Napata College

Medicine Program

Community Medicine Department

Thesis title

Impact of war on children mental health in Sudan 2024

A proposal submitted In partial fulfillment of the academic requi rement for the degree of MBBS

Submitted By

Fatima Mahgoub Eltaher Adlan

Shahd JahallahAdam Alzaky

Wisal Mustafa Ibrahim Mohamed

Supervisor

Assistant professor

Dr. Murwan Eissa Osman

MBBS, MD Community Medicine

MSc Tropical Medicine and Infectious Disease

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Dedication

We would like to dedicate this work to our par ents, families, loved ones, and colleagues. If it were not for their continuous, everlasting supp ort and kindness, we would not be here.

Acknowledgement

We give thanks to our supervisor Dr. Murwan, who has provided guidance and wisdom throughout this process. He has been a beacon of wisdom.
We would also like to thank the administration of N apata College.
We would also like to thank our participants.

Abbreviations:

CAMH = child & adolescent mental health

CBT = Cognitive-Behavioral Therapy

IDMC = Internal Displacement Monitoring Center

IDPs =Internally displaced persons

NGOs = Non-governmental Organizations

PTSD = Post-Traumatic Stress Disorder

SPSS = Statistical Package for Social Sciences

SSA = sub-Saharan Africa

WHO = World Health Organization

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Abstract

This study was conducted in conflict-affected areas of Sudan, including regions with high levels of violence and displacement. Communities and refugee camps were selected based on accessibility and representation of diverse socio-economic backgrounds. The study sample included children aged 5 to 18 years residing in conflict-affected areas of Sudan, including internally displaced children and those living in host communities, in order to gain a comprehensive understanding of the impact of war on children's mental health.Variables Under Study:

Dependent Variables: Prevalence and severity of mental health disorders (post-traumatic stress disorder, depression, anxiety) in children.- Independent Variables: Exposure to violence and displacement status.- Confounding Variables: Age, gender, ethnicity, and previous trauma exposure.- Background Variables: Educational attainment, family structure, and access to healthcare services.

Results:A total of 100 displaced individuals from various residential areas across Sudan were interviewed, with a focus on the northern and eastern provinces of the country. 63% of participants were male, and 37% were female. Most participants (42%) were aged between 13 and 15 years, 24% were between 10 and 12 years, 23% were between 6 and 9 years, and 11% were between 16 and 18 years. Among the participants, 38% had been displaced for less than one year, 27% had been displaced for between one and two years, and 35% had been internally displaced for more than two years.

Mental Health Assessment:When asked, "How often do you feel sad or depressed?" 17% of participants responded "always," 27% said "often," 30% said "sometimes," 21% said "rarely," and 5% said "never."

Regarding sleep difficulties, 22% of participants reported experiencing them "always," 39% said "often," 33% said "sometimes," and 6% said "rarely."

When we asked, "How often do you feel anxious or fearful?" 15% said "always," 62% said "often," 18% said "sometimes," 3% said "rarely," and 2% said "never."

When asked if they had trouble concentrating, 17% of participants said "always," 28% said "often," 39% said "sometimes," 11% said "rarely," and 8% said "never."

We also asked participants if they suffered from physical ailments (such as stomach pain and headaches) associated with psychological disorders (like depression and PTSD). 4% said "always," 71% said "often," 17% said "sometimes," and 8% said "rarely."

Next, we asked participants directly how often they felt safe in their new settlement. 57% said "sometimes," 23% said "rarely," and 20% said "never."

We asked participants whether they had been given access to age-appropriate activities (such as games, competitive sports, etc.). 24% said "yes," and 76% said "no."

When asked about their optimism for the future, 3% said they always feel hopeful, 9% said they often feel hopeful, 27% said they sometimes feel hopeful, 54% said they rarely feel hopeful, and 7% said they never feel hopeful

We then asked participants to list all the challenges they face as displaced individuals (they could select more than one option). 51% mentioned food shortages, 79% mentioned lack of access to clean drinking water, 82% mentioned lack of access to education, 97% mentioned safety concerns, 47% mentioned separation from family, and 68% mentioned poor health conditions.

Finally, we asked participants how often they find themselves feeling angry or frustrated. 23% said "always," 42% said "often," 26% said "sometimes," 7% said "rarely," and 2% said they never feel angry or frustrated.

We also asked participants if they had witnessed acts of violence. 96% said they had, and 4% had not directly witnessed violence. We then asked participants how often they think about the events they witnessed. 20.8% said "always," 22.9% said "often," 38.5% said "sometimes," 7.3% said "rarely," and 5.2% said "never."

Correlations:Our survey indicators of mental health disorders (such as PTSD and/or depression) included: 1) how often participants felt sad and its correlation with: a) exposure to violence, and b) duration of displacement. It was found that feelings of sadness among participants were significantly related to both exposure to violence and increased duration of displacement. The study showed a high prevalence of mental health disorders among participants. This is significant as it reinforces the idea that war impacts not only the physical and mental health of adults but also the health of children.

Recommendations:

1. Increase the availability of mental health services for war-displaced individuals.

2. Enhance efforts towards global peace.

3. Increase research efforts towards better preventive options.

Arabic Abstract

المستخلص:

أجريت هذه الدراسة في المناطق المتضررة من النزاع في السودان، بما في ذلك المناطق التي ترتفع فيها مستويات العنف والنزوح. واستندت مجتمعات محددة ومخيمات اللاجئين إلى إمكانية الوصول إليها وتمثيلها لخلفيات اجتماعية واقتصادية متنوعة. وقد تألف مجتمع الدراسة من الأطفال الذين تتراوح أعمارهم بين 5 إلى 18 سنة المقيمين في المناطق المتضررة من النزاع في السودان. تم تضمين كل من الأطفال النازحين داخليًا وأولئك الذين يعيشون في المجتمعات المضيفة في العينة للحصول على فهم شامل لتأثير الحرب على الصحة العقلية للأطفال.

وكانت المتغيرات محل الدراسة هي :

– المتغيرات التابعة: مدى انتشار وشدة اضطرابات الصحة النفسية (اضطراب ما بعد الصدمة، الاكتئاب، القلق) لدى الأطفال.

– المتغيرات المستقلة: التعرض للعنف وحالة النزوح.

– المتغيرات المربكة: العمر، الجنس، العرق، والتعرض السابق للصدمات.

– متغيرات الخلفية: التحصيل العلمي، وتكوين الأسرة، والحصول على خدمات الرعاية الصحية.

النتائج:

تمت مقابلة ما مجموعه 100 نازح في مناطق سكنية مختلفة في جميع أنحاء السودان، مع التركيز على المقاطعات الشمالية والشرقية من البلاد. 63% من المشاركين ذكور، و37% إناث.

كانت أعمار معظم المشاركين (42%) بين 13 و15 عامًا، و24% بين 10 و12 عامًا، و23% بين 6 و9 أعوام، و11 شخصًا بين 16 و18 عامًا.

من بين المشاركين، 38% نزحوا لمدة تقل عن سنة واحدة، و27% نزحوا لمدة تتراوح بين سنة وسنتين، و35% نزحوا داخليًا لأكثر من عامين.

تقييم حالة الصحة العقلية:

- عندما سألنا "كم مرة تشعر بالحزن أو الاكتئاب؟"، أجاب 17% من المشاركين دائمًا، و27% أجابوا كثيرًا، و30% أجابوا أحيانًا، و21% أجابوا نادرًا، و5% أجابوا أبدًا.
- وفيما يتعلق بصعوبات النوم، قال 22% من المشاركين أنهم يعانون منها دائمًا، وأجاب 39% كثيرًا، وأجاب 33% أحيانًا، وأجاب 6% نادرًا.
- سألنا المشاركين "كم مرة تشعر بالقلق أو الخوف؟" لإجراء مزيد من التقييم، قال 15% دائمًا، و62% أجابوا كثيرًا، وأجاب 18% أحيانًا، و3% قالوا نادرًا، وأجاب 2% أبدًا.
- عندما سألنا عما إذا كانوا يواجهون صعوبة في التركيز، أجاب 17% من المشاركين دائمًا، وأجاب 28% كثيرًا، وأجاب 39% أحيانًا، وأجاب 11% نادرًا، وأجاب 8% أبدًا.

