

POLICY BRIEF

Promoting Forcibly Displaced Children's Mental Health Through Educational Interventions

A Policy Memo for the Global Health Studies Program

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EXECUTIVE SUMMARY

This policy memo addresses the trauma-related mental health needs of forcibly displaced children. The trauma of forced displacement, and the mental health challenges it intensifies, requires culturally sensitive and community-centered educational interventions in host communities. Drawing on literature reviews and case studies of child displacement in Venezuela, Somalia, and Ukraine, this study aims to 1) examine the current realities and challenges faced by forcibly displaced children during their pre-displacement, displacement and post-displacement experiences 2) propose strategic education policy interventions and frameworks to support refugees, asylum seekers and other displaced children in their host communities.

The dual-focused approach in this policy brief aims to enhance the quality of life and restore the dignity of forcibly displaced children. The mental health of displaced populations is inadequately addressed and usually overlooked. Lack of attention to the mental health needs of forcibly displaced children hinder their social, cognitive, and emotional development. These repercussions extend far beyond the individual and result in challenges for host communities, such as poor self-settlement, limited access and engagement with public goods, and stunted local community development. Addressing these challenges through targeted mental health interventions is essential for fostering resilience and integration into host societies.

Forcibly displaced children are individuals under 18 years old who are compelled to flee their homes due to factors such as armed conflicts, widespread violence, persecutions, violations of human rights, and natural disasters.¹ Forced displacement can be categorized into groups such as internally displaced persons (IDPs), refugees, unaccompanied minors and other displaced people. This study focuses on cross-border displacement resulting from conflict and violence. This experience as forcibly displaced in a host country creates complex and significant mental health challenges, including emotional distress, neurological development disruptions and disorders, and the long-term effects of unaddressed trauma.² These challenges require interventions that address the immediate and long-term precarity to health and well-being by supporting the resilience of displaced children. A mental health-centered approach to forced displacement can foster children's neurological development, resilience and prevent downstream effects such as substance use disorders and lack of educational attainment leading to poor socioeconomic outcomes such as poverty.

Across the displacement journey, mental health interventions such as psychosocial support programs, trauma-focused cognitive behavioral therapy (TF-CBT), culturally informed counseling services, and community-based peer support play critical roles in fostering resilience and recovery. This brief adds to these mental health-centered approaches to enhance the effectiveness of these practices through educational policy. Educational interventions act as a transformative mechanism, equipping children, families, and communities with the knowledge, tools, and skills necessary to support mental health support and outcomes.

This brief emphasizes the critical importance of the three interconnected pillars for psychoeducational interventions: culturally informed, locally based, and family-centered. With this framework, mental health interventions as well as public policies that aim to support forcibly displaced children must position the family and community members



Figure 0: (<https://pixabay.com/photos/child-kid-play-study-color-learn-865116/>)

as cornerstones and targets of educational interventions to support children refugees, asylum seekers and/or migrants attain basic services and security and cultivate family and community support.

Given the complexity and diversity of forcibly displaced children's pre-displacement experiences, this report provides policy recommendations tailored for host community settings where direct engagement with children and adolescent populations is practical and effective by stakeholders such as healthcare providers, educators, and local community leaders. Recognizing the pivotal role of basic services and security, community and family support, the following policy recommendations are designed to increase meaningful outcomes for the mental health and well-being of forcibly displaced children. These recommendations aim to create a supportive ecosystem that addresses both immediate needs and long-term resilience of displaced children.

Policy Recommendations

- 1.** Enhance Gender and Culture-Sensitive Mental Health Literacy for Key Actors (e.g. parents, school teachers, community leaders) in Post-Displacement Settings
- 2.** Transform Health and Legal Frameworks Through Culturally Informed Education on Displacement Experiences
- 3.** Prioritize Programs and Initiatives to Strengthen Community Awareness of Displaced Children's Mental Health

INTRODUCTION

Forced displacement poses significant challenges that intersect political, economic, and social dimensions, disproportionately affecting millions of children globally.³ As countries grapple with accommodating global displacement, it requires multifaceted strategies tailored to a country's political economy to address the challenges and needs of children and adolescents. The complex and polarizing nature of forced displacement has led to mismanagement and inadequate efforts, especially for children and adolescents. The trauma-related mental health needs of forcibly displaced children remain critically under-addressed. Access and quality mental health care services for displaced populations is well-documented and remains a persistent issue within migration and health systems.

This lack of attention and focus on addressing trauma of forced displacement and mental health needs of children creates numerous repercussions and consequences for host countries. By centering mental health in forced displacement management, countries can foster positive social, political, and economic outcomes for both displaced populations and host communities.

A key approach for this solution is to harness educational policy and interventions to drive improvements in mental health of displaced children. Educational policy and interventions present a powerful approach to addressing the mental health challenges of forcibly displaced children. These interventions go beyond traditional schooling to encompass comprehensive, community-based strategies that actively involve key local stakeholders, including parents, teachers, healthcare professionals, legal advocates, and social workers. By embedding mental health considerations into educational frameworks, host communities can foster resilience, facilitate integration, and enhance the overall well-being of displaced children.

Countries such as Poland, United States, and Columbia, located near the three countries utilized as case studies in this policy brief, face unique challenges and responsibilities in addressing the needs of displaced populations. These nations, often functioning as first points of refuge, have varying capacities and strategies to accommodate and integrate displaced individuals, including children and adolescents. Their approaches are influenced by geopolitical, economic, and social factors, as well as their proximity to the crises causing the displacement. None-

theless, the realities faced by displaced children in host communities urge critical reflection and strategic action to address their vulnerabilities and needs, specifically trauma-induced mental health needs. Addressing this enables meaningful shifts in displacement management to drive positive social, economic and health outcomes for child and adolescent health in host communities.

Through the three case studies in this report, children fleeing wars in East Africa and Europe, such as those affected by ongoing conflicts in Somalia and Ukraine, grapple with violence, trauma, loss of family, and instability. Similarly, children escaping economic crises and authoritarian regimes in Latin America, such as Venezuela, face unique challenges, including long-term displacement, limited access to education, and exposure to exploitation during the displacement process. All these real-world examples highlight the varied yet interconnected experiences of forcibly displaced children, emphasizing the need for tailored interventions that address specific regional and cultural contexts of displacement and children's mental health.

In the midst of these political debates and inadequate immigration policy measures, thousands of children are grappling with traumatic consequences from their experiences in their native countries to the arduous and often traumatic journey to host communities. Against this context, the diverse conditions and experiences that displaced children experience in detention centers, across different stages of displacement and their new communities can be utilized as opportunities to implement educational efforts that enhance capacity for communities to support and address trauma effectively.⁴

Employing community-centered education policies can mitigate the trauma-induced challenges children and adolescents face in new communities.⁵ Through education efforts, educating their communities to support children in their traumatic experience recovery. This offers the potential to alter the health outcomes for host communities to support its most effective assets, its young population. This approach is crucial to support and build understanding and compassion towards displaced children who have experienced traumatic events.

