



**“Improving the mental health of children in conflict affected and
low-resource settings: from children’s steps to a leap forward”**

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The journey to this moment starts in 1999, when I was a freshly graduated child psychologist. Through influences that were not entirely, or entirely not, in my control I moved abroad. The primary influence was my love for the person who has become my life-partner, who had decided to go to Nepal to work, and my roots having grown up in a family that was shaped by living in Tanzania for years prior to my birth – an experience with ripple effects well into my childhood. Having arrived in Nepal, working on setting up counselling services for street children and then for the Center for Victims of Torture, I was moved to contact what seemed to me like a large international organization called Transcultural Psychosocial Organization. This organisation – with Professors Joop de Jong and Ivan Komproe at the helm - seemed to be doing exactly what I was interesting in doing – developing mental health care in countries like Uganda, Cambodia, Burundi and Nepal. They were doing global mental health *avant-la-lettre*, bridging research and practice by working to establish mental health care systems in low and middle income countries, following an approach of training non-professionals in what is now called *task-shifting*. These themes have remained the red line throughout my work, and converge in the overarching question for my Chair in Child and Adolescent Global Mental Health: How can we improve the mental health and psychosocial wellbeing of children in low and middle income countries - particularly in humanitarian settings?

Like so many academics before me, I stand on the shoulders of giants who have shaped the field that has now become to be known as **Global Mental Health**. Historically, the study of mental illness in non-Western settings can be traced to the colonial psychiatry of more than a century ago, when the German

psychiatrist Kraepelin conducted research in Java, Indonesia. Since then the field has been characterized by two epistemologies. The first is the “emic” approach of anthropologists and cultural psychiatrists who studied mental illness as shaped by contextual and cultural factors. The second is “etic” approach of clinicians and epidemiologists who interpreted mental illness in universal- typically biomedical— frameworks. Since the 1970s a group of scholars, such as Professors Joop de Jong and Laurence Kirmayer, started to bridge this divide in what was being coined ‘transcultural psychiatry’. They aimed to balance and converge - as complementary schools of thought - the biological and cultural foundations to understanding mental health and illness.

This thinking led to the emergence of Global Mental Health as a multidisciplinary field that integrates insights from the traditional medical sciences with those from the social sciences, including medical anthropology and – most importantly - public health. For me, the primacy on public health thinking is an important progression from the previous iterations, and it is captured by the definition put forward by colleagues Martin Prince and Vikram Patel. They define Global Mental Health as being the *‘area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide’*.

The focus on ***improving mental health for all*** is a central concern of mine. ‘Improving mental health’ means thinking about how best to address mental illness within any given cultural context, over and above a focus on understanding the development or manifestations of mental illness. ‘For all’ means taking a population perspective involving the spectrum from interventions that promote mental health, interventions that prevent the development of mental illness and treatment for people who do suffer from mental illness.

A recent milestone in the history of our field is our publication of the Lancet Commission on Global Mental Health and Sustainable development, led by Professor Vikram Patel. This paper brings together much of the learning from the many decades of development to propose this: “First, mental health is a global public good, relevant to sustainable development in all countries. Second, mental health problems exist along a continuum from mild, time-limited distress to chronic, progressive and severely disabling conditions. Third, the mental health of each individual is the unique product of social and environmental determinants, in particular during the early life course, interacting with genetic, neuro-

developmental and psychological processes. Fourth, mental health is a fundamental human right for all people.”

Global Mental Health is driven by a need to address a deep-rooted and long-existing problem - that of the enormous amount of suffering associated with untreated mental illness. The vast scale on which mental disorders occur has become clearer in recent years, with data showing that the disease burden attached to mental illness, captured in a metric called DALY (disability adjusted life years), is approximately 14% of combined illness burden. In contexts of low resources and humanitarian crises, this vast problem is met with a near-total absence of quality services. This gap between need and availability of care is called the ‘treatment gap’ - and it is estimated to be between 95% and 99% in these settings. While current thinking explicitly goes beyond only treating mental illness, as I mentioned before, the stark reality of this treatment gap provides the backdrop for much of the work that my colleagues and I do.

