local perception of good mental health?
2. What are the perceived risk and protective factors for a good mental health?

The results from this study may inform efforts to promote the psychosocial wellbeing of children and adolescents attending school. It has also the potential to inform future studies on how to measure resilience.

Who is responsible for the research project?
The Norwegian University of Life Sciences is the institution responsible for the project, in collaboration with ADRA South Sudan.

Why are you being asked to participate?
Adult school stakeholders have been selected to inform this study, including teachers and members of the Parent Teacher Association (PTA). We will ask a total of 15-20 participants to partake in this study. You were identified as a possible candidate by the ADRA South Sudan staff.

What does participation involve for you?

If you chose to take part in the project, this will involve that you take part in an interview or a focus group discussion. Only PTA members will be included in the focus group discussions, but both selected PTA members and teachers will be included in the individual interviews. The individual interviews will take no more than 1 hour and the focus group discussions will take approximately 1,5 hours. The survey includes questions about how some people recover well after adversities, and others do not. Your answers will be audio recorded electronically.

Are there any risks related to participating in this study?
We do not know of any physical harm that can come from participating. Please be aware that the conversations will include talking about emotionally challenging life-experiences of people you know and are familiar with, although we want to focus on the cases where people managed well despite difficult life experiences. We will not store any personal data about any third person mentioned in the interview or group discussions.

Participating in this study might lead to an increased risk of exposure to COVID-19 due to social interaction. To reduce this risk we have taken the following preventative measures for your protection:

- We follow the national COVID-19 guidelines
- We will ensure proper physical distancing during registration and interview/group discussions.
- We ensure that handwashing facilities and hand sanitizers are available and used.
- We will also disinfect common-touch areas, such as tables and pens.
- We will wear a mask when we cannot maintain physical distancing.

Participation is voluntary
Participation in the project is voluntary. You will receive a soda-drink as a token of appreciation for your participation, but there is no payment. If you chose to participate, you can withdraw your consent at any time without giving a reason. All information about you will then be made anonymous. The information you give will not be able to be traced back to you. There will be no negative consequences for you if you chose not to participate or later decide to withdraw. It will not affect your relationship with the school or teachers.

Your personal privacy – how we will store and use your personal data

We will only use your personal data for the purpose(s) specified in this information letter. We will process your personal data confidentially and in accordance with data protection legislation (the General Data Protection Regulation and Personal Data Act). The project group, student and supervisors will have access to your personal data. Your de-identified personal data will be processed and analysed in Norway. The results from the study will be disseminated, and sought to be published.

- We will take the following measures to ensure that no unauthorized persons are able to access your personal data.
    - We will replace your name and contact details with a code.
    - The list of names, contact details and respective codes will be stored separately from the rest of the collected data.
    - We will store the data in a locked cabinet and then transfer the data to a protected folder on an encrypted cloud server called OneDrive.

Participants will not be recognizable in publications. Only the following personal information might be published: age, gender, education level, livelihood, years lived in Maiwut and how many children you have.

What will happen to your personal data at the end of the research project?
The project is scheduled to end June 1st 2021. All personal data and audio recordings will be deleted at the end of the project.

Your rights
So long as you can be identified in the collected data, you have the right to:

- access the personal data that is being processed about you
- request that your personal data is deleted
- request that incorrect personal data about you is corrected/rectified
- receive a copy of your personal data (data portability), and
- send a complaint to the Data Protection Officer or The Norwegian Data Protection Authority regarding the processing of your personal data

What gives us the right to process your personal data?
We will process your personal data based on your consent.

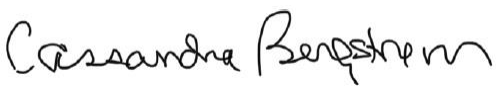
Based on an agreement with NMBU - The Norwegian University of Life Sciences, NSD – The Norwegian Centre for Research Data AS has assessed that the processing of personal data in this project is in accordance with data protection legislation.

Limits of confidentiality
Depending on the laws of the country and the protection and social services systems in place, I may have to break confidentiality and tell the appropriate agency or authority if I learn of or believe that you are at risk of ending your life or of harming someone else. You may choose to give me permission in writing to release any or specific information about you to any person or agency that you designate.

Where can I find out more?
If you have questions about the project, or want to exercise your rights, contact:

- ADRA South Sudan
  - Main field research supervisor Basilla Ciakuthi Katoni by email bkatoni@adrasouthsudan.org
- NMBU - The Norwegian University of Life Sciences via
  - Graduate student Sandra Björk O. Bjerkan by email sandra.b.olafs@gmail.com or
  - Supervisor Cassandra E. Bergstrøm by email cassandra.bergstrom@nmbu.no
  - Our Data Protection Officer: Hanne Pernille Gulbrandsen by email personvernombud@nmbu.no
- NSD – The Norwegian Centre for Research Data AS, by email: (personverntjenester@nsd.no) or by telephone: +47 55 58 21 17.