Children who endure forced displacement, whether as refugees, asylum seekers or unaccompanied minors, face

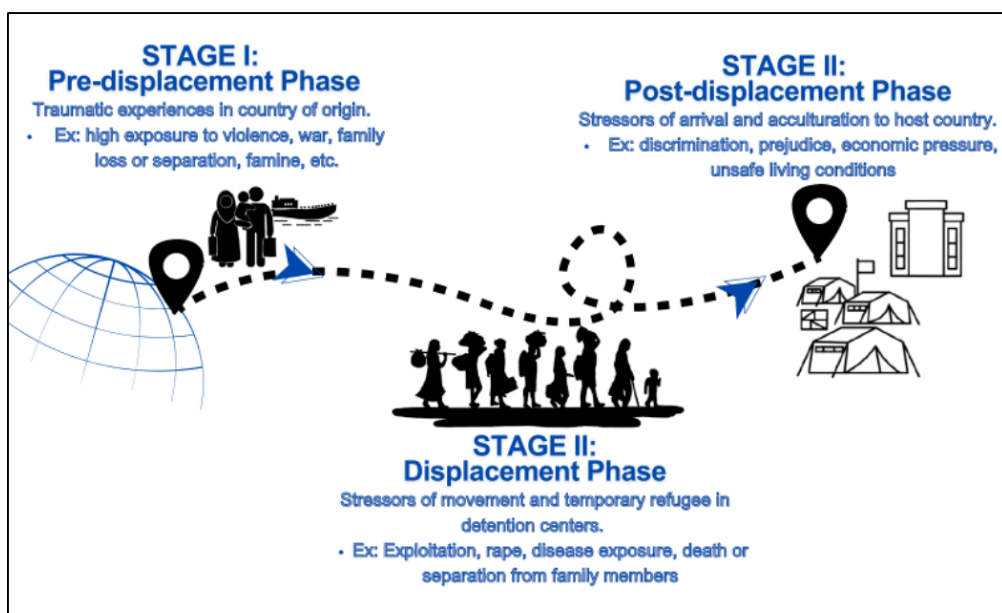


Figure 1: Forcibly displaced children experience traumatic stressors at each stage of their displacement journey (pre-displacement, displacement, and post-displacement).

immense psychological stressors across three distinct phases of their journey: pre-displacement, displacement and post-displacement.⁶ Along these three phases, children can encounter war, violence, family separation or death, racism, social exclusion, language barriers and varied forms of complex traumatic experiences.⁷ All of these experiences usually lead to enduring mental health issues, including anxiety, post-traumatic stress disorder, and depression.

With unmet mental health needs, this health risk becomes a critical and underlying factor in important future outcomes such as long-term socioeconomic development, educational attainment, workforce participation, and social cohesion. With the crucial issues arising from the importance of integrating mental health in health systems supporting displaced populations, students from the Global Health Studies program at the Yale Jackson School of Global Affairs, in collaboration with global health and migration organizations, conducted collaborative research on these challenges at the intersection of migration and health.

This study presents critical policy interventions and programmatic approaches to support forcibly displaced children through community-centered educational practices. In presenting these findings, the team hopes to address trauma and its role in forcibly displaced children's experiences to support them in having a dignified and fulfilling life in host communities.

Trauma is a psychological response to an event causing emotional distress or physical harm, which can lead to long-term effects on mental health, especially for children's neurological development and psychosocial

health.⁸ As trauma is related to an event or series of events, a displaced person's experiences and narratives are essential in making sense of the specific trauma experienced to support recovery and healing. All of these stages and phases of trauma bring with them their own complex role in the experiences and realities of displaced persons themselves.

This trauma encountered at different stages of the displacement journey often manifests as anxiety, depression, post-traumatic stress disorder (PTSD), and behavioral issues that profoundly impact social, cognitive, and emotional development. Displacement often disrupts access to stable education, a factor essential to the forcibly displaced children's psychological well-being and resilience.⁹ Resilience is the ability to adapt and recover from their traumatic experiences and live productively and meaningfully.⁹ The journey to safer territories frequently includes severe stressors such as violence, family separation, and insecurity, all of which compound their vulnerability. Once resettled, children encounter new challenges – social isolation, language barriers, and the need to adapt to unfamiliar cultural and social norms. Despite the resilience many displaced children demonstrate, without adequate support systems, this stress can lead to long-term mental health issues and diminished educational and economic outcomes.

EVALUATING EFFECTIVE PSYCHOEDUCATIONAL INTERVENTIONS FOR DISPLACED CHILDREN'S MENTAL HEALTH

Psycho-educational mental health interventions have been implemented in diverse settings across the world (e.g., classrooms, refugee camps, and cultural/religious centers). These interventions can also be implemented across the three stages of displacement. We performed a literature review of articles, feasibility studies, and systematic reviews relating to mental health interventions for forcibly displaced children (Figure 2).

We identified three core themes across successful psychoeducational interventions for forcibly displaced children in pre-displacement, displacement, and post-displacement settings:

- 1. Community-based** initiatives enable children to form social connections both during and after the implementation of the initiative.
- 2. Culturally relevant** initiatives acknowledge the context and experiences that children have and use these to address mental health stigma among communities.
- 3. Family-centered** initiatives empower parents, caregivers, and other adults in the child's life to support children's mental health throughout the three stages of displacement.

These themes from local psychoeducational interventions can be incorporated into educational policies at the local, state and national levels in pre-displacement, displacement, and post-displacement settings.

Community-Based Interventions

Community-based initiatives allow community leaders to show their support for the initiatives by playing a direct role in the implementation process. Additionally, children are able to form relationships with other members of the broader community.¹⁰ Many mental health and psychosocial support (MHPSS) interventions are shifting from targeted therapy provided in clinical settings to community-based group initiatives that are led by lay practitioners who are members of the community. This not only improves the scalability of the intervention but also enables resilience-building as children form connections within their new communities.¹¹

Community-based interventions can be implemented in pre-displacement, displacement, and post-displacement settings. The following studies are examples of effective interventions that have been implemented by community members and nongovernmental organizations to support the mental health of forcibly displaced children in these various settings. In a pre-displacement setting, trained community facilitators implemented a modified written exposure therapy (m-WET) group-based intervention for adolescent Afghan girls following terrorist attacks in the city of Kabul. In comparison with a targeted trauma-focused cognitive behavioral therapy (TF-CBT) delivered by a clinical psychologist, there was no significant difference in the level of PTSD symptom severity between groups. Both forms of the therapy also had significantly lower PTSD symptom severity than the control, showing that community-based group initiatives were also feasible and acceptable ways to address mental health needs among Afghan adolescents in a humanitarian setting.¹²



Figure 2: A literature review highlighted three key themes of successful mental health interventions for forcibly displaced children: 1) involve or are facilitated by members of the community, 2) incorporate aspects of the children's heritage culture into the intervention, and 3) include family members in the implementation.