As my Chair will predominantly focus on mental health for children and adolescents, I believe it is useful to zoom into the situation of this group. Interestingly, attention for children and adolescents oftentimes comes after the attention given to adults. The evidence-base for mental health interventions for children and adolescents trails that of adults. This shortfall is also financial - we have found that of all the money spent on mental health as part of development aid, only 16% of an already very limited amount is spent on children and adolescent mental health programs. This underrepresented attention is strange for a number of reasons. It is primarily strange in terms of sheer numbers – children and adolescents by far represent the majority of the population in low- and middle income countries. And from a public health perspective, there are several compelling arguments for prioritizing child mental health.

Acting early in the life course is key to preventing mental health problems later in life. This is because the majority of mental disorders in adult life have their onset in childhood. Neurological changes during the ‘sensitive periods’ of childhood and adolescence provide major opportunities to positively impact upon the developing brain. Childhood neglect, maltreatment and deprivation are among the strongest risk factors for future mental health problems. Yet there remains an enormous lack of child mental health services across the public health spectrum, with young people having the lowest rates of access due to under-detection, poor awareness and help-seeking and insufficient priority in policy frameworks.

So, let's turn our attention to ***what we can do about this***. The themes that have been constant throughout my work, and which I hope to continue throughout the combined work at the University of Amsterdam and War Child, center on two key questions. The first is: *How to set up services that improve the mental health and psychosocial wellbeing of children in the absence of existing services?* The second is: *How can effective care be delivered so that it is scalable and impactful?* In the remainder of my talk I will try to unpack these relatively simple questions, which represent the two pillars of my Chair: First, a care system approach. Second, a roadmap to impact.

The Care System Approach

Within the development and humanitarian sector, mental health and psychosocial support is clearly en vogue, most recently shown by the Interministerial Summit on Mental Health and Psychosocial Support in Emergencies. Contrast that with just a decade ago when there was little attention paid to, and scant consensus on the place of such services. This change is, to a degree, characterized by the co-creation and publication of a set of guidelines in 2007 on how to set up mental health and psychosocial support in emergency settings, under the auspices of the Interagency Standing Committee. One of the foundational principles of these guidelines is to think in terms of multi-layered support. There are different levels of support that correspond with the different ways in which violence and emergencies affect populations.

Take the example of children affected by armed conflict. 420 million children grow up in conflict zones – that's nearly one in 10 children worldwide. 140 million of them live in high intensity conflict zones. 2 million children have lost their lives in the past decade due to conflict. 10 million children are refugees. 20 million children are internally displaced. Beyond these dry numbers lie stories of hardship, suffering and resilience. While many children are able to develop and thrive in the face of significant adversity, all of them have to deal with the impact of war and violence. War results in grave violations against children in many conflict-affected settings, including killing and maiming; the recruitment and use of children in armed groups; sexual violence; abductions. War results in increased risks of both short- and long-term mental health and psychosocial problems among children – and this results in high levels of post-traumatic stress disorders, depression, behavioral or substance abuse problems. 1 in every 5 people at any point in time in conflict-affected populations have mental health problems. War results in schools and educational systems that no longer function - depriving some 27 million children of their

right to learn. War disrupt and erodes the social and moral fabric of communities - increasing risks of child abuse, neglect and maltreatment. War results in the shifting of behavioral norms including increases in disrupted family environments, and the intergenerational transmission of trauma, which can exacerbate and perpetuate the social, emotional, and economic consequences for young people. The combination of these social determinants of mental health, and daily stressors as promoted by colleague Miller, are part of the constellation of factors that need to be addressed to improve children's psychosocial wellbeing and mental health. This means moving towards a *systems approach*.