- سألنا المشاركين إذا كانوا يعانون من أمراض جسدية (آلام في المعدة والصداع) مرتبطة باضطرابات نفسية (الاكتئاب واضطراب ما بعد الصدمة وغيرها)، أجاب 4% من هؤلاء المشاركين بـ دائمًا، و71% أجابوا كثيرًا، وأجاب 17% أحيانًا، 8 أجاب ٪ نادرا.
- بعد ذلك، سألنا المشاركين مباشرة عن عدد المرات التي شعروا فيها بالأمان في مستوطنتهم الجديدة. أجاب 57% منهم بـ أحيانًا، و23% منهم أجاب نادرًا، وأجاب 20% منهم بـ 20%.
- سألنا المشاركين عما إذا كان قد تم منحهم إمكانية الوصول إلى الأنشطة المناسبة لأعمارهم (الألعاب، الرياضات التنافسية، وما إلى ذلك)، فقال 24% منهم أنه تم منحهم إمكانية الوصول (نعم)، وأجاب الباقي 76% منهم بشكل سلبي.
- وعندما سئلوا عما إذا كانوا متفائلين في نظرتهم للمستقبل، قال 3% إنهم يشعرون دائمًا بالأمل بشأن المستقبل، وقال 9% إنهم غالبًا ما يشعرون بالأمل بشأن المستقبل، وقال 27% إنهم يشعرون أحيانًا بالأمل بشأن المستقبل، وقال 54 % إنهم نادراً ما يشعرون بالأمل بشأن المستقبل، وقال 7% إنهم لا يشعرون بالأمل أبداً بشأن المستقبل.
- بعد ذلك، طلبنا من المشاركين إدراج جميع التحديات التي يواجهونها كأفراد نازحين (كان لديهم إمكانية اختيار أكثر من خيار واحد). أشار 51% إلى نقص الغذاء، و79% إلى عدم الحصول على مياه الشرب النظيفة، و82% إلى عدم الوصول إلى التعليم، و97% إلى مخاوف تتعلق بالسلامة، و47% إلى الانفصال عن الأسرة، و68% إلى سوء الحالة الصحية.
- سألنا المشاركين عن عدد المرات التي يجدون فيها أنفسهم يشعرون بالغضب أو الإحباط. قال 23% دائمًا، و42% قالوا كثيرًا، و26% قالوا أحيانًا، و7% قالوا نادرًا، وقال 2% إنهم لا يشعرون أبدًا بالغضب أو الإحباط.
- سألنا المشاركين أيضًا عما إذا كانوا شهود عيان على أعمال العنف. أجاب 96% أنهم فعلوا ذلك، و4% لم يشهدوا العنف بشكل مباشر.
- ثم سألنا المشاركين عن عدد المرات التي يفكرون فيها في الأحداث التي شهدوها. قال 20 (20.8%) منهم دائمًا، 22% (22.9) قالوا كثيرًا، 37% (38.5%) قالوا أحيانًا، 7 (7.3%) قالوا نادرًا، و5 (5.2%) قالوا أبدًا.

الارتباطات:

كانت مؤشرات اضطرابات الصحة العقلية (اضطراب ما بعد الصدمة و/أو الاكتئاب) في استبياننا هي (:كم مرة شعر المشاركون بالحزن وارتبط هذا بـ :التعرض للعنف، و (مدة النزوح) وتبين أن مشاعر الحزن بين المشاركين ترتبط بشكل كبير بكل من التعرض للعنف وزيادة مدة النزوح. أظهرت الدراسة أن هناك نسبة كبيرة من اضطرابات الصحة العقلية بين المشاركين. وهذا أمر مهم لأنه يعزز فكرة أن الحرب ليس لها تأثير على الصحة البدنية والعقلية للبالغين فحسب، بل على صحة الأطفال أيضًا.

التوصيات:

1) زيادة توفر خدمات الصحة النفسية للنازحين بسبب الحرب،

2) زيادة الجهود نحو السلام العالمي،

3) زيادة الجهود البحثية نحو خيارات وقائية أفضل.

Chapter One
Introduction

1.1. Background

Large-scale population displacement often arises from conflicts and natural disasters due to environmental degradation,political persecution, or economic hardships (1). Internally displaced persons (IDPs) face unique challenges compared to refugees, as they may not receive equivalent assistance from international agencies unless specifically requested by their home country (2).Mental health is a key component of health. Unfortunately, Africa, which has a large youth population and significant cultural and linguistic diversity, has contributed very limited data to global child & adolescent mental health (CAMH) research (1, 2). Nevertheless, there is a growing awareness of the importance of CAMH, which has shaped global health initiatives over the past two decades (3). A recent systematic review and meta-analysis showed considerable mental health problems among children and adolescents in sub-Saharan Africa (SSA), with 19.8% positive on screening tools, 14.3% meeting criteria for one or more psychopathology, and 9.5% diagnosed with clinical diagnostic instruments (4). Despite these facts, CAMH services on the African continent are still underdeveloped, and CAMH research is highly lacking (2, 5-8). In a study conducted by Davis and colleagues about CAMH in Africa, the authors identified significant gaps in CAMH-related policies, community participation, CAMH institutions, and interpersonal communication in relation to CAMH (9).

The World Health Organization (WHO) developed a framework to guide the evaluation and strengthening of mental health services globally (10). The ‘healthcare pyramid’ framework proposed that tertiary and specialist services are costly and should be required by only a small portion of the population, while informal, community-based, and primary healthcare services (which can be provided at a relatively low cost) should be made available to a large proportion of the population (10).

Sudan is a low-income African country in the Northeast part of Africa, bordered by seven countries - Egypt, Eritrea, Ethiopia, South Sudan, the Central African Republic, Chad, and Libya. It occupies 1.8 million km2 and has an estimated population of 38.6 million, of which 61.7% are under the age of 24 years (11). Recent United Nations Population Fund data showed that about 39.5% of Sudanese people are between 0 and 14 years (12). Two-thirds (66.7%) of the Sudanese population live in rural settings, and almost half of the overall population (both urban and rural) live at or below the poverty threshold. The country was ranked 166 out of 187 countries across the world on the Human Development Index. The yearly GDP per capita in 2019 was around 2000 USD (12). Sudan consists of 18 states (provinces), with Khartoum as the capital state (13) with an area of 22,000 km2. Official estimates in 2005 put the population of the capital city at 4.5 million, although unofficial estimates suggest a population over 7 million

(14). , Khartoum state is divided into seven localities (Khartoum, Jabal Awliya, Omdurman, Ombada, Karary, Bahry, and SharqEnil).

Children exposed to war often suffer from a range of psychological issues, including post-traumatic stress disorder (PTSD), anxiety, and depression. The constant exposure to traumatic events, such as bombings, shootings, and the loss of loved ones, can lead to severe emotional distress. Symptoms of PTSD, such as flashbacks, nightmares, and severe anxiety, are common among these children. Additionally, the pervasive sense of insecurity and fear can contribute to chronic anxiety and depression, affecting their ability to engage in everyday activities and relationships.

The consequences of violent conflicts, wars, and displacement events are well-documented, leadingtocomplexhumanitarian crises with profound impacts on the well-being of affected populations (3). These impacts manifestbothdirectly through violence and physical harm, and indirectly, resulting in increased rates of infectious diseasesandmalnutrition (4). Sudan, marked by a history of conflict and instability, experienced another wave of violencein2023,resulting in a significant number of IDPs seeking refuge in camps and settlements acrossthenation (5). According to the Internal Displacement Monitoring Centre (IDMC), Sudan ranked eighthgloballyinterms of the number of internally displaced people due to conflict and violence in 2020 (6). Access to medical care in IDP camps is often limited, leading to preventable deaths and increased morbidity, particularlyamongwomen and children (7). Malnutrition prevails in such settings and significantly elevates the risks of short andlong-term morbidity and mortality (8). Additionally, conflict-induced displacement increases the risk of mental healthdisorders, including depression and post-traumatic stress disorder (PTSD), among affected populations (9,10). Thepsychological distress stemming from conflicts may also contribute to the adoption of unhealthy behaviorssuchashazardous drinking and smoking, leading to a higher burden of non-communicable diseases (11). The Sudan armed conflict of 2023 resulted in a substantial number of IDPs in the country, manyof whomfaceprecarious living conditions and exposure to traumatic events. Despite the evident need, comprehensivedataontheprevalence of physical and mental health problems among Sudanese IDPs following the armed conflict arelacking.Inorder to evaluate and address the health issues facing IDPs,

Sudan has been embroiled in conflicts for decades, involving civil wars, ethnic violence, and political turmoil. These conflicts have resulted in extensive loss of life, destruction of infrastructure, and massive displacement of populations. Children, who constitute a significant portion of the affected population, are particularly vulnerable to the adverse effects of such instability. The disruption of families, communities, and basic services like education and healthcare further exacerbates the trauma experienced by children.

1.2. Problem Statement

The ongoing conflict in Sudan has inflicted profound repercussions on the mental heal th of children, constituting a pressing humanitarian concern in 2024. The problem is ro oted in the exposure of children to various forms of violence, displacement, and depriv ation of basic needs due to the protracted war (17). Amidst the chaos, children are subj ected to traumatic experiences that significantly impact their psychological well-being , leading to heightened levels of stress, anxiety, and depression (17). The absence of a dequate mental health support exacerbates their vulnerability, perpetuating a cycle of d istress and hindering their ability to lead fulfilling lives (18).

The magnitude of the issue is alarming, with a substantial portion of Sudanese childre n grappling with mental health challenges. Recent surveys indicate that over 70% of c hildren in conflict-affected regions exhibit symptoms of post-traumatic stress disorder (PTSD), while depression and anxiety rates exceed 60% (18). Additionally, a significa nt proportion of children experience disruptions in their education and social developm ent, further exacerbating their mental health struggles (17). The consequences of untre ated mental health issues extend beyond individual suffering, contributing to a broader societal burden characterized by decreased productivity and increased healthcare costs (19). Furthermore, the intergenerational transmission of trauma threatens to perpetuate cycles of violence and instability, posing long-term challenges to the nation's recovery and development (20).

1.3 Justification:

The justification for addressing the impact of war on children's mental health in Sudan is undeniable. Firstly, it aligns with fundamental principles of human rights, as safeguarding the well-being of children, especially in conflict zones, is a universal moral imperative. Beyond moral obligations, investing in children's mental health serves as a strategic imperative for long-term stability and peacebuilding efforts in Sudan. By addressing their mental health needs, interventions can mitigate the risk of perpetuating cycles of violence and contribute to sustainable development. Furthermore, improving children's mental health outcomes yields significant societal benefits, including enhanced educational attainment, greater resilience, and strengthened social cohesion. Therefore, prioritizing the mental health of Sudanese children not only addresses immediate humanitarian concerns but also lays the groundwork for a more peaceful and prosperous future for the nation.