Community-based interventions have also been implemented in displacement settings (refugee camps) to provide psychosocial support for children at various developmental stages.

For example, a refugee-led early childhood education program, Little Ripples, was established by the Jesuit Refugee Services in eastern Chad. The program, run by refugee women, provided daily meals and a safe learning environment for children between the ages of three and five. Community feedback showed high levels of support for the program, and caregivers described how their children developed skills for empathy and relationship building.¹³

Another group-based intervention, Strengths for the Journey, was implemented in three refugee camps in Greece to build resilience among children and adolescents between the ages of seven and fourteen. The intervention itself was developed in collaboration with refugee youth, camp managers, and service providers. Participants in the intervention reported significantly improved well-being, optimism, and self-esteem, and decreased levels of depressive symptoms. In a focus group following the intervention, the children described finding social connections through teamwork and developing feelings of hope and strength.¹⁴ These examples illustrate how children at different developmental stages formed social connections during the intervention that helped build resilience in a displacement setting.

In post-displacement settings, community-based interventions can be implemented to promote resilience and reduce distress.

One intervention, Creating Opportunities for Patient Empowerment (COPE) for adolescent Syrian refugees in Lebanon, was implemented at a community center that also provided educational programs, vocational services, and daily meals. The group-based cognitive behavioral therapy (CBT) intervention was developed in collaboration with staff from the community, and participants reported improved relationships with others and feeling a sense of community. Additionally, the intervention showed a reduction in depression and anxiety, and an increase in quality of life among participants.¹⁵

Another study led by Mercy Corps examined the impact of a psychosocial intervention, Advancing Adolescents, on the mental health and physiological responses of Syrian refugees and Jordanian youth in Jordan. The intervention was delivered by trained community health workers in a community center, and the research team included

members of the community and humanitarian workers, as well as Jordanian research scholars.¹⁶ The eight-week program includes fitness activities, crafts, vocational and technical skills, and also provides psychosocial support to build empathy and compassion. The evaluation, which was led by students affiliated to Yale University and authors from Yale and Jordan, found that the strongest sustained impact for youth who participated in building technical skills, with reductions in Human Insecurity, Human Distress, Perceived Stress, and Arab Youth Mental Health measures.¹⁷

Core benefits of community-based interventions include the ability to shape formative connections among participants and with facilitators. As reflected by the previous examples, these interventions can also connect participants to other community resources, providing structures of support for children and adolescents to develop stronger ties with the surrounding community.

CASE STUDY 1

Forcibly Displaced Venezuelans in Colombia, Ecuador, and Peru

Forcibly displaced Venezuelan children in Colombia and Peru can be supported through community-led interventions. In Colombia, these interventions include children's books and video games that aim to promote altruism and combat xenophobia.¹⁸⁻²² In Peru, feminist community organizing programs host workshops for adolescent girls on women's rights and raise awareness of gender-based violence, while another program hosts workshops for adolescent boys on non-toxic masculinity and preventing gender-based violence.²³⁻²⁵ In the case of Ecuador, public education policy can be implemented in collaboration with nongovernmental organizations. In Ecuador, a joint effort between the Ministry of Education, United Nations High Commissioner for Refugees, and the humanitarian aid organization World Vision, has enabled teachers and staff to create inclusive environments to address xenophobia and prevent violence in schools.²⁶ This is an example of a public policy implemented in collaboration with nongovernmental organizations. These examples of community-based initiatives highlight the importance of buy-in from community members. Community-based interventions play a key role in fostering relationships among participants and building structures for social support.

Culturally Relevant Interventions

Initiatives can further foster relationships by connecting to children's cultures and addressing stigma among communities. In a post-displacement setting, children and adolescents must adjust to a new culture and value system. Increased competence in the heritage cultures of forcibly displaced children can help moderate this difficult transition during the resettlement period.²⁷ The following studies demonstrate how culturally relevant interventions can be developed to effectively respond to the diverse backgrounds of forcibly displaced children in post-displacement settings.

One study employed community-based participatory research to conduct interviews with members of Somali Bantu and Bhutanese refugee communities that had settled in Massachusetts. These interviews revealed unique language and conceptualizations of depression and emotional distress that differed across communities.²⁸ Integrating these concepts and language phrases within mental health interventions is critical to ensure that the interventions can effectively reach community members in need.

Another intervention piloted in Somaliland incorporates a community base and cultural relevance through Islamic Trauma Healing (ITH). This program, led by trained lay facilitators, explicitly integrates Islamic faith principles in order to address psychological reactions after trauma. The program is led by members of the community and administered in mosques and focuses on community healing, rather than on individual trauma experiences. The intervention incorporates prophet narratives and individual prayer (turning to Allah in Dua) followed by group discussion.²⁹ By connecting to spiritual and religious aspects of the participants' cultural contexts, the Islamic Trauma Healing program can shift the narrative from mental health stigma towards building connections within community to promote healing through spirituality. By circumventing the stigma associated with mental illness, this intervention aims to reach more people who otherwise might not have accessed mental health care or clinical resources.

The tools we use to measure the effectiveness of interventions must also be tuned to the cultural context. One such study developed a qualitative conceptualization of resilience through collaboration with youth through storytelling and questionnaires. These insights helped a panel of fieldworkers and scholars adapt existing tools like the Child and Youth Resilience Measure to be more relevant to the cultural context for Syrian refugee children living in Jordan.¹⁷

CASE STUDY 2

Forcibly Displaced Somalis in the United Kingdom and the United States of America

Somali refugees face cultural challenges in the post-displacement settings of the United Kingdom and the United States. One culturally relevant intervention builds relationships within the Somali refugee community by recruiting 'peer campaigners' as mental health advocates who understand both Somali and Western conceptualizations of mental health.³⁰ Another mental health intervention was implemented at an Islamic cultural center, further connecting directly to Somalis through a trusted religious institution.³¹

In the United States, an educational handbook for educators who teach in areas with large Somali refugee populations describes aspects of Somali culture and Islamic principles of mental health.³² Another program provides outpatient mental health resources and holistic treatment groups for Somali refugees in collaboration with professionals who come from similar cultural backgrounds.³³ These culturally informed interventions can better connect forcibly displaced people with the mental health resources they need.