A "system" can be understood as a combination of services that come together for a purpose. This sees us move away from a singular intervention focus to one that combines a set of multilevel and interconnected interventions that together cover the different needs of a population – such as those outlined above for children affected by armed conflict.

This brings me, again, to the relevance of a public health approach, defined as "the art and science of preventing disease, prolonging life and promoting health *through the organized efforts of society*". Public health focuses on the entire spectrum of health and wellbeing - not merely the eradication of particular diseases. Why is this so relevant? This approach provides the mandate to go beyond a focus on only those that have a mental disorder – for example, previous efforts to improve the mental health of conflict-affected children solely focused on reducing post-traumatic stress disorder – but also to think beyond the more narrow confines of the health sector and in addition address some of the social determinants that contribute to wellbeing and can prevent mental illness.

In adopting this approach we also operationalize the true meaning of 'psychosocial', by intervening in social processes related to psychological suffering. It also leads to employing an integrated approach, one where efforts in education, health and protection are not isolated but instead combined in a package of services and interventions to address the spectrum of needs - thereby truly embracing a population-based approach. But how can we do that in volatile settings with limited care infrastructure? The main approach is based on the aforementioned 'task-shifting', which refers to the notion that non-professionals implement tasks that are traditionally the domain of specialists, who in turn shift their attention to capacity building, supervision and addressing the most severe cases. To give an example; I have been involved in a project called the Programme for Improving Mental Health [PRIME] that has shaped a lot of my thinking. This project aims to integrate mental health services in primary health care

by training primary health care workers to detect, diagnose and treat people with mental disorders. After years of developing, implementing and evaluating this population-wide mental health care package, the results are promising. We were able to demonstrate that six months after a brief training, health workers detected 1 out of 4 patients with depression and 3 out of 5 patients with alcohol use disorder among patients presenting to primary care facilities. Subsequently, of the patients detected with depression and alcohol use disorder 95% received minimally adequate care. As a result, those receiving treatment for depression, alcohol use disorder, or psychosis showed improvements in both symptoms and daily functioning at 12 months after starting treatment.

These findings are compatible with synthesis of the evidence of task-shifting by non-specialist health workers and of psychological interventions. It actually seems to work. So, is task-shifting the silver bullet? Not quite. Or rather, it is only a starting point. That's because the evidence base for interventions for children is much less clear. But also, how do you go about task-shifting if there is no functional health-system to integrate into? To what degree does task-shifting become task-dumping on already stretched non-professionals? So let me return to the question: *How do we set up services that improve the mental health and psychosocial wellbeing of children in the absence of existing services?*

Enter War Child. When this job opportunity came along, several in the audience know the difficulty I had in deciding to take on the challenge of setting up a research department in War Child. Yet I could not have wished for a better place to work on the previously outlined dilemmas.

My colleagues and I drew on the design characteristics mentioned above - namely integrated multi-sectoral care; a public health and population-based approach; a reliance on task-shifting, and working across all socio-ecological levels – to begin to develop a blueprint for a system of care. The development of the combined interventions is central to the research focus of my Chair, so I will elaborate a little on the content of these services – a set of 9 interventions.

Two of the psychosocial interventions have a distinct preventive focus. One sees children acquire a set of life skills, which aim to strengthen their resources to cope with the adversities they experience. Another intervention is geared towards improving social connectedness, normalcy, emotional regulation and a sense of hope and self-efficacy through movement-based activities. Following the population-based approach, these interventions target all children in the vulnerable contexts where War Child works. For those amongst us that have struggled with definitional issues of prevention, we see these are