1.4.Research Question

What is the impact of war on children’s mental health in Sudan?

1.5.Objectives:

1.5.1 General Objective

To assess the Impact of war on children mental health in Sudan 2024

1.5.2 Specific Objectives

To determine the prevalence and types of mental health disorders, including PTSD, de pression, and anxiety, among children residing in conflict-affected areas of Sudan.

To investigate the socio-economic and environmental factors contributing to the ment al health challenges faced by Sudanese children impacted by war, such as displacemen t, exposure to violence, and limited access to essential services.

To evaluate the effectiveness and accessibility of existing mental health support mech anisms for children in conflict zones, identifying gaps and barriers to care and proposi ng recommendations for improvement.

To examine the long-term consequences of war-related trauma on children's psycholo gical well-being and development, with a focus on understanding resilience factors an d identifying opportunities for intervention and support.

To assess the impact of gender, age, and other demographic factors on the mental heal th outcomes of children affected by war in Sudan, aiming to inform targeted interventi ons and policies to address disparities and promote equitable access to mental health c are.

Chapter Two

Literature Review

Children exposed to war often suffer from a range of psychological issues, including post-traumatic stress disorder (PTSD), anxiety, and depression. The constant exposure to traumatic events, such as bombings, shootings, and the loss of loved ones, can lead to severe emotional distress.

Unfortunately, in Sudan, where wars continue to ravage the country, there is a lack of attention given to the psychological problems that children face. Many parents are preoccupied with providing basic needs like food and drink, leaving little time to focus on their children's mental well-being. Additionally, research on this topic is lacking, particularly in central Sudan where the majority of the population resides.

PTSD can develop after a highly stressful, frightening, or distressing event or a prolonged traumatic experience. Examples of such events include serious accidents, physical or sexual assault, abuse, exposure to traumatic events at work, serious health problems, childbirth experiences, the death of a loved one, war and conflict, and torture. It is estimated that about 1 in 3 people who experience severe trauma develop PTSD.

The reasons why some individuals develop PTSD while others do not are not fully understood. However, certain risk factors have been identified. Individuals with a history of depression or anxiety, as well as those who lack support from family and friends, are more likely to develop PTSD after a traumatic event. There may also be a genetic predisposition to the condition, as having a parent with a mental health problem increase one's chances of developing PTSD.

Although the exact cause of PTSD is unclear, several theories have been proposed. One suggestion is that the symptoms of PTSD are a survival mechanism, designed to help individuals navigate future traumatic experiences. For example, the re-experiencing of past trauma through flashbacks may prepare individuals to better cope if a similar event were to occur again. The feeling of being constantly "on edge" (hyperarousal) may also function as a means to react quickly in times of crisis. However, these responses hinder the individual's ability to process and move on from the traumatic experience .

Studies have shown that people with PTSD have abnormal levels of stress hormones, such as adrenaline. Normally, in dangerous situations, the body produces stress hormones to trigger a reaction that aids in survival. However, elevated levels of these hormones in individuals with PTSD can contribute to their persisting symptoms and difficulties in recovery.This reaction, often referred to as the "fight or flight" response, helps numb the senses and dull pain. Individuals with PTSD have been found to continuously produce high levels of fight or flight hormones even when there is no danger. It is believed that this may be the cause of the numbed emotions and hyperarousal experienced by some individuals with PTSD.

Changes in the brain

Brain scans have revealed that certain parts of the brain involved in emotional processing appear different in individuals with PTSD. One particular area responsible for memory and emotions is called the hippocampus. In those with PTSD, the hippocampus appears smaller in size. It is thought that these changes in the brain may be related to fear, anxiety, memory problems, and flashbacks. The malfunctioning hippocampus may prevent flashbacks and nightmares from being properly processed, thus leading to a lack of reduction in the anxiety they generate over time.

Symptoms of PTSD:

PTSD can significantly impact one's daily life. In most cases, these symptoms develop within the first month following a traumatic event. However, in some cases, there may be a delay of months or even years before symptoms start to appear. Some individuals with PTSD experience periods of less noticeable symptoms followed by periods of worsening symptoms, while others experience constant severe symptoms. These medicines are not usually prescribed for people younger than 18 unless recommended by a specialist. If medicine for PTSD is effective, it'll usually be continued for a minimum of 12 months before being gradually withdrawn over the course of 4 weeks or longer.

If a medicine is not effective at reducing your symptoms, your dosage may be increased. Before prescribing a medicine, your doctor should inform you about possible side effects and withdrawal symptoms. For example, common side effects of paroxetine include feeling sick, blurred vision, constipation, and diarrhea. Possible withdrawal symptoms associated with paroxetine include sleep disturbances, intense dreams, anxiety, and irritability.

Withdrawal symptoms are less likely if the medicine is reduced slowly.

Children and young people:

Trauma-focused cognitive-behavioral therapy (CBT) is usually recommended for children and young people with PTSD. This normally involves a course of 6 to 12 sessions that have been adapted to suit the child's age, circumstances, and level of development. Treatment may also involve consulting with and involving the child's family.

What is post-traumatic stress disorder?

Post-traumatic stress disorder (PTSD) is a debilitating condition that occurs after experiencing a terrifying event, causing persistent, frightening thoughts, memories, or flashbacks of the ordeal. Sometimes, the effects of trauma can be delayed for 6 months or longer, but when PTSD occurs soon after an event, the condition generally improves after 3 months. Some people with PTSD may experience long-term effects and often feel emotionally numb. In children, PTSD usually becomes a chronic disorder.

The events that trigger PTSD may be something that occurred in the person's life, the life of someone close to them, or something the person witnessed. For children, the

risk of developing PTSD is often influenced by various factors, including their proximity and relationship to the trauma, the severity and duration of the traumatic event, the recurrence of the event, the child's resiliency and coping skills, and the support resources available from their family and community.

PTSD can be treated. Early detection and intervention is very important and can reduce the severity of symptoms, enhance the child's normal growth and development and improve the quality of life experienced by children or adolescents with PTSD. Treatment should always be based on a comprehensive evaluation of the child and family. Treatment recommendations may include cognitive behavioral therapy for the child. The focus of cognitive behavioral therapy is to help the child or adolescent learn skills to manage his or her anxiety and to help him or her master the situation(s) that contributed to the PTSD. Some children may also benefit from treatment with antidepressant or antianxiety medication to help them feel calmer. The child or adolescent's recovery from PTSD is highly variable and dependent on the child or adolescent's internal strengths, coping skills, and resiliency (ability to "bounce back"). Recovery is also influenced by the support available within the family environment. Parents play a vital supportive role in any treatment process.

Prevention of post-traumatic stress disorder

Preventive measures to reduce the incidence or lessen the chance of traumatic experiences in children include, but are not limited to, the following:

Teach children that it is OK to say NO to someone who tries to touch his or her body or make him or her feel uncomfortable.

Provide appropriate support and/or counseling for children and adolescents who have experienced or witnessed a traumatic event. Encourage prevention programs within your community or local school system.

Previous studies

Over one billion children worldwide inhabit countries or territories torn apart by armed conflict, war, or terrorism (1), principally in lower- and middle-income countries where 90% of the world’s children and adolescents live (2). Armed conflict can last throughout an entire childhood, such as in Liberia where civil war caused widespread trauma from 1989 to 2004 (3). The effects of war extend beyond isolated areas of crisis: in 2016, the United Nations High Commission on Refugees reported that 59.5 million people worldwide were forcibly displaced, and over half of these were children under the age of 18 (4).

The present review provides an overview of research on the psychological impact of war and conflict on children, including the types of mental disorders that arise following war trauma; differences in the type of exposure, individual traits, and environmental

characteristics that increase risk for mental disorders; and interventions to minimize psychological harm following exposure to war and conflict.

Prevalence of Mental Disorders Following Conflict

Children exposed to war manifest a higher rate of mental disorders compared with children in the general population (5), although prevalence data are inconsistent and likely depend on the nature of the trauma, the duration of exposure, diagnostic criteria used, and cultural discrepancies (6). The distress of a child following trauma may be overlooked due to children's difficulties communicating or articulating their experiences (7). Adults tend to underestimate the posttraumatic stress reactions of their children, and their initial response to the effects of trauma on their children may be denial (8). While it was previously believed that children did not understand or remember traumatic occurrences, there is now increasing awareness that children are very vulnerable to the stresses of war and terrorism.

Adverse Childhood Experiences

The negative long-term effects of childhood trauma or adverse childhood experiences on physical and mental health are well established in the literature (4). Childhood adversity, commonly experienced as child abuse, neglect, and/or household dysfunction has been linked to increased risk for various long-term chronic illnesses. It increases the risk for depression 4.5-fold and suicide attempts 12.2-fold (7). Childhood adversity may increase impulsive behaviors, reward orientation, and unhealthy lifestyle choices (4). Epigenetic changes, posttranslational modification, and an unregulated inflammatory response may accompany the behavioral and cognitive response to childhood trauma (4). Exposure to war or terrorism increases a child's risk for both medical and psychiatric disorders in adult life.

Psychiatric Disorders Following Trauma

The past two decades have marked increasing interest in the psychological impact of war on children (9). The relationship between exposure to war trauma and development of acute stress disorder and posttraumatic stress disorder (PTSD) is well documented in the literature (1, 3, 6, 9, 10). Children may experience acute PTSD, with hyperarousal, re-experiencing, and sleep disruption, or chronic PTSD, characterized by dissociation, restricted affect, sadness, and detachment (6). Exposure to trauma increases both internalizing and externalizing reactions in children. Internalizing reactions, such as depression, suicidal thoughts, worry, and anxiety were prevalent among Liberian youths exposed to armed conflict (3) and in a study of 300 Syrian refugee children in Turkey (1). These Syrian refugee children who had been exposed to war commonly exhibited anxiety and excessive fears, manifested by dependent behavior, clinging to parents, and fear of being left alone or sleeping in the dark (1).