Family-Centered Interventions

In addition to connecting to culture and community, it is critical to connect to children's family structures. Support from caregivers and family cohesion is an important protective factor for children's and adolescents' mental health.^{34,35} Including parents and caregivers in the process of implementing the mental health intervention can also bolster cultural connections and reduce mental health stigma by showing buy-in from the children's family members and close relations.

Interventions that address the mental health of caregivers and adult supporters are critical in promoting mental health for forcibly displaced children. The International Rescue Committee (IRC) implemented an emergency education intervention for Kunama adolescents in a refugee camp in Ethiopia. The study assessed caregiver and adolescent mental health before and after the intervention, while adapting the survey questions to be acceptable in the cultural context. The study found that caregiver distress was strongly positively associated with children's psychological distress, independent of the educational interventions in the camp. This example from a displacement setting underscores the importance of interventions that include the family support

system to aid children's recovery from trauma associated with displacement.³⁶

Another intervention, the Happy Families Program, was implemented by the IRC in Thailand for Burmese migrant, including displaced children. Participating children and caregivers were guided through a 12-week parenting and family skills training program. Children and caregivers received some training modules separately before being brought together for play and feedback sessions with facilitators. The intervention was adapted at the surface-level to be culturally appropriate for Thai and Burmese families and was led by lay facilitators in community spaces that provided meals and onsite childcare to encourage building social networks.³⁷ This study is a core example of an intervention in a post-displacement setting that incorporates the key themes of family, culture, and community to improve mental health of forcibly displaced children.

In another post-displacement setting, a family-based home visitation program was implemented in Somali Bantu and Bhutanese refugee communities in Massachusetts. This program aimed to improve communication and promote positive parent-child dynamics to reduce risk of mental health problems among children in the community. The home visits were conducted by trained members of the communities and included group discussions with the families, along with support from licensed clinical social workers and child psychiatrists. The study found that children and caregivers reported improved mental health and depression symptoms for children, but no significant improvements in mental health outcomes for caregivers themselves.³⁸ This study is another key example of a culturally relevant, family-centered, community-based intervention to address mental health for forcibly displaced children in a post-displacement setting.

CASE STUDY 3

Forcibly Displaced Ukrainians in Germany, Poland, and the United Kingdom
Ukrainian refugees in Germany, Poland, and the United Kingdom experience significant trauma throughout their displacement journeys. The family-centered interventions and public education policies support parents and care-

givers to address the mental health of forcibly displaced Ukrainian children. In Germany, public education policies allow caregivers to choose to enroll their children in online Ukrainian schools in addition to the local German education, enabling children to preserve their cultural connections. Some German schools have hosted events and school walkthroughs to introduce Ukrainian students and their families to the classroom.³⁹ The nationwide educational policy centers the family and supports caregivers as decision-makers in the new post-displacement setting, while local, school-level interventions to welcome Ukrainian students and showcase community buy-in. In Poland, the education system implemented a policy which mandates in-person enrollment so that Ukrainian and Polish children have an opportunity to form connections and learn together.^{40,41} In the United Kingdom, an education and mentorship program provides employment resources to parents and caregivers in order to empower families to care for their children.⁴² This is an example of a local community-level intervention that uplifts families by supporting caregivers in developing key resources to raise their children in a post-displacement setting. In these ways, policies can be implemented to support families both inside and outside of the classroom to ultimately support the mental health of forcibly displaced children. The effective interventions we analyze here exemplify three key characteristics: they are based in the community, relevant to the cultural context, and center children and their families. Our policy recommendations aim to incorporate these characteristics into existing educational, legal, and political frameworks to inform public policy that supports the mental health of forcibly displaced children and their families.

CASE STUDY 1

Forcibly Displaced Venezuelans in Colombia, Ecuador & Peru⁴³

Since 2014, 7.7 million Venezuelans have been displaced from their native country, forming the largest diaspora in the Western Hemisphere. The majority of Venezuelans have relocated to Latin America and the Caribbean, with the largest communities in Colombia (2.86 Million), Peru (1.54 M), and Ecuador (444.8 K).⁴⁴ A scoping review of Venezuelan's mental health has indicated that in these three countries, there are themes of anxiety, depression, PTSD, and suicidal behaviors in the community.⁴⁵



Figure 3: A literature review highlighted three key themes of successful mental health interventions for forcibly displaced children: 1) involve or are facilitated by members of the community, 2) incorporate aspects of the children's heritage culture into the intervention, and 3) include family members in the implementation.

Forcibly displaced Venezuelans face various mental health stressors in Venezuela, throughout the displacement journey and after resettlement. These stressors can start a vicious cycle of trauma that is compounded by other factors throughout the displacement journey. Children and women also disproportionately face gender-based violence in all stages of this cycle.^{46,47} Stage I (pre-displacement) factors include: Venezuela's humanitarian crisis, political corruption, violence, and collapsed healthcare system, which have affected millions of families. Stage II (displacement) factors include crossing dangerous paths, witnessing deaths, surviving armed groups, and being separated from one's loved ones. Stage III (post-displacement) factors include lack of documentation, a lower socioeconomic status, inadequate access to the healthcare system and medicine, a lack of safety nets, and social discrimination. This section will highlight different examples of community-based educational initiatives in Colombia, Ecuador, and Peru that target the Stage III factor of social marginalization.

Colombia

Several books have been developed to combat anti-Venezuelan xenophobia in Colombia. Among them are *El Libro Viajero* (The Traveling Book) and *Seamos Panarceros* (Let's Be Friends). In *El Libro Viajero*, Venezuelans narrate their experiences through drawings and letters. In turn, Colombians express their empathy and welcome through letters.^{18,19} This book gives space for Venezuelan children's feelings while allowing Colombians to show solidarity with them. It has two editions and it is also

digitized for anyone to access on the internet. *Seamos Panarceros* is a children's book that touches on themes such as borders, migration, Colombia and Venezuela's shared history, human trafficking, and inclusion in a way children can digest.²⁰ It uses several fictional characters whose stories are inspired by the real-life circumstances and experiences of Venezuelans. Both of these books expose Colombian children to the realities of the Venezuelan experience which can counter any misconceptions that they may have been taught. These books serve as an engaging and accessible intervention to both prevent and combat anti-Venezuelan xenophobia.

A recent study with a subject pool of 897 people has further shown that online interventions such as video games and documentaries can increase altruistic attitudes toward Venezuelans.^{21,22} The video game allows the player to take on the role of a forcibly displaced Venezuelan by thinking through her choices. On the other hand, the documentary highlights the challenges that Venezuelans face as they cross the Colombian border. The game was associated with increased self-reported trust toward Venezuelans while the documentary was four times more effective in increased altruism in a shorter duration of time. Though both of these initiatives were not implemented in a community setting beforehand, this study proves that they can have a very positive impact on how host community members view Venezuelans which in turn reduces social discrimination towards them.