selective preventive interventions. And we know from experience and epidemiological data within this group that there will be between 20-40% of children who show moderate to severe internalizing or externalizing problems. For this subgroup, we have, together with the World Health Organization, developed an intervention called Early Adolescent Skills for Emotions. This intervention combines a set of specific evidence-based therapeutic components - including problem solving, behavior activation and promoting social support – that target severe emotional distress. We hope these interventions make children feel better – but if we are not addressing some of the determinants or causes of their distress, our efforts may be in vain. That’s why we also focus on the family, school and community. It is widely recognized that a positive and nurturing family environment is essential for child development and wellbeing. Indeed, secure and consistent caregiving relationships can play a critical role in helping children to cope effectively with the various stressors present in contexts of violence and armed conflict. Yet in these settings, caregivers are exposed to these same stressors, can have high rates of distress and may have difficulty in providing responsive and effective parenting. As a result, we have two interventions focusing on the family context. Our caregiver support intervention combines improving parental wellbeing with parenting support, based on the hypothesis that parenting support only really works if wellbeing is addressed. For some families the effects of armed conflict compound those of other structural problems such as poverty, inter-partner violence and parental mental illness. Another intervention in the care system aims to support those multiple-problem families, following a multi-component approach to address the combination of stressors. Another well-established and robust risk factor is child abuse and neglect. These problems are so deep-rooted in many contexts that a case-by-case approach is barely feasible. For that reason our community-driven child protection intervention aims to strengthen community owned and led action to prevent child abuse, through local champions leading a process of understanding the problem and formulating and implementing change. Finally, the important role of education. Like parents and caregivers, teachers play a vital role in positively or negatively influencing children’s wellbeing. By having an intervention that addresses teachers’ wellbeing, as well as improving the classroom climate and teachers’ social emotional skills in dealing with children, we hypothesize that teachers can provide better social, emotional and academic learning environments.

But what about the children that do not even have teachers as a result of conflict, or those who have no access to quality education at all? Another intervention, Can’t Wait to Learn, provides a solution to help close this global education gap. The programme offers children the opportunity to learn to read and do numeracy through playing educational games on tablet devices.

I recognize the need for this care system to be implemented within the real-world contexts of humanitarian work - contexts which are complex, variable and unpredictable. That's why a number of interventions will support the implementation of the interventions and promote access to care. First, we are developing a tool to proactively identify children and families who may benefit from the more targeted interventions mentioned above, and promote uptake of these services. This tool, made up of illustrated narratives depicting common examples of children experiencing emotional, behavioural and/or family problems, will enable us to more effectively allocate interventions to higher risk children and families. Together with colleagues in Nepal, we have worked on this tool to get adults with mental health problems to seek help, and have been able to demonstrate that community members using this simple tool resulted in a 50% increase in help seeking among people requiring mental health services. We are now evaluating whether the approach will also work with children. Another significant barrier to accessing services is stigmatization. Our approach to tackling stigmatization and discrimination encompasses distinct steps to increase the understanding of stigmatisation within communities and offer specific strategies that can be employed to reduce the drivers of stigmatization – aiming to positively impact children.

This short description of the content of the system of care hides a multitude of research questions and considerations. What is already known about how to address the problems outlined above? How can we ensure the relevance of the interventions within the cultural contexts of Gaza, Lebanon or Ugandan refugee settlements? How best to implement the intervention, and how is it perceived by those participating? Having answered these questions and finalized the development of the intervention, it leads to the second overarching question of this Chair: *How can effective care be delivered so that it is both scalable and impactful?*

The Roadmap to Impact

To answer this question we are proposing a model that unpacks the question into a roadmap that aims to demonstrate a practical trajectory from current practice to demonstrating actual impact. A model that bridges academia and practice. First, the model combines a research space with an intervention space. The research space involves intervention-level studies that transfer current practice to meaningful evidence-based practice. Second, the implementation space involves system-level work that transfers meaningful evidence-based interventions to large-scale impact.