After 9/11, 15% of New York City school children surveyed had developed symptoms of agoraphobia, 12% developed separation anxiety, 10% developed generalized anxiety, and 9% developed panic attacks (8). Externalizing behaviors, such as delinquency, bullying, and drug and alcohol use, also appear to increase after trauma (7).

Risk and Protective Factors Mediating Trauma

Characteristics of the Trauma

Traumatic exposure can be direct or indirect. Direct exposure occurs when a child has personal experience with a traumatic incident, such as living in a conflict zone or experiencing the death of a parent. Conversely, indirect exposure occurs through television, the Internet, or hearing others talk about a traumatic event. Indirect exposure through media can also produce significant distress. Following the 9/11 attacks and the Oklahoma City bombing, children who watched more television coverage of the traumatic events experienced more posttraumatic stress symptoms (8, 11). War and conflict are often accompanied by changes to a child's environment; for example, a child may experience the closing of his or her school after destruction of infrastructure or financial hardship after loss of family members (12).

When children are exposed to war and conflict directly, the number of conflict-related traumatic events (11), the duration of the threat (13), and the severity and nature of the threat mediate psychological outcomes and distress. Severe reactions occur when there is threat to the child's life and/or physical harm (1, 13), as well as in cases of death of a parent or loss of social support (14).

Children's Individual Risk andProtective Factors

Many children demonstrate incredible resilience, and recovery is the expected outcome of acute stress responses for most children (13). However, when traumatic exposure has lasting effects on a child, individual differences mediate these effects. A child's developmental stage affects his or her reaction to trauma, and reactions range from regressive behaviors in younger children (15) to problems at school, nightmares, and substance use in older children and adolescents (1, 14).

Individual genetic vulnerabilities also play a role in response to trauma. Maternal anxiety and depression levels are correlated with the child's levels (11), and severity of PTSD in fathers has been linked to that in children (6). Protective factors include religion (correlated with fewer PTSD symptoms) (11), emotional regulation, self-control, problem-solving skills, and a close relationship with caregivers (1).

Characteristics of the Environment

Conflict and war may damage a child's environment and subsequently impair a child's ability to recover from a traumatic event. For example, the 1989–2004 Liberian civil war damaged infrastructure such as schools and health services, which impaired Liberia's ability to treat injuries or address concerns (3). Children who have access to more resources (e.g., higher socioeconomic status and quality education) tend to fare better after trauma (1).

Conflict and terrorism may have devastating effects on individual families, through the loss of family members or disruption in household routines (1). Moreover, children may lose parental support, parenting styles may change, and negative parental expressions increase levels of distress in children (8). Following a traumatic event, parenting style can mediate a child's reaction to stress; punitive parenting styles are associated with less resilient attitudes in children (11), while a parent who provides emotional support, encourages self-esteem, and answers questions directly may minimize the effects of trauma (6, 8).

Interventions

The devastating effects of war and terrorism call for a "multilayered" approach to supporting communities, families, and individuals. Following a traumatic event such as 9/11, the first interventions should target communities to promote safety, self- and community efficacy, connectedness, and hope (1). Priority should be given to reunite families (12) and restore infrastructure. Schools should have emergency plans. First responders, such as police, firefighters, medical personnel, and teachers, should be trained regarding the effects of trauma on children and effective communication regarding traumatic events (13).

The literature supports using community-wide screening to identify children and families at high risk for trauma-related psychological distress. Children whose lives are personally disrupted by trauma, such as those who have witnessed family members killed and/or had their homes demolished and/or have become orphaned or live in distressed families, are particularly vulnerable (10). Because adults often have difficulty recognizing children in distress, children with the greatest need may go unrecognized, making screening essential (16). Screening and aid may be delivered in clinic or school settings; schools are readily accessible, may help normalize the experience, and reduce stigma about mental health care (16).

Finally, children and families who manifest psychiatric symptoms will benefit from mental health care. While research supports the use of psychotherapy, there is limited information on specific pharmacologic interventions for psychiatric disorders related to war trauma. Trauma-focused cognitive-behavioral therapy, in combination with resilience-based and symptom-based techniques that can take advantage of the child's social network, may be particularly helpful (10).

Conclusions

The literature examining the effects of war and terror on children shows significant levels of psychological distress and psychiatric problems following exposure to conflict. Internalizing disorders such as PTSD, depression, and anxiety, as well as externalizing behaviors, are prevalent following exposure to war and terrorism. Future research should investigate interventions to reduce a child's distress and improve resiliency in the setting of war and terrorism

This article reviews and reflects on studies that have explored the effects of war on children around the world. Most are cross-sectional and based on self-reports. They describe a range of mental health problems, related to dose effects and to the negative impact of being a victim or witness of violent acts, threats to and loss of loved ones, prolonged parental absence, and forced displacement. The more recent the exposure to war, and the older the child, the higher was the likelihood of reported posttraumatic stress disorder symptoms. Especially vulnerable to long-term emotional distress were child soldiers, children who were raped, and children who had been forcibly displaced. In adulthood, war-traumatized children displayed significantly increased risks for a wide range of medical conditions, especially cardiovascular diseases. Among protective factors that moderated the impact of war-related adversities in children were a strong bond between the primary caregiver and the child, the social support of teachers and peers, and a shared sense of values. Among the few documented intervention studies for children of war, school-based interventions, implemented by teachers or locally trained paraprofessionals, proved to be a feasible and low-cost alternative to individual or group therapy. More longitudinal research with multiple informants is needed to document the trajectories of risk and resilience in war-affected children, to assess their long-term development and mental health, and to identify effective treatment approaches.

Children who survive in a war situation and then receive proper medical care and nutrition seemingly suffer only physical scars. But seen from within the psychological make-up of the child, a different picture emerges. Psychological wounds and trauma suffered in childhood may affect the individual child and, as a consequence, the society for decades. While health and nutritional needs are routinely looked after by relief operations, governments, UN agencies, the Red Cross and NGOs, psychological care is also important. The first scientific report to confirm this view came from research focusing on long-term after-effects on adult Holocaust victims from German concentration 1, 17 camps. More recent research from Finland revealed that a large number have suffered because of psychological problems stemming from their childhood experiences of the Winter War in 1939. Children who were evacuated to

Sweden and separated from their families were the most affected as adults. Case studies document that the occurrence of traumatic incidents in childhood can produce 2, 3 anxiety attacks 50 years later.

The Psychological Impact of War and the Refugee Situation on South Sudanese Children in Refugee Camps in Northern Uganda: An Exploratory Study

Published online by Cambridge University Press: 01 May 1999

This paper presents the results of an exploratory study on the psychosocial effects of the war situation and subsequent flight on South Sudanese children who were compared to a group of Ugandan children who did not have these experiences of war and flight. In addition to the independent variables such as sociodemographic variables and traumatic events and daily life stress, the dependent variable psychological consequences—according to parents and children themselves—as well as the influence of the mediating factors of social support and coping behavior are presented.

Results showed that Sudanese refugee children had experienced significantly more traumatic events and suffered more daily hassles than the Ugandese comparison group. They were less satisfied with the social support they received. At the same time, they used more coping modes. Compared to Ugandan children, the Sudanese reported significantly more PTSD-like complaints, behavioural problems, and depressive symptoms.

Chapter Three
Methodology

3.1 Study Design:

A mixed-methods cross-sectional study design was utilized to comprehensively assess the prevalence and impact of trauma experiences on children's mental health. This design allows for the collection of both quantitative and qualitative data at a single point in time, providing insights into the current state of children's mental well-being amidst the conflict.

3.2 Study Area:

The study was conducted in various conflict-affected regions across Sudan, including areas with high levels of violence and displacement. Specific communities and refugee camps were based on their accessibility and representation of diverse socio-economic backgrounds.

3.3 Study Population:

The study population will comprise children aged 5 to 18 years residing in conflict-affected areas of Sudan. Both internally displaced children and those living in host communities were included in the sample to capture a comprehensive understanding of the impact of war on children's mental health.

Inclusion criteria: children, male or female aged 5 to 18 years residing in conflict-affected areas of Sudan.

Exclusion criteria: any male or female who are under 5 years or above 18 years residing in conflict affected area and any children male or female aged 5 to 18 years residing in safe areas

3.4 Study duration:

From March 2024 to July 2024

3.5 Variables under Study:

- Dependent Variables: Prevalence and severity of mental health disorders (PTSD, depression, anxiety) among children.

- Independent Variables: Exposure to violence and displacement status.

- Confounding Variables: Age, gender, ethnicity, and previous trauma exposure.

- Background Variables: Educational attainment, household composition, and access to healthcare services.

3.6 Sampling Technique and Sample Size:

A multi-stage cluster sampling technique was employed to select representative samples of children from various conflict-affected regions. Sample size calculation was based on the anticipated prevalence rates of mental health disorders and adjusted for design effects and non-response rates.

n = z2. p*q)/ d2

n= sample size

z= confidence level = 95%= 1.96

p= estimate proportion of the study variable = 70%

q= 1-p = 20%

d = margin of error =5%

Sample size will be = 100

3.7 Data Collection Techniques / Data Collection Tools:

Data collection involved administering standardized assessment questionnaires to children and their parents to gather qualitative insights into trauma experiences and coping strategies.