Ecuador

Unlike the initiatives discussed so far, Ecuador's Respiramos Inclusion (Breathing Inclusion) program is mostly aimed at educators and school staff.^{26,48,49} As a collaboration between the Ministry of Education, humanitarian aid organization World Vision, and United Nations High Commissioner for Refugees (UNHCR), the program was developed to prevent violence and target different forms of social discrimination including xenophobia and racism.⁵⁰ Since its start in 2013, more than 127 educational institutions have joined and have impacted over Ecuadorian 170,000 students.⁵¹ Respiramos Inclusion has a series of introspective workshops and activities that equip educators with tools to make schools inclusive learning environments. Educators reflect on their prejudice and then develop pedagogies that encourage critical thinking. Students, parents, and caretakers can also attend art-based workshops which also help to transform social spheres. At least in one Ecuadorian town, Respiramos Inclusion is paired with an after school or extracurricular program that allows both Ecuadorian and forcibly displaced children to meet each other, play sports, and find safe spaces. To this point, an 11-year old Venezuelan boy in this program has stated that his classroom is very welcoming of him now.⁵² Several parents and educators have also noted that the program has made a difference at home and in learning environments. One parent has testified that she now takes an active role in dismantling xenophobia and that this program has improved attitudes toward Venezuelan children.²⁶ In June 2024, the three collaborating entities celebrated the completion of the implementation of Respiramos Inclusion in schools in Quito.⁵¹

Peru

Feminist community organizing also bridges solidarity between Venezuelan and host community girls and women. The Peruvian organization Quinta Ola (Fifth Wave) has several initiatives that accomplish this.⁵³ Among them is the Las Micaelas Solidarias program (funded by Germany) aimed to empower girls (ages 7 to 17) to be leaders and bond through sports.²⁴ It consists of 8 volleyball workshops and 2 workshops on women's rights. Parents have stated that the program has positively impacted their children's lives. Interestingly, they have also learned from their children's conversations, pointing to an intergenerational impact.⁵⁴ Chamas en Acción (Girls in Action) (UNHCR funded) is a multi-regional program comprising workshops on girls' and adolescents' rights, gender-based violence, human

trafficking, feminist organizing, and community healing.²³ At the end of the program, participants join a national network of adolescent feminist activists. On the other hand, Chamos en Acción: Somos Comunidad Y Luchamos Contra La Violencia (Boys in Action: We Are Community and We Fight Against Violence) (OIM, US German funded) is aimed at Venezuelan and Peruvian adolescent boys (ages 13-17).²⁵ This program constructs non-toxic ideas of masculinity and educates boys on identifying, preventing, and reporting gender-based violence. In this way, not only are girls forming communities to empower each other but boys are taught to not conform to violent notions of manhood. In these examples, it is clear that social cohesion through feminist organizing can be effective in fighting social discrimination against Venezuelan children.

CASE STUDY 2

Forcibly Displaced Somalis in the United Kingdom & United States of America

Decades of civil war, political instability, and recurrent climate crises have forcibly displaced over one million people from Somalia.⁵⁵ Children born during the civil war, who represent approximately 60% of the Somali population, often have never experienced life outside of a conflict zone and are particularly vulnerable to the range of physical and mental health challenges that result from the effects of trauma, discrimination, and social marginalization in host countries.⁵⁶ Compounding such issues, the context from which these forcibly displaced children come makes them particularly vulnerable to further psychological trauma. Somalia has one of the highest rates of mental illness in the world, yet, according to a 2010 report, there are only five mental hospitals nationwide recognized by the WHO, with no government investment in the mental health sector.⁵⁷

Forcibly displaced Somali children, especially girls, may also face heightened risks of gender-based violence within Somalia, during displacement, and in host countries. One in seven women within Somalia reported experiencing childhood physical or sexual violence, with higher rates among those with disabilities.⁵⁸ Displacement further amplifies these risks, exposing children to violence during transit and in refugee camps with inadequate protection. Such victimization has been strongly linked to depression and could negatively impact long term mental health outcomes.⁵⁹

This section focuses on the importance of culturally sensitive and community-centered interventions for forcibly displaced children through a reflection of Somali refugee communities in the United Kingdom and the United States of America.

United Kingdom (UK)

The UK has the longest-established and largest Somali community in Europe, with arrivals beginning in the late 1800s to 1960s.⁶⁰ In countless studies, Somali communities in the UK have been shown to have relatively high mental health needs with 48.1% of Somali refugees meeting Post-Traumatic Stress Disorder (PTSD) criteria.⁶⁰ However, Somali youth have very low rates of mental health service use, and often utilize alternative coping strategies such as religious practices, reliance on social networks, and community-led interventions.⁶¹ A large contributor to this low use of mental health services in the UK, apart from language misinterpretation and discrimination, is due to mistrust of Western-based mental health systems and cultural stigma towards those suffering from such issues.^{60,62} The following are ongoing UK-based mental health interventions which seek to address such issues:

Somali Hayaan Project (funded by the Mercers Trust)³⁰

The Somali Hayaan Project, based in Harrow, UK, aimed to reduce isolation that Somalis face when dealing with mental health issues due to community stigma, and provided better understanding of mental health and relevant services available in the area.³⁰ This intervention did so through building community infrastructure and resilience for mental health using recruitment and training of ‘peer campaigners’ within the Somali communities themselves. These ‘peer campaigners’ act as direct liaisons who are trained on mental health services available and are community members themselves, are intimately familiar with the Somali culture and identity.³⁰ The Somali Hayaan Project had four main areas of focus: (1) Group sessions run by both a certified advocate and “peer campaigners”, (2) Information meetings where professionals discuss issues specific to the community and provide updates on available services, (3) Support sessions where all community members are able to offer support, and (4) Advocacy which works to combat isolation of those with mental health conditions by the community through ensuring individuals can obtain services they need and want.³⁰ This intervention reached over 4,000 Somalis within Harrow, and 92% of those who participated in workshops felt less isolated and more valued

following their services.³⁰ Although this intervention was aimed at those 18 and older, the use of “peer campaigners” trained in understanding the Western-based definition of mental health and specific services in the area could be utilized more broadly for forcibly displaced children as it strengthens channels of communication and direct involvement of the community itself.