As a starting point we take an intervention that is *relevant* within a given resource-challenged setting. Relevance is demonstrated by compatibility within the cultural context, and the degree to which the intervention addresses actual and current mental health needs within the target population. Only once the criterion of relevance is met, does it make sense to move towards the criteria of evidence-based care. The study of the effectiveness of mental health services is not new, and has been a building block for the development of psychological treatment for several decades now. Within humanitarian settings this push is more recent. After a first wave of studies focusing on demonstrating the prevalence and burden of mental health problems, the research agenda has shifted towards questions on the **effectiveness** of interventions. This has resulted in a burgeoning of randomized controlled trials in low and middle income countries. In a so-called umbrella review of 129 primary studies from ten meta-analyses, representing over 22,000 participants, there is robust evidence for psychosocial interventions for adults with depression, schizophrenia, as well as PTSD in humanitarian settings.

For children, the evidence base is much smaller with suggestive evidence only for children with disruptive behaviour or Post Traumatic Stress Disorder in humanitarian settings. This means that there is still some way to go for a package of interventions with a solid evidence base, covering multiple mental health conditions, as well as preventive interventions addressing the social determinants of mental health. This is inherent in the War Child care system.

Besides demonstrating effectiveness, there is also a need for dismantling studies to better understand the mechanism and pathways by which interventions are effective, if we want to maximize the effect of interventions. So, more investment is needed in the 'research space', in order to drive practice that is relevant and effective.

For those interventions that do meet both of the aforementioned criteria, the next challenge is how such interventions can be implemented to make scale up feasible. We now enter the implementation space in the model. This domain of study, implementation science, is gaining momentum in global mental health. Yet initiatives that focus on the implementation science are typically research studies - **but what about the real world?** How can we ensure that interventions have the intended results on a large proportion of people in need of care? Our model does that by again proposing a number of criteria along two axes; a quality of care axis and a feasibility axis. In order to assure that the results

demonstrated in a well-controlled trial are also achieved in a real-world setting, we propose that three quality criteria are assessed – competence, adherence and attendance.

Competence is defined as the extent to which a service provider has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects. Adherence is defined as the extent to which a psychological treatment is delivered well enough for it to achieve its expected effects. This covers participants needing to receive enough of the intended content - attendance. We argue that - with this minimum set of criteria - a program can assess quality of care at scale. And if adequate levels of competence, adherence and attendance have been obtained, the positive outcome, as demonstrated in the research space, can be assumed, rather than needing to be measured, which is often not feasible at scale.

For example, a service provider can be highly competent, but if different content is implemented (that is low adherence) we cannot then assume a positive outcome. Similarly, if a provider meticulously follows the manual, but lacks core therapeutic skills and competencies, again a positive outcome cannot be assumed. The same goes for service providers that demonstrate high levels of competence and adherence, but where participants are dropping out of care. If, however, adherence, competence and attendance are all adequate, we can rely on the positive research findings – or else the evidence-based treatment paradigm does not uphold.

For this approach to work, there is a need for each of these criteria to be validated, such that we know what level of adherence, competence and attendance needs to be obtained to substantiate that assumption. Validation of the competence criteria is currently underway in an effort to guide the scaling of psychological treatments by the World Health Organization as well as War Child. This is based on prior work done with Brandon Kohrt and my colleagues at War Child to develop new tools that allow for the assessment of competencies, both for adults and children. We have developed feasible ways to assess the skills that are common across all mental health interventions.

In studies in Nepal and Gaza, we have already been able to demonstrate that such competency assessment, using standardized role-plays and life observations, captures changes before and after training, and can be used by multiple raters with sufficient reliability.

The monitoring of these criteria also allows for quality improvement. The tracking of levels of adherence, competence and attendance provides supervisors with an overview of what indicators fall below the validated thresholds. For example, if a group of service providers consistently score low on certain competencies or specific treatment components, or certain sessions are frequently skipped, then supervisors can remediate this with bespoke solutions. I hypothesize that such targeted quality monitoring is more cost-effective than approaches that do not have such data at their disposal. I do realize that for such approach to be operational, a central data-base is needed where data is stored and accessed. In fact, with War Child we envision that the validated quality criteria can become endorsed inter-agency standards. Any agency scaling up evidence-based treatment would therefore strive to achieve these standards, but also agree to report against them in the database or repository. And finally, if such data, at aggregate level, is made open access it will allow for monitoring of overall scaling efforts across geographic areas, interventions and organizations.