3.8 Data Analysis:

Quantitative data was analyzed using statistical software (SPSS) to calculate prevalence rates, assess correlations, and identify predictors of mental health outcomes. Qualitative data was thematically analyzed to uncover patterns and themes related to trauma experiences and resilience factors among children.

3.9 Ethical Considerations:

Ethical approval was sought from the ethics committees of Napata College. Participants will be informed about the study's purpose, procedures, and their rights. Written informed consent was obtained. Confidentiality was maintained by anonymizing data, and participants had the right to withdraw from the study at any time without any consequences.

Chapter Four:

Results

4.1: Demographic Data:

A total of 100 IDPs were interviewed in different housing areas around the country of Sudan, with a focus on the Northern and Eastern Provinces of the nation.

63% of our participants were males, while 37% were females (Figure 4.1). Most (42%) of our participants were between 13 and 15 years of age, 24% were between 10 and 12 years of age, 23% were between 6 and 9 years of age, and 11 were between 16 and 18 years of age (Figure 4.2).

Of our participants, 38% have been displaced for under 1 year, 27% have been displaced between 1 and 2 years, and 35% have been internally displaced for over 2 years (Figure 4.3).

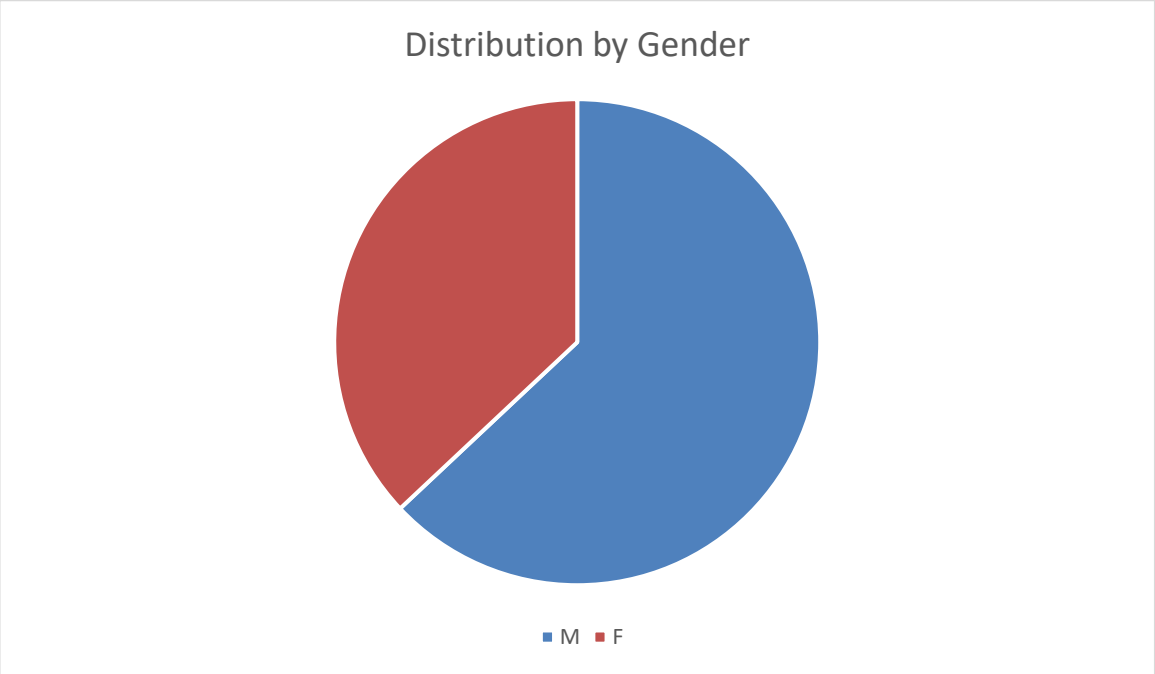

Figure 4.1: Distribution of Participants by Gender

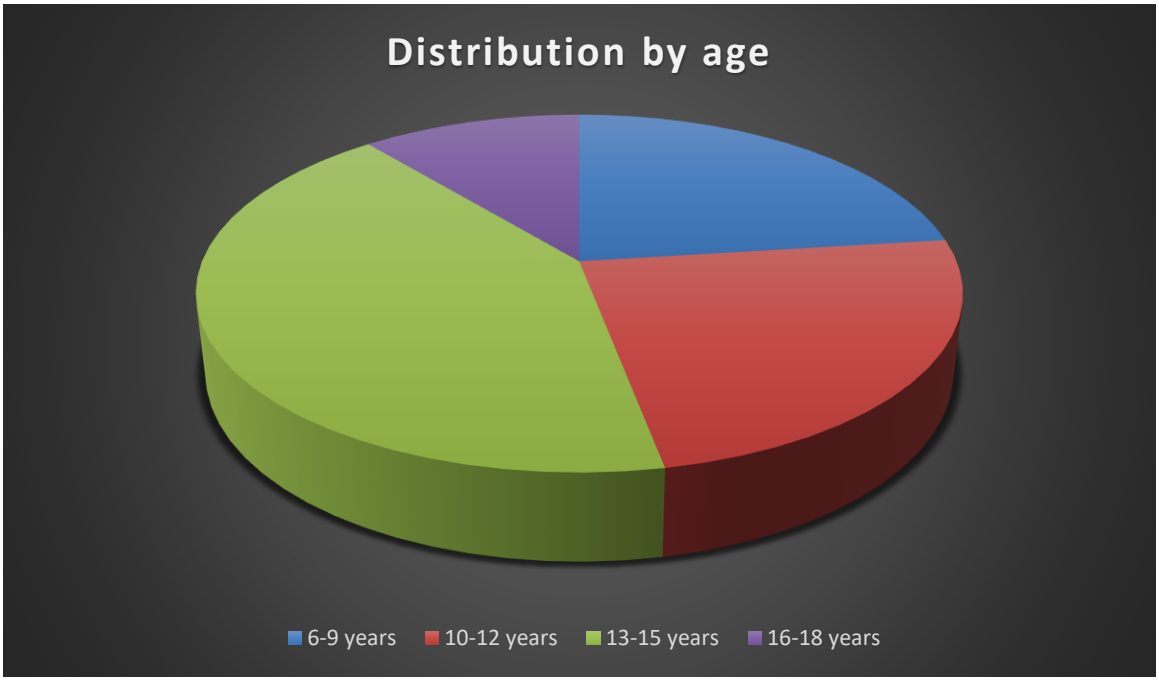

Figure 4.2: Distribution of participants by age

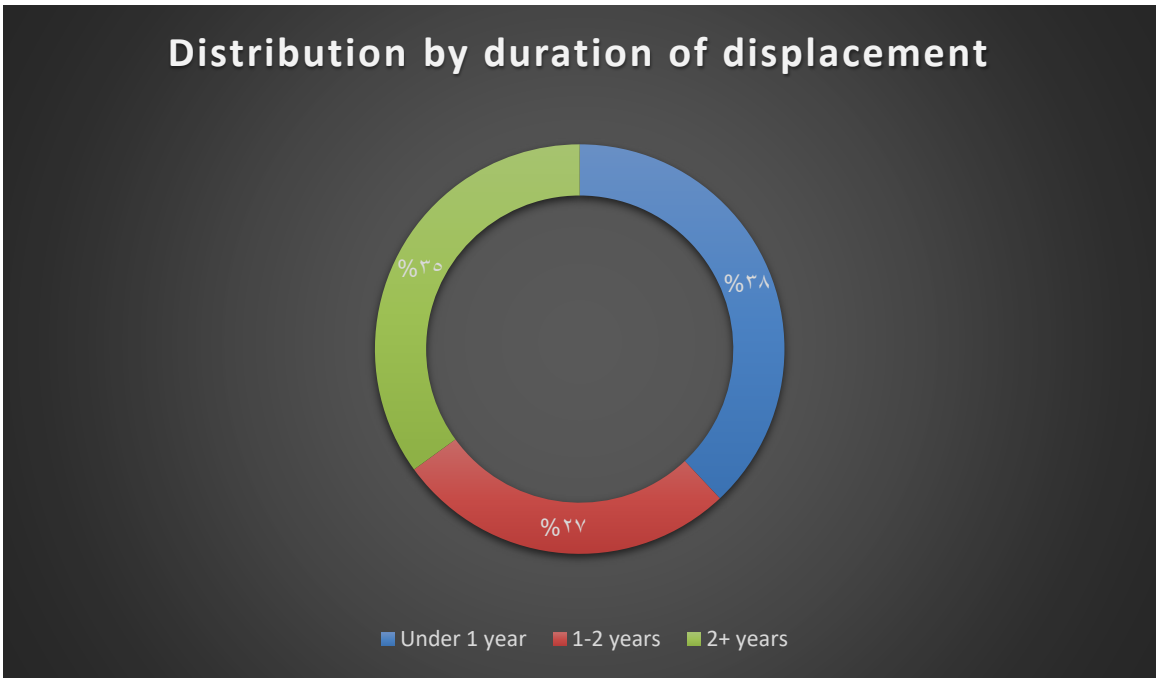

Figure 4.3: Distribution of participants by duration of displacement

Section 4.2: Assessment of mental health status

When asked 'How often do you feel sad or depressed?', 17% of our participants responded with always, 27% responded often, 30% responded sometimes, 21% responded rarely, and 5% replied never (Figure 4.4).