Yours sincerely,



Cassandra E. Bergstrøm
Project Leader

Sandra Björk O. Bjerkan
Graduate Student

Consent form

I have received and understood information about the project *Resilience among children and adolescents in Maiwut county* and have been given the opportunity to ask questions. I give consent:

- ☐ to participate in an individual interview
- ☐ to participate in a focus group discussion

I understand:

- ☐ The risks related to this study
- ☐ The nature and limits of this confidentiality agreement

I give consent for my personal data to be processed until the end date of the project, approx. June 1st 2020

(Signed by participant, date)

Appendix 7 – Initial coding table

Research Topic: Locally defined resilience indicators among chiuldren and adolescents in South Sudan

Research question:
What do adult local stakeholders within the school-context of selected communities in Maiwut County, South Sudan, perceive as key indicators of resilience among children and adolescents?

Sub-RQs or main issues	**Data needed/collected to answer them**	**Main codes used**
How do adult local stakeholders perceive mental illness and wellness?	Local understanding of good mental health Local understanding of poor mental health Local perceptions of the recovery process	1. Good mental health a. 2. Poor mental health a. 3. Recovery process
What are the perceived risk and protective factors to good mental health outcomes?	Perceived risk factors to good mental health outcomes/good recovering process Perceived protective and promotive factors for good mental health outcomes/good recovering process	1. **Adversity** a. Type b. Time scale i. Passed ii. Persistent c. Gender i. Girl ii. Boy d. Effect i. Behavior ii. Expression iii. School **2. Individual level** a. Risk factors b. Protective factors **3. Family level** a. Risk factors b. Protective factors **4. Community and multi-level** a. Risk factors b. Protective factors

Appendix 8 – Analysis color map

Cross cutting themes: Basic needs, Hop, Supportive relationships, Peace

1. Individual level

Protective	Risk
A. Personal strength	Lack of personal strength
B. Openness (and coherence)	Withdrawn
C. Positive focus	Negative focus
Crosscutting theme (Basic needs and Hope)	

Risk factors	**Protective and promotive factors**
1. Vulnerable a. Weak spirit b. Dependant on others c. Sensitive to talk about difficult life experiences d. Cries easily e. Doesn't speak up for themselves 2. Reserved a. Isolated b. Doesn't talk about their problem *3. Lacking right attitude* a. Lack zeal (resilience) *b.* Lack of confidence c. Low self-esteem *4. Bad feelings and thoughts / Overwhelmed* a. Bad thoughts b. Feeling that none cares c. Fear of stigma (e.g. orphan) d. Self-pity e. Entangled and *overwhelmed* by life conditions *f.* Doesn't feel equal *(Basic needs)* *5. Negative behaviour / poor adaptation* a. Doesn't want to go to school b. Dropped out of school	i. Attitude 1. Strong will a. Confident b. Has Zeal c. Has resilience d. Speaks up for themselves 2. Hopeful a. Religious belief b. Reunited with mother 3. Positive focus a. Acknowledges own abilities b. Has positive rolemodels / motivated by success stories 4. Adapts well to new circumstances ii. Behavior 1. Listens to advice 2. Encourages others 3. Extraverted 4. Openess towards others a. Share's their experiences iii. Basic needs are met 1. Feels equal

c. Drug abuse d. Doesn't listen to advice	

2. Family level

Protective	Risk
Supportive caregiver	Child maltreatment
	Loss of parent
Peace within the family	conflict in the family

Crosscutting theme (Basic needs and Hope)

Risk	Protective and promotive
1. Neglect a. Lacks basic needs i. Poverty ii. Un-fair treatment/neglect b. Lack of family/care-giver support c. Lack of equality between children d. Hindered by care-givers to go to school 2. Abuse a. Verbal b. physical 3. Exploitation a. child labour 4. Conflict in the family 5. Loss of parent 6. Family seperation due to conflict	1. Supportive care-giver a. Belonging / (*accepted?)* b. Loved c. Protected 2. Child rearing a. Communicate/uphold boundries and standards b. Encourage school attendence 3. Reunited with family 4. Peace between family members 5. Basic needs met

3. Community level and higher

Protective	Risk
Encouragement and acceptance	Discrimination and rejection
Peace and safety	Conflict and insecurity
Supportive structures/institutions	Lack of supportive structures/institutions
Crosscutting theme (Basic needs and Hope)	

Risk	Protective and promotive
1. Lack of community acceptance and support /Discrimination a. Disabled children that cannot contribute b. Orphans c. Bullying at school 2. Lack access to medical care 3. Lack of peace and safety a. Sexual abuse b. Insecurity regarding possible new conflict c. Family seperation	1. Community support and acceptance a. Community visits to encourage children b. Community gives advice 2. Positive behaviors a. Consideration of the vulnerable b. Sharing 3. Local coping strategies a. Pray / hope in God's help b. Local expressions of encouragement i. "problems come and go" "this too shall pass" ii. Turn focus on positive narratives / role models iii. "This person made it" iv. "It is not the end of life" c. Positive rolemodels 4. Peace and Security a. National conflict, between neighbors and in the family circle 5. Supportive structures a. Humanitarian organizations b. Education opportunities c. Medical care d. Religion/Church

Norges miljø- og biovitenskapelige universitet
Noregs miljø- og biovitskapelege universitet
Norwegian University of Life Sciences

Postboks 5003
NO-1432 Ås
Norway