This brings me to the last axis, feasibility, and the associated criterion - coverage. This is vital because population-level impact is only achieved if a large enough proportion of those for whom the intervention is intended are actually reached. The level of uptake is expressed as contact coverage, and defined as the ratio between the number of people who have contacted the service and the size of the target population. It may be that a certain threshold level of coverage might need to be determined for scale-up to be deemed successful. Consider the PRIME program that evaluated the integration of mental health into primary health care services in five low and middle income countries. The program was unable, to demonstrate population-level changes in contact coverage in certain participating countries – even after significant efforts to make services available. Besides the supply-side approach, demand-side drivers will also need to be addressed in order to actually achieve significant changes in contact coverage. Community-level awareness raising, stigma-reduction approaches, proactive case detection and behavior change initiatives may be strategies that increase demand.

Whereas the assessment of the criteria along the quality of care axis are quite extensive, contact coverage can be calculated with the attendance data combined with epidemiological data on the prevalence of the condition the intervention is targeting. In fact, the combination of the feasibility and quality criteria provides us with a proxy calculation of effective coverage - the ratio of people who both received and benefited from the intervention. Effective coverage is the 'Holy Grail' for all scaling efforts in my opinion.

Robust data on relevance, effectiveness, quality and feasibility will also allow for improving the interventions. For example, attendance data may help us to determine the minimum number of sessions needed or contribute to research strategies to keep people in care. Relevance data will help us understand who the service delivery agent should be. Coverage data will allow for evaluation of strategies to overcome barriers to accessing care. The competence and adherence data will positively shape development of training and supervision to increase quality. In summary, for each intervention I've outlined here, I argue that, once evidence-based, monitoring adherence, competence and attendance against validated thresholds or standards, combined with a target for contact coverage, will provide the minimum set of criteria to guide the process of scaling interventions and achieve population-level impact.

I acknowledge that there are limitations to this approach. The main limitation is the viability of the evidence-based paradigm that forms the foundation of this model. First, while the notion of evidence-based care is increasingly adopted, one can argue that we are still far removed from having a solid evidence-base. Pim Cuypers, a professor at the Vrije Universiteit, and a master in synthesizing the literature on treatments in low and middle income countries, has argued that the effects that have been demonstrated in the literature tend to be over-estimated - provocatively asking whether psychological treatments work at all. That would represent quite a setback for the decades of effectiveness studies. Fortunately, in the nuances of his analyses, there is hope for treatments to be effective, just less robust.

A second challenge to the model is whether standardizing is possible. This harkens back to the debates about emic vs. etic approaches that I mentioned earlier. Consider the standardization of establishing evidence – many will be of the opinion that the impact of our interventions might not be captured by abstract self-report instruments, particularly among children and adolescents. That is a fair point - one that may explain the difficulties we are collectively having to demonstrate effectiveness of care for children in the settings where we work. But consider also the standardization of interventions across participants and across cultural settings. Are they so formulaic that we can presume that the processes by which change is obtained are universally relevant? At its core this touches on the cultural universalism and relativism debate that is a red line in medical anthropology. If manifestations of mental suffering and healing are inherently culture-specific (as relativists would argue), then replication of a common approach becomes conceptually challenging as they would differ *ad infinitum*; whereas the universality of mental disorders would allow for identical treatment. The latter point is rather naïve and

the former could serve to potentially deny people good care. This dichotomy is very outdated, with utility taking primacy over ideology. We are working with and from community perspectives in our care system to target contextual problems such as expressions of stigmatization and discrimination or beliefs that endorse forms of child maltreatment. I therefore very much look forward to engaging in an ongoing debate with my new University of Amsterdam colleagues on embracing a multi-disciplinary and mixed methods approach.