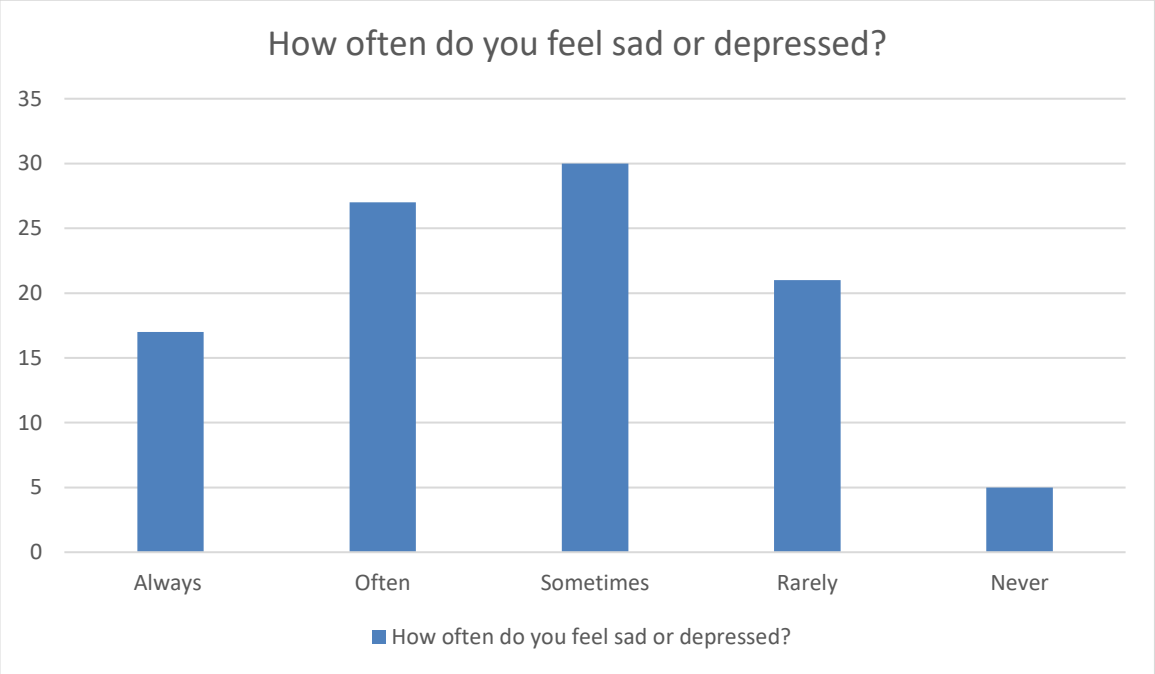

Figure 4.4: How often do you feel sad or depressed?

Regarding sleep difficulties, 22% of our respondents say they always have them, 39% replied often, 33% replied sometimes, 6% replied rarely (Figure 4.5).

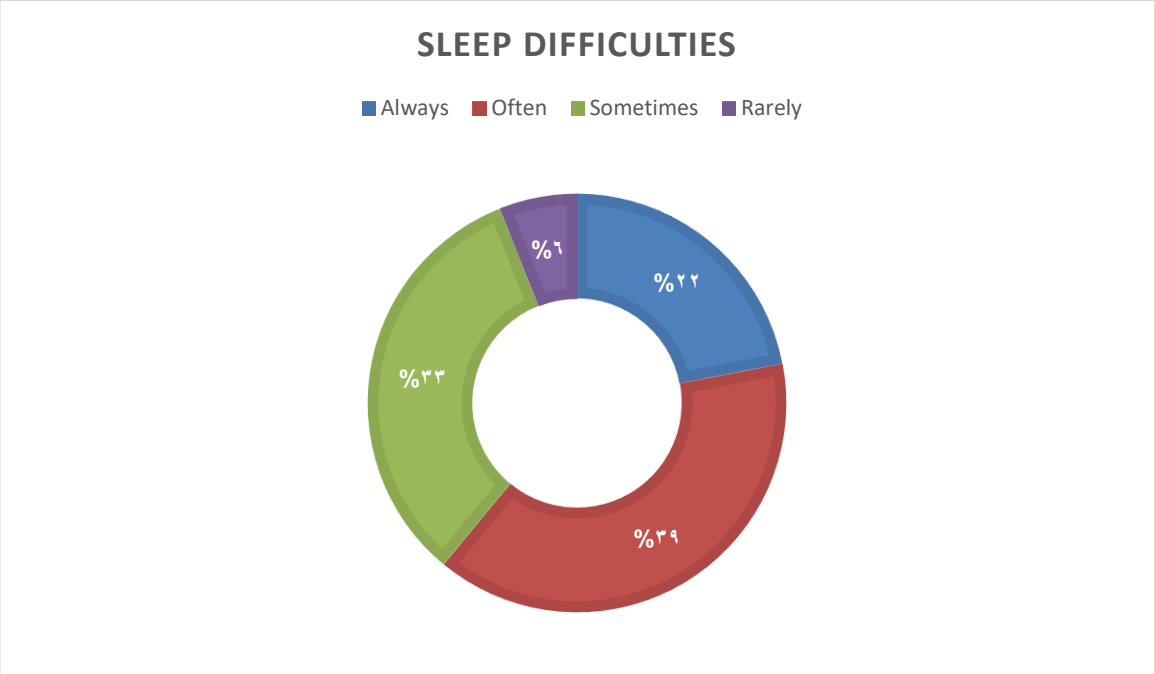

Figure 4.5: Sleeping difficulties

We asked our participants ‘How often do you feel anxious or scared?’ to further assess them, 15% said always, 62% said often, 18% replied sometimes, 3% said rarely, and 2% answered never. This is shown below in Figure 4.6.

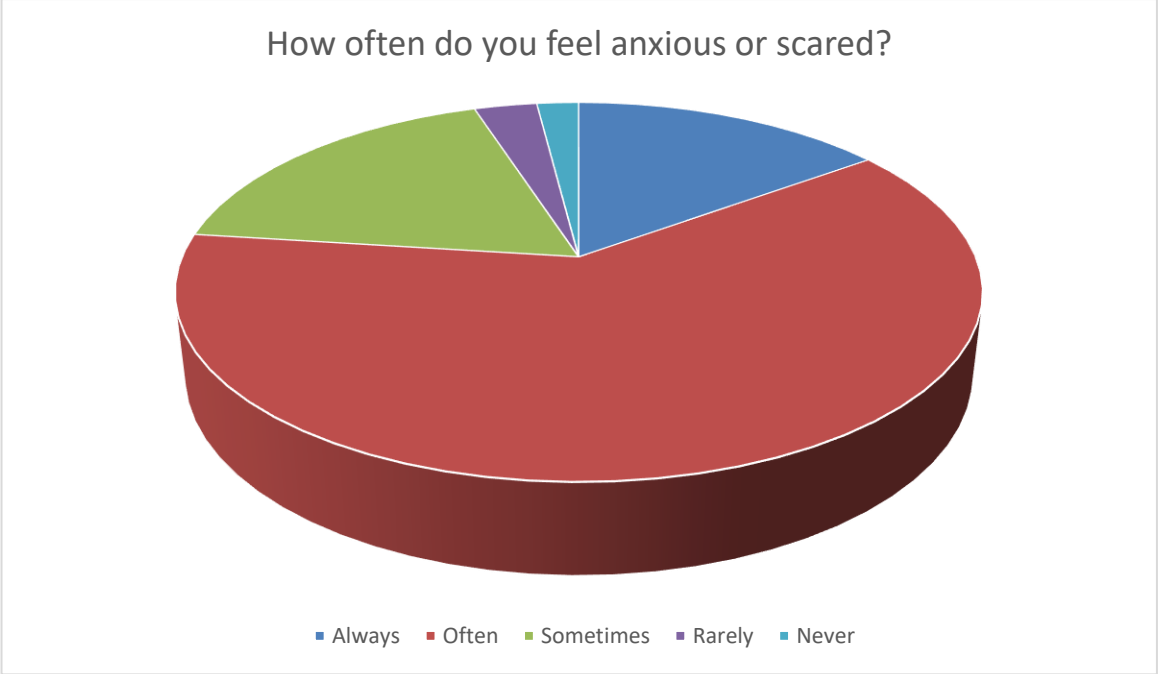

Figure 4.6: How often do you feel anxious or scared?

When asked if they face difficulty concentrating, 17% of our participants responded with always, 28% replied with often, 39% replied sometimes, 11% replied rarely, and 8% replied never. This is shown in Figure 4.7 below.