Somali Mental Health Project 2022/23 by RISE Projects & Assunnah Islamic Centre³¹

The Somali Mental Health Project was developed in May 2022 to support the Somali community (based in the North Central London area) in navigating mental health resources.³¹ The project has three main focus areas: (1) Parental engagement, (2) Community well-being, and (3) Youth engagement activities, which were delineated to holistically improve mental health with culturally-centered services.³¹ Therapy treatment sessions are held at the Assunnah Islamic Center, which is a community setting which many Somalis trust as a means of support and guidance in this area, and allows for effective outreach sessions that allow acknowledgement of religious and cultural understandings of mental health in coordination with resources for Western-based mental health services.³¹ Such sessions and workshops have provided a means of addressing the Somali cultural view of mental health in services by bringing such issues directly to a hub which is a cornerstone of the community and provides religious-based mental health care. This has helped to reduce community stigma and made resources more accessible for youth through direct community involvement.⁶³

United States of America

Similar to the UK, forcibly displaced Somalis in the US face significant cultural stigma towards mental health, and a lack of culturally appropriate services often leave these needs unmet. This reluctance, combined with systemic barriers, creates a gap in mental health care that leaves children without adequate support to process their trauma. The following are US-based interventions which highlight means of overcoming such cultural barriers and stigma towards mental health:

Accommodating and educating Somali students in Minnesota schools: a handbook for teachers and administrators; Minnesota, USA³²

A US-based educational intervention to bridge the cultural gap between forcibly displaced Somali youth and educators was a book published in 2004 titled, *Accommodating and educating Somali students in Minnesota schools: a handbook for teachers and*

administrators. This book was written as a means of providing educators in Minnesota schools with high Somali refugee populations a better understanding of how Somali culture impacts students' views on Western education and how to better understand their behavior through such a context.³² It does so through specific examples of situations that educators may face in a classroom, and compares a Western-based understanding to a culturally informed explanation of student behaviors based on Somali social and religious norms. There is mention of psychosocial stresses caused by PTSD and mental health issues caused by acclimating to a new country. It also provides educators with knowledge on how Somali culture and Islamic understandings of mental health may cause Somali youth to perceive personal mental trauma and hardship from a spiritual lens or as an inevitable fact of life, and how to navigate parent objections to psychological testing for their children based on cultural stigma.³² Providing educators and school administrators with this background allows them to provide culturally sensitive solutions based on better informed understandings of forcibly displaced Somali youth. Similar means of communicating information on culture and religion to practitioners and those directly providing care should be considered in potential mental health interventions for forcibly displaced youth.

The Somali Mental Health Program; Minnesota, USA³³

The Somali Mental Health Program, established in 1998 at the Community University Health Care Center (CUHCC) in Minneapolis, provides culturally tailored outpatient services to Somali refugees.³³ It offers psychiatric assessments, medication management, therapy, and case management for both adults and children, utilizing a community health approach through formal partnerships with other local health clinics.³³ Central to the program is the bi-lingual, bi-cultural provider model, where Somali clients are assigned providers who share their cultural and linguistic background and are trained in Western mental health practices.³³ This model helps build long-term relationships based on trust, addressing the challenges of cultural differences and the lack of equivalent Somali vocabulary for Western-based mental health concepts. Additionally, in Somali culture, mental health is often viewed through a binary lens—as either physical illness or spiritual distress—making it difficult to discuss mental

illness in ways that align with Western models.³³ The program works to bridge this divide by educating both the Somali community and professionals on respective understandings of mental health through presentations and printed resources, which has reduced stigma and promoted greater acceptance of Western-based mental health care.

Furthermore, the program employs a multidisciplinary team of Somali mental health counselors, psychiatric nurses, family therapists, and licensed social work supervisors, who meet regularly to discuss both community-wide issues and individual patient cases.³³ This holistic approach integrates mind-body-spirit principles in treatment, as Somali culture views these aspects of mental wellbeing to be intertwined rather than separate like in Western-based culture.³³ Treatment groups, where patients discuss mental health progress and difficulties, also create a safe space for community sharing and progress tracking, further reducing stigma. Additionally, the program emphasizes client and family education, empowering Somali families to navigate the mental health system and fostering culturally sensitive care for professionals working with the community. Overall, the Somali Mental Health Program serves as an effective model for bridging cultural gaps in mental health care and promoting the well-being of Somali refugees and immigrants. Lessons from this must be applied to broader interventions for educational initiatives to improve mental health outcomes of forcibly displaced children.

CASE STUDY 3

Forcibly Displaced Ukrainians in Germany, Poland & the United Kingdom

Since the escalation of the Russo-Ukrainian War in 2022, over 6.7 million people have been registered as refugees outside of Ukraine, with another 3.7 million internally displaced.⁶⁴ For many children, the violence and trauma of war have not only been physically harmful, but left lasting psychological scars, contributing to conditions such as PTSD, anxiety, and depression. A study on the mental health impact of the 2014 invasion found that 60.2% of adolescents had witnessed armed attacks, while 13.9% had been direct victims of violence.^{65,66}



Figure 4: Two million Ukrainian children have been forcibly displaced from their country, seeking refuge across borders. (Picture distributed under creative commons license from President Of Ukraine from Україна)⁶⁷

This section focuses on pointed educational policies designed to equip young children with the life skills and coping strategies necessary to strengthen their mental health and psychosocial development. Furthermore, it highlights programs that support the caregivers of children, helping them acquire employable skills and foster hope for a positive future despite their families' hardships.

Germany *A Case for Bridging Education*

As highlighted in the discussion of policies in Poland, many Ukrainian caregivers opt to enroll their children in online Ukrainian schools alongside local education systems. This dual enrollment allows students to benefit in a multitude of ways. Foremost, they maintain a strong connection to their culture and heritage. Secondly, they work to secure a diploma that may prove valuable if they return to Ukraine. Lastly, the additional structure provided by the lessons and homework of their two schools helps to build resilience and fortitude for students dealing with anxiety about the world around them. These positives come together and ensure that dual schooling truly expands the opportunities of these children, expanding their future opportunities and granting them greater control over their life trajectories.³⁹

German schools have excelled in balancing this dual-schooling approach with additional personalization. Some of these initiatives include the organization of communal breakfasts to help students form new social connections. Other schools have led school walkthroughs to ensure that students feel comfortable with the layout of the school and the staff they may learn from. Furthermore, German schools have upheld their commitment to social cohesion and dual education by making logistical adjustments to help accommodate Ukrainian children. These adjustments ensure the two school schedules can blend seamlessly for children to attend both sets of lectures and exams, and grow as scholars.

Poland *Ensuring Education and Engagement*

The Polish Education System has instituted mandatory enrollment for Ukrainian children for the 2024-2025 school year, a reform strongly advocated for by European Commission experts. This policy aims to develop resilience in young children and further establish unity between Polish and Ukrainian populations as students interact and learn together. Although many caregivers still try to enroll their children in online schools to preserve Ukrainian culture and

Policy Recommendations



Figure 5: The three policy recommendations stemming from our analysis of psycho-educational interventions and case studies.

language, the compulsory in-person attendance has proven beneficial for students who are eager to move away from online learning. In-person classes are often more engaging, minimizing the frustrations of internet disconnections and the distractions common in home environments.