The two proposed pillars – the **Care System** and the **Roadmap to Impact** – may both be considered utopian, particularly in low-resources settings with limited infrastructure. That is why further research is needed to strengthen the evidence base, establish validated quality standards and demonstrate the real-world applicability of this approach. And this is precisely the essence of my Chair and the work of my colleagues and me in War Child and beyond!

The passion that drives me to do this work is to improve the mental health of children that have to cope with extremely difficult circumstances. With the research agenda that I have shared with you today, I hope that we can at least contribute towards closing the massive treatment and service gap for children affected by armed conflict. And that we can do so by facilitating the best quality of care, which these children deserve. I strongly believe that these children cannot be further punished by receiving sub-optimal care. And we should have the aspiration to provide quality care for **all** children in need of support. That we owe them. I owe them.

Thank you

With that, I have come to the final part of my speech – my opportunity to thank the many people without whom I would not be standing here today. For the confidence entrusted in me I am thankful to the Executive Board of the University of Amsterdam and the Dean of the Social and Behavioural Sciences Faculty of the University of Amsterdam. Thank you to the Supervisory Board of War Child – you have been an integral part of this journey, and I thank you for accepting, even embracing, the research work within War Child.

Much of the thoughts presented today find their origin in my work with my two PhD mentors, Professors Joop de Jong and Ivan Komproe. You have been responsible for my transformation into a researcher, for analytical thinking, for instilling the TPO approach – but most importantly for giving me the freedom to develop professionally. Professor Reis, Ria, I want to thank you for having been so

instrumental in the process of establishing this Chair - your guidance and trust were important for me to take this on. Mark van Ommeren, you are another person that was there at one of the crossroads. I also want to thank all my colleagues from the TPO Nepal family. Seeing TPO Nepal develop into what it is now has been an enormous source of joy. I must mention my many years of collaboration with Nagendra Luitel, Nawaraj Upadhaya and Suraj Koirala; I hope they have shaped you as much as they have me.

I also want to thank my new professional family, War Child. I want to thank Tjipke Bergsma, and the entire Management Team, for courageously supporting our research and development work and enduring my endless diagrams. While being somewhat distanced by the spurious constraints of being a researcher, I am deeply appreciative of the real work being done by everyone in Amsterdam and the 14 countries where War Child is active. And then, of course, the R&D team -Ken, Felicity, April, Kim, Rinske, Myrthe, Freek, Jasmine, Alexandra, Gabriela and Anna - as well as the research teams in Lebanon, Gaza and elsewhere – I hope I did justice to our collective work today. It is very exciting to be working on this with you. This is truly a joint endeavour.

Friends that are spread out over the world, but have been present and important throughout. Michiel, our friendship, joint projects and discussions provide a very welcome different perspective. Liesbeth, Paul, Pip, Saar and Bas – you have made the transition from Nepal to the Netherlands much easier to endure – I am thankful for the times we've shared together.

Drs. Tol and Kohrt. Wietse, the countless discussions, contemplations and our joint venturing into the world of research, has shaped me – much deeper than that presented today. Brandon, thank you for the incredibly stimulating and productive collaboration over all these years, your energy and support have made this possible. I count myself extremely lucky for having taken this journey together with you both.

And finally my dear family. I began this speech alluding to the seeds that were planted by all of you. The warm and accepting nest that you have created, the implicit and explicit values of doing something good and being a good person drive me.

Katia and Sayam. I hope you know that above all you are the most important to me. Katia, thank you for helping me keep a balance, but more importantly to keep looking at what is important. I enjoy our many

discussions. Sayam, when I am with you work is far away – I thank you for that, and for the joy you have given me for the past 19 years!

Within this somewhat pompous setting, I actually stand here in front of you very humbly. Wondering whether the work I do – and have laid out today – is meaningful in actually helping some children, unfairly affected by some unnecessary war somewhere, feel or cope better. It is that, and only that, which counts.

Ik heb gezegd.

Amsterdam, 21 November 2019