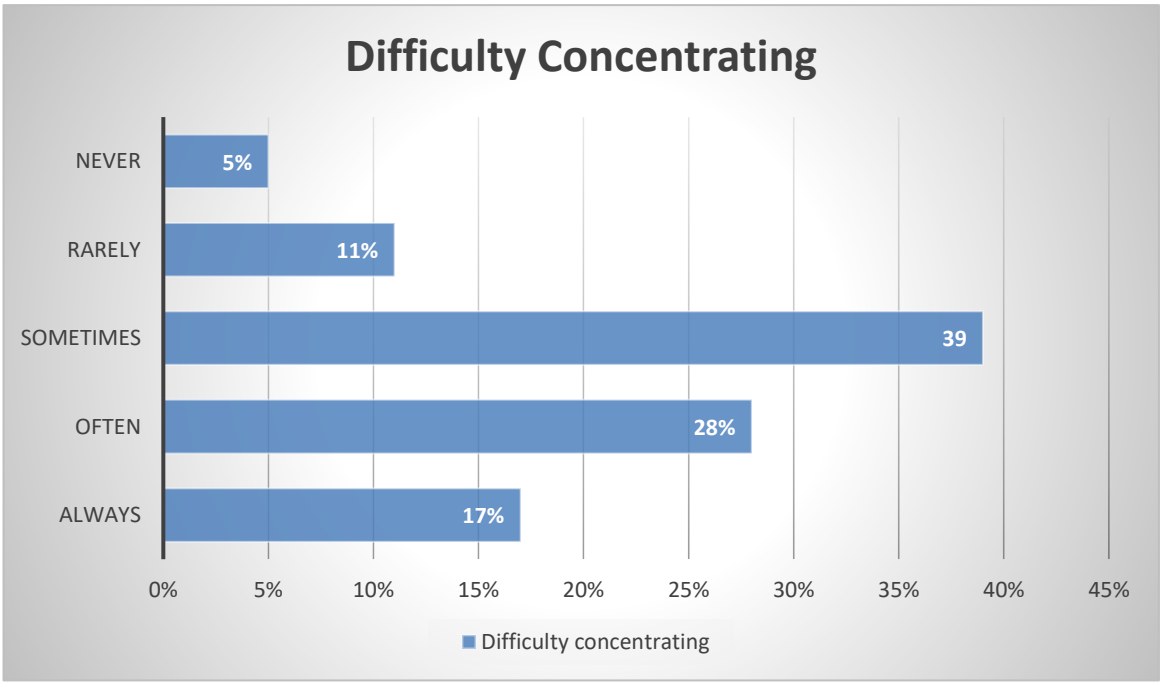

Figure 4.7: Difficulty concentrating

We asked our participants if they suffered from physical ailments (stomachaches and headaches) associated with psychological disturbances (depression, PTSD, and others), 4% of those participants replied with always, 71% replied with often, 17% replied with sometimes, 8% replied with rarely. All of this data is shown below in Figure 4.8.

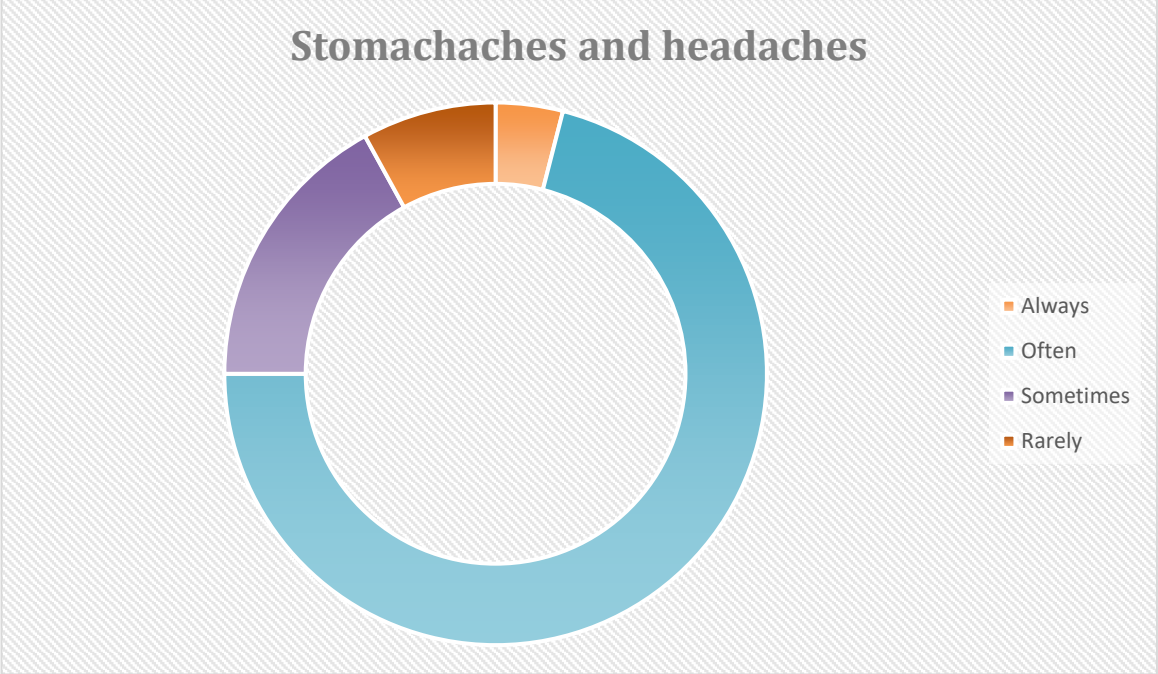

Figure 4.8: Physical ailments

Following this, we asked our participants directly how often they felt safe in their new settlement. 57% of them replied with sometimes, 23% of them replied rarely, and 20% of them replied with 20%. This is shown in Figure 4.9 below.

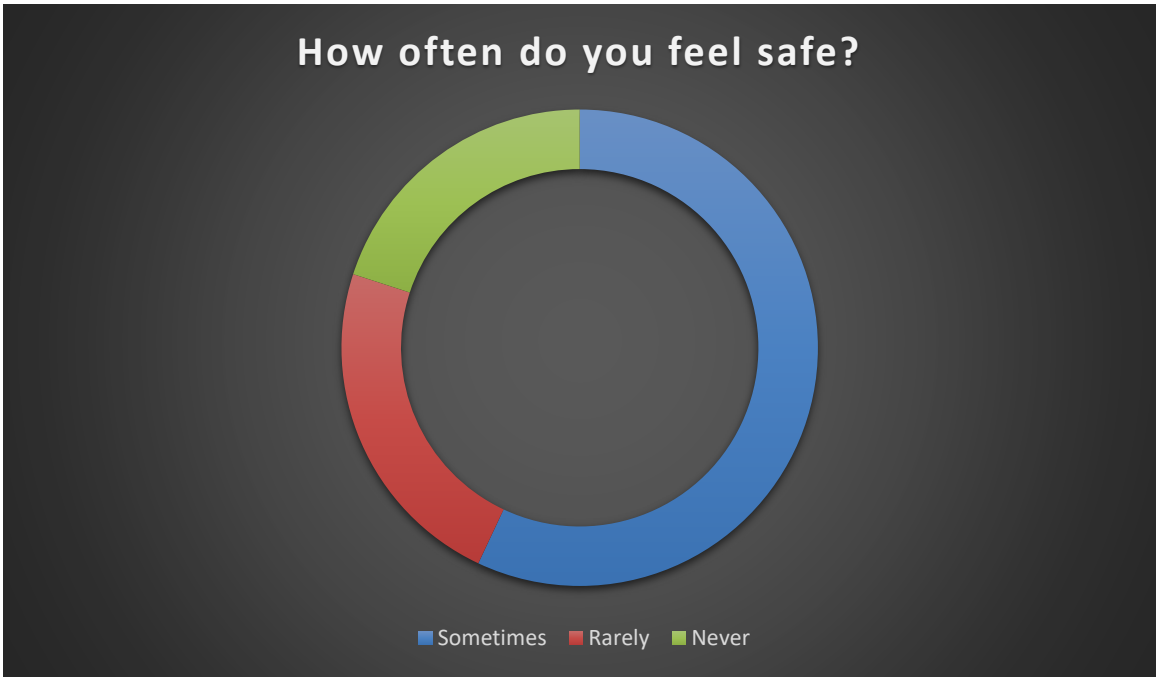

Figure 4.9: Physical ailments

We asked our participants if they are provided access to age-appropriate activities (games, competitive sports, etc.), 24% of them said that they are provided access (yes), the remainder 76% of them replied negatively. This is shown in Figure 4.10 below.

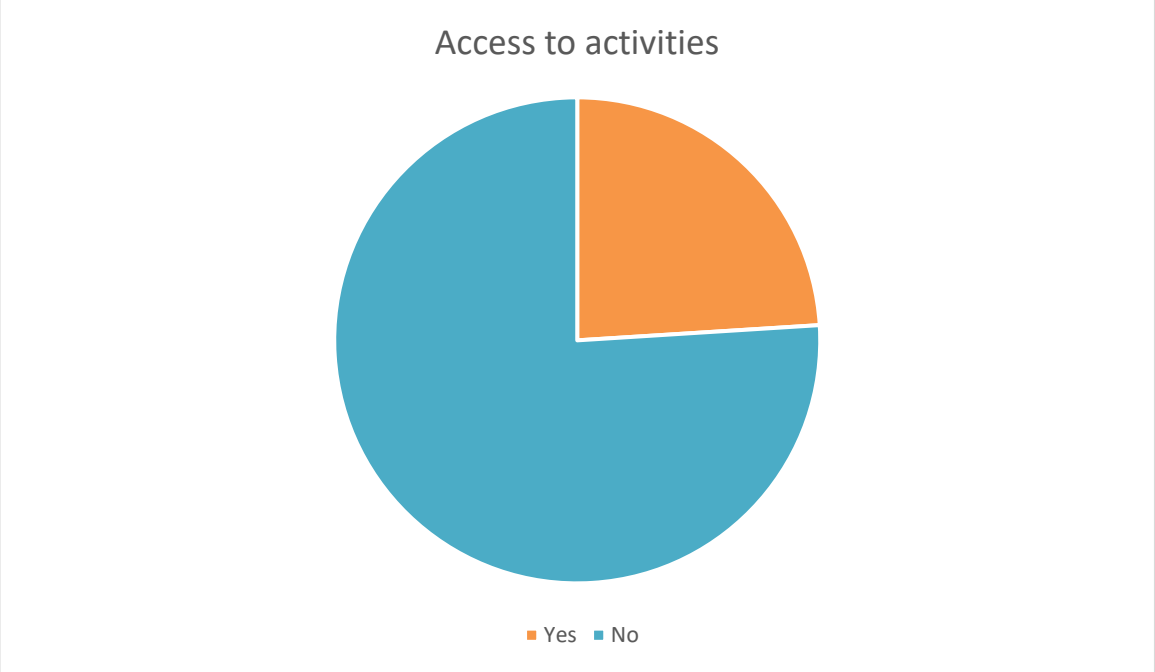

Figure 4.10: Access to activities

When asked if they are hopeful in their outlook towards the future, 3% said that they always feel hopeful about the future, 9% said that they often feel hopeful about the

future, 27% said that they sometimes feel hopeful about the future, 54% said that they rarely feel hopeful about the future, and 7% said that they never feel hopeful about the future. This is all shown in Figure 4.11 below.