Nevertheless, challenges remain in fostering positive relationships between new students and their Polish peers in the post-displacement setting. A report by the Centre for Civic Education (CEO) in Warsaw highlights how Ukrainian children face a spectrum of attitudes from Polish students, from kindness and support to indifference or even hostility.⁴⁰ Despite these hurdles, many students have found that sports and art provide effective ways to bridge these social divides. Activities like winning soccer medals and bonding over Polish comic books have helped displaced children find common ground and build friendships, mirroring how teenagers connect globally.⁴¹

United Kingdom (UK)

The Facework Ukraine Project, London, England

Nearly 250,000 Ukrainians have registered as refugees in the UK, navigating a new cultural ecosystem as they rebuild their lives. While children adapt to new schools and environments, caregivers often face the daunting task of learning a foreign language and securing financial stability.

Many Ukrainian mothers have taken low-paying jobs, far removed from their previous professions, leading to dissatisfaction and anxiety as they struggle to balance earning a living with the pressures of social and cultural adjustment.

The Facework Ukraine Project Pilot has been addressing these challenges through employability training tailored to working women in the Ukrainian refugee population. This gender-responsive program provides education and mentorship to women — helping them transfer university credits, obtain degree accreditation, and develop soft skills essential for meaningful employment.⁴² By empowering caregivers to pursue careers aligned with their passions and expertise, the program not only enhances their economic stability and sense of purpose but also creates a more stable and supportive environment for their children. Recent psychosocial research underscores this connection, showing that mothers' job autonomy during a child's early years directly predicts fewer behavioral problems and more adaptive skills in children.⁶⁸ This highlights how initiatives like the Facework Ukraine Project can have a profound, multigenerational impact, fostering both caregiver well-being and healthy child development.

POLICY RECOMMENDATIONS

Enhance Gender and Culture-Sensitive Mental Health Literacy for Key Actors (e.g. students, parents, school teachers, community leaders) in Educational Post-Displacement Settings

Displaced children face gender-unique social challenges that are often exacerbated by the trauma of displacement and the challenging process of resettlement. The UNHCR recently reported a 50% spike in conflict-related gender-based violence against forcibly displaced girls and women.⁶⁹ Girls and adolescents are also affected by misogyny and restrictive gender roles which are context-dependent.⁷⁰ LGBTQ+ (queer) children may also face gender-based violence, homophobic, transphobic, and heteronormative discrimination and restrictions at home and in larger society.⁷¹ It is critical for community actors to acknowledge and address how systemic discrimination embedded in social norms have an impact on the mental health of forcibly displaced children. The government can aid in accomplishing this by implementing a curriculum that enhances gender and culture responsive mental health literacy in education settings. We broadly define mental health literacy as general knowledge on wellness, recognizing symptoms of mental unwellness, risk factors of trauma, and knowing where to find help for mental health conditions. Teachers, community leaders, and families in educational settings would be encouraged to take an active role in creating spaces that encourage social wellness for children, prevent discrimination, and target prejudice that lead to prejudice and violence against forcibly displaced girls and queer children.

As seen in the Ecuador Respiramos Inclusion initiative that was supported by the Ministry of Education, schools were able to adopt a framework that helped educators confront their own prejudice and learn about systems of oppression that lead to xenophobia, misogyny, and racism. The workshops and activities that underlay this framework helped educators make schools more inclusive of different identities that children and adolescents have. Host country governments can follow the example of the Ecuadorian Ministry of Education by implementing policies that require educators to take training focusing on gender-sensitive mental health literacy. In this sense, educators will be able to 1) introspect and learn about different forms of social discrimination with an emphasis on the challenges that boys and girls, including LGBTQ+ children, face, 2)

recognize the negative consequences of social discrimination against forcibly displaced children on mental health, 3) make educational spaces more inclusive of the varying identities and experiences of displaced children and 4) intervene when a forcibly displaced child is being marginalized and/or needs mental health services.

The Respiramos Inclusion initiative in various cases has also included workshops, games, community activities, and extracurricular programs that children and families could participate in. These programs are important for involving the wider community in being part of the change. Similarly, in Peru we found similar programs like Las Micaelas Solidarias, Chamas en Acción, and Chamos en Acción that empower host countries and forcibly displaced children and adolescents to build community and be engaged in gender-based violence prevention and social justice. There is an opportunity for policies to also implement similar programs as part of the curriculum that focus on gender and sexual orientation-sensitive mental health literacy in a way that children and adolescents can digest. Forcibly displaced children would be encouraged to learn about their legal rights and protections and where they can go to seek out help.

Mental health literacy should be incorporated into school curriculums, and educators must be equipped with knowledge about trauma-informed approaches in order to support children who may have faced violence or separation from their family. On the community-level, peer support networks can be particularly beneficial for children experiencing isolation. By creating safe spaces where they can share their experiences and seek mutual support, communities can help displaced children feel less alone in their struggles.

The success of programs like Las Micaelas Solidarias in Peru, which helps empower girls through sports and leadership workshops, can be expanded to include mental health education and peer counseling components in multiple other communities. Using the example of the Accommodating and Educating Somali Students handbook used in Minnesota, similar educational resources should be created and mandated for schools in countries hosting Somali migrants. Such resources are essential in implementing cultural competency training in helping children who may perceive mental health and education through a specific cultural or religious lens. Educators

must also learn to recognize signs of trauma, such as withdrawn behavior, and be better equipped to respond in a culturally sensitive manner.

Transform Health and Legal Frameworks Through Culturally Informed Education on Displacement Experiences⁷²

Health and legal frameworks that fail to recognize the unique obstacles faced by displaced children can further increase their vulnerability to exploitation, marginalization, and mental health challenges. These frameworks must explicitly protect the rights of displaced children and address their unique psychological needs, while also addressing unique cultural and gender-specific concerns. Enhancing appropriate mental health literacy into policies on the government and community-level is essential so that policymakers, law enforcement, and social service providers receive appropriate training on the displaced experience.

These policies must include access to education, health-care, and social services, regardless of legal status, as well as provisions for mental health care as part of a child's right to receive holistic support. Seamos Panarceros in Colombia, encourages understanding through the use of shared narratives. It can serve as a model for policies that promote legal literacy among displaced children and their families, helping them navigate complex legal systems. Social workers must also be trained to recognize the cultural barriers that might prevent displaced families from accessing care, such as stigma, religious views on mental illness, or the perceived incompatibility of Western mental health practices with religious teachings. In many communities, mental health challenges may either be ignored, or highly stigmatized. For these reasons, children may not easily open up about their struggles or may even think that their challenges are not worth mentioning. These barriers can become significant for an individual's own health and access to resources.

Health interventions specifically designed for displaced children must focus on addressing barriers such as language differences, cultural disparities, and legal uncertainties in host communities. They must also adequately address needs such as reproductive health for women and recognizing signs of trauma related to gender-based experiences. Support services for survivors of gender-based violence, including counseling, medical care, and legal assistance is crucial for addressing trauma and promoting healing. Employing multilingual staff or interpreters, while also offering language classes for displaced children can help them better navigate the healthcare system and

communicate their needs effectively. Designing health programs that recognize, respect, and incorporate culture and gender differences can increase participation and effectiveness. Legal support can include assistance with documentation, understanding eligibility for services, and advocating for their rights.

Initiatives must include the use of culturally sensitive educational materials and the involvement of health workers who share the same cultural background as the target population. It is also essential to build the capacity of educators and healthcare workers so that they can recognize and respond to the mental health needs of children. By promoting culturally sensitive legal literacy, forcibly displaced communities can obtain the help they need. A good model for this is the Somali Mental Health Program in Minnesota, which works to educate both Somali families and healthcare providers about the intersections of Somali cultural views on mental health with Western practices. This in turn helps create a safe environment for children to heal. Frameworks like this are essential to encourage multi-disciplinary, cross-sector cooperation that meets the diverse needs of displaced children.

German schools have provided examples that prioritize social cohesion and inclusivity, offering support such as communal breakfasts and school walkthroughs to help displaced children adjust. Similar policies should be introduced in other countries to ensure that a child's cultural backgrounds and previous educational experiences are acknowledged and integrated into their host schools. Although many times, the resources may already be there, they become limited in their effectiveness when they are not properly framed for the displaced experience. The Facework Ukraine Project in the UK, which supports refugees in transferring university credits and finding employment, also addresses some of the economic barriers that can prevent families from accessing mental health services. By reducing these barriers, economically stable families can provide a safe and comfortable space for their children.

Prioritize Programs and Initiatives to Strengthen Community Awareness of Displaced Children's Mental Health

Public campaigns can be effective in reducing stigma around mental health for children in displaced settings. By having conversations around the psychological and emotional challenges faced by displaced children, a collective effort towards community support can be encouraged. The Respiramos Inclusion program in Ecuador encourages

educators to create inclusive environments, and is an example that can be expanded to include community-wide programs that engage parents and local leaders. Programs that bring together displaced and native communities in shared activities can help foster mutual understanding and reduce social isolation. El Libro Viajero in Colombia is an example that fosters empathy by allowing Colombian children to understand the feelings and experiences of Venezuelan displaced children. Such initiatives help build solidarity. Expanding these programs to include activities focused on mental health, such as group counseling or art projects, can help children process their experiences and build resilience.

The interconnected nature of social identities when it comes to race, class, and gender, often results in overlapping and independent systems of discrimination or disadvantages for forcibly-displaced children. The intersecting identities can have a profound impact on children's mental health and access to resources. Programs working with forcibly displaced children must focus on creating safe spaces for these children. For girls, this may mean providing an environment where they can discuss issues related to gender-based violence or receive education on reproductive health. For boys, these safe spaces may address pressures of masculinity and provide support for those who have experienced or witnessed violence. To support LGBTQ+ (queer) children, anti-discrimination policies should be prioritized into services and inclusive language should be used to ensure all children feel safe and accepted. Organizing workshops and seminars that educate communities about the mental health challenges faced by displaced children and how they can vary based on gender and intersecting identities, are not only more effective in properly addressing their needs, but are also essential in reducing stigma and marginalization in host communities. Prior to implementing community programs, organizations should collect data on the mental health needs of displaced children, disaggregated by gender and other intersecting identities. They must then also establish mechanisms for children and their families to provide feedback to continuously improve services and ensure they are meeting the diverse needs of the community. Policies should prioritize funding for community-led mental health campaigns like the Somali Hayaan Project in the UK, which utilizes local leaders from within the Somali community to disseminate mental health

information and resources. These programs work at a community-level to provide safe spaces where youth can openly discuss their mental health and be empowered to seek support. Programs should also teach coping strategies and resilience-building, acknowledging the compounded stressors faced by displaced children. Creating culturally responsive mental health services in spaces that are more familiar for children helps foster an environment they feel safer in. The integration of sports, art, and peer mentorship programs into school systems, such as those implemented in Poland, can help forcibly displaced children build social connections while combating stigma and creating new friendships. Community outreach programs promoted by local governments can facilitate dialogue between forcibly displaced and local communities, while promoting understanding and acceptance.

CONCLUSION

Forcibly displaced children represent one of the most vulnerable populations globally, with multiple intersections of trauma occurring pre-displacement, during displacement, and post-displacement. This study highlights the intersection of mental health with education, social integration, and long-term health while emphasizing the need for pointed interventions to address these needs and provide a pathway toward resilience and recovery. Evidence from case studies in Venezuela, Somalia, and Ukraine underscores that culturally relevant, community-based, and family-centered educational frameworks are essential for mitigating the long-term psychosocial impacts of forced displacement.

Educational interventions, when designed to be culturally and contextually sensitive, serve as more than academic tools—they are essential mechanisms for mental health promotion, trauma recovery, and social inclusion. Initiatives such as caregiver training, dual-enrollment systems, and peer-based psychosocial support not only enhance mental health outcomes but also strengthen the social fabric of host communities. Addressing mental health challenges requires a whole-of-society approach, linking policymakers, educators, and healthcare providers together to leverage these insights and bridge the gap between immediate humanitarian needs and long-term development goals

for displaced children and their families. The lessons from these psychoeducational interventions must be incorporated into developing public policies that support the mental health of forcibly displaced children and their families. Lastly, future research should continue to evaluate and refine these interventions, ensuring they remain adaptive, scalable, and effective when they are needed.

About

The Global Health Studies Multidisciplinary Academic Program (GHS MAP) is a Yale College undergraduate program supported by the Jackson School of Global Affairs.⁷³ The program supports students interested in understanding and addressing pressing global health challenges. Undergraduate students at Yale College, all of which are student researchers and key contributors in the planning, drafting, researching, interviewing of this report engage critically and analytically in global health from multiple disciplinary approaches. In doing so, students are able to integrate different fields to encourage the development of effective policies and strategies in addressing key problems in global health.

The GHS MAP supports students, through rigorous training and engagement, to develop skills and knowledge relevant to global health research and practice. A cornerstone of the program is the Global Health Research Colloquium, which the authors of this report enrolled and completed in Fall 2024. In this capstone research course, students collaborated with multilateral global health partner organizations to help develop real-world policy interventions aimed at addressing a particular global health issue or challenge.

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