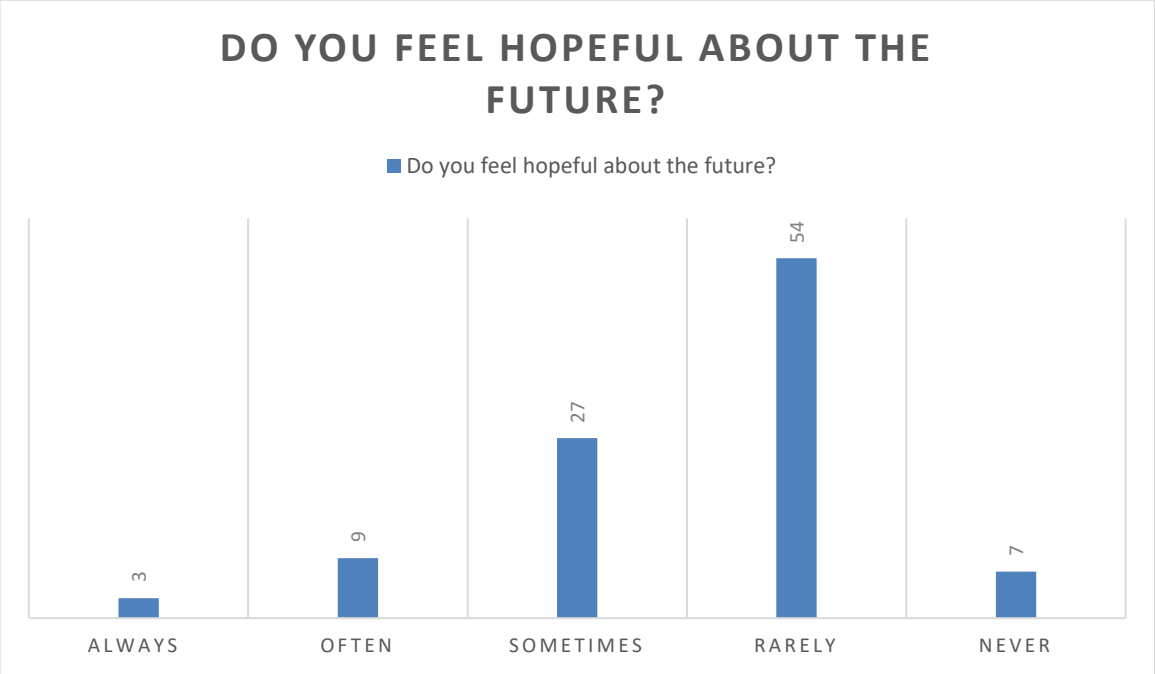

Figure 4.11: Do you feel hopeful about the future?

Following this, we asked our participants to list all the challenges they face as displaced individuals (they had the possibility to choose more than one choice). 51% ticked lack of food, 79% ticked lack of access to clean drinking water, 82% ticked lack of access to education, 97% ticked safety concerns, 47% ticked separation from family, 68% ticked poor health. This is shown in Figure 4.12

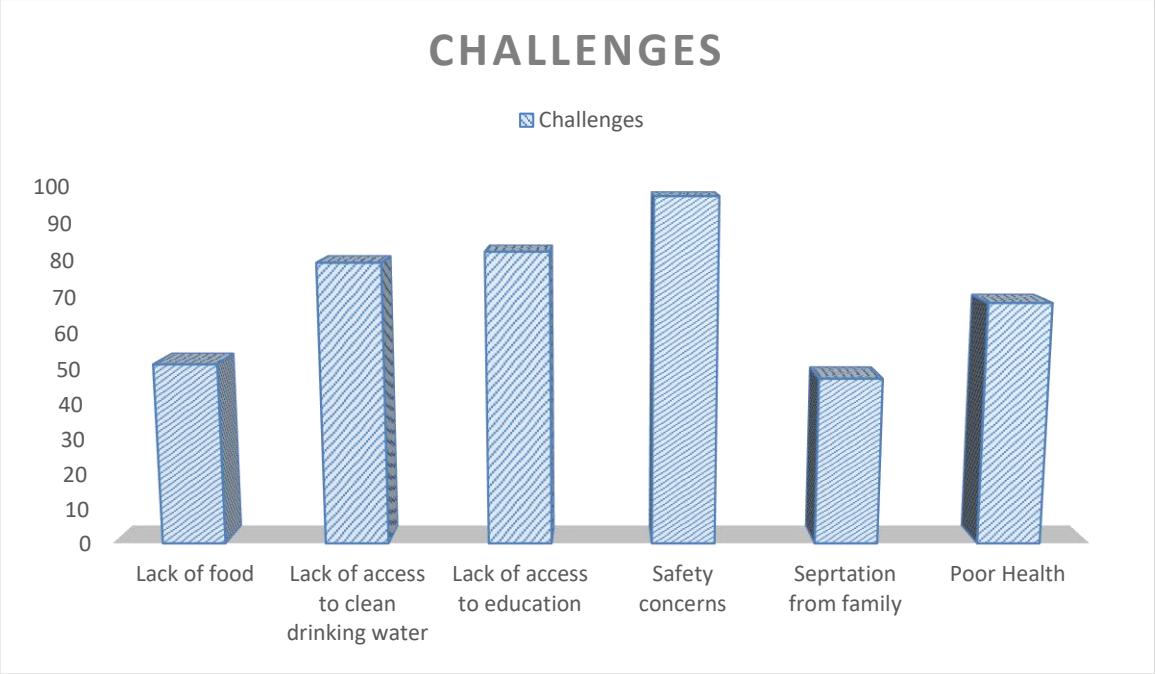

Figure 4.12: Challenges faced by participants

We asked our participants how often they find themselves feeling angry or frustrated. 23% said always, 42% said often, 26% said sometimes, 7% said rarely, and 2% said they never feel angry or frustrated. This is illustrated in Figure 4.13 below.

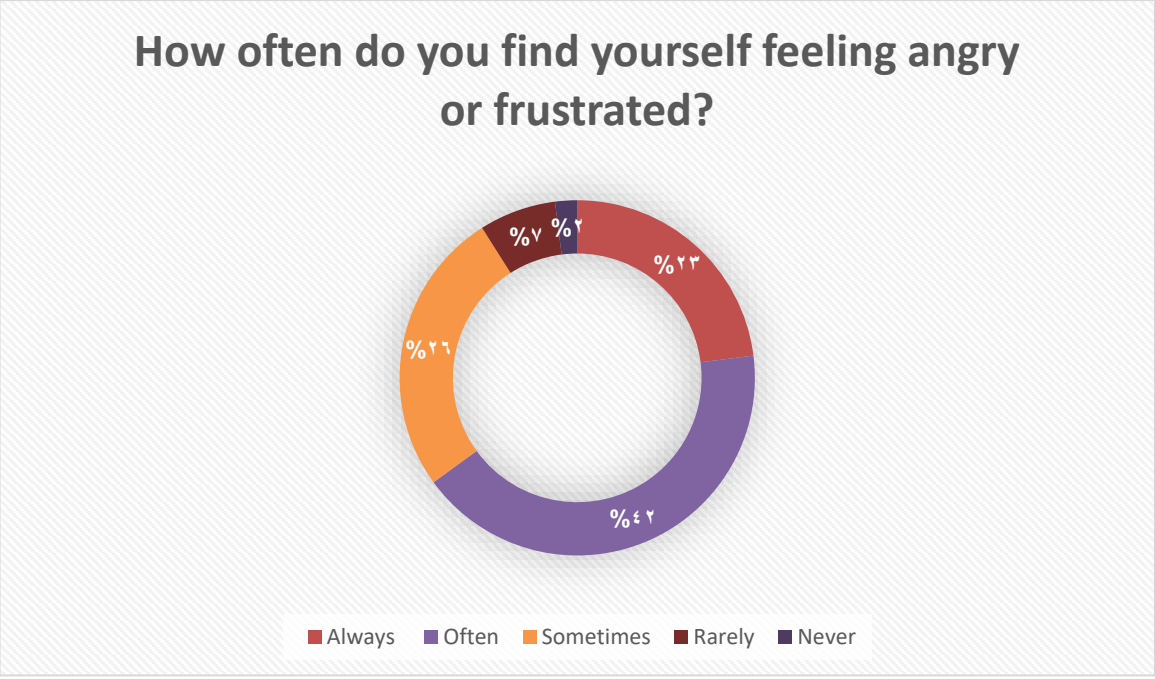

Figure 4.13: How often do you feel angry or frustrated?

We also asked our participants if they were ever eye-witnesses if to violence. 96% responded that they have, 4% did not witness violence first-hand. This is shown in Figure 4.14 below. We then asked our participants how often they think about the events they witnessed. 20 (20.8%) of them said always, 22% (22.9) said often, 37% (38.5%) said sometimes, 7 (7.3%) said rarely, and 5 (5.2%) said never. This is indicative of PTSD. This data is illustrated in Figure 4.15 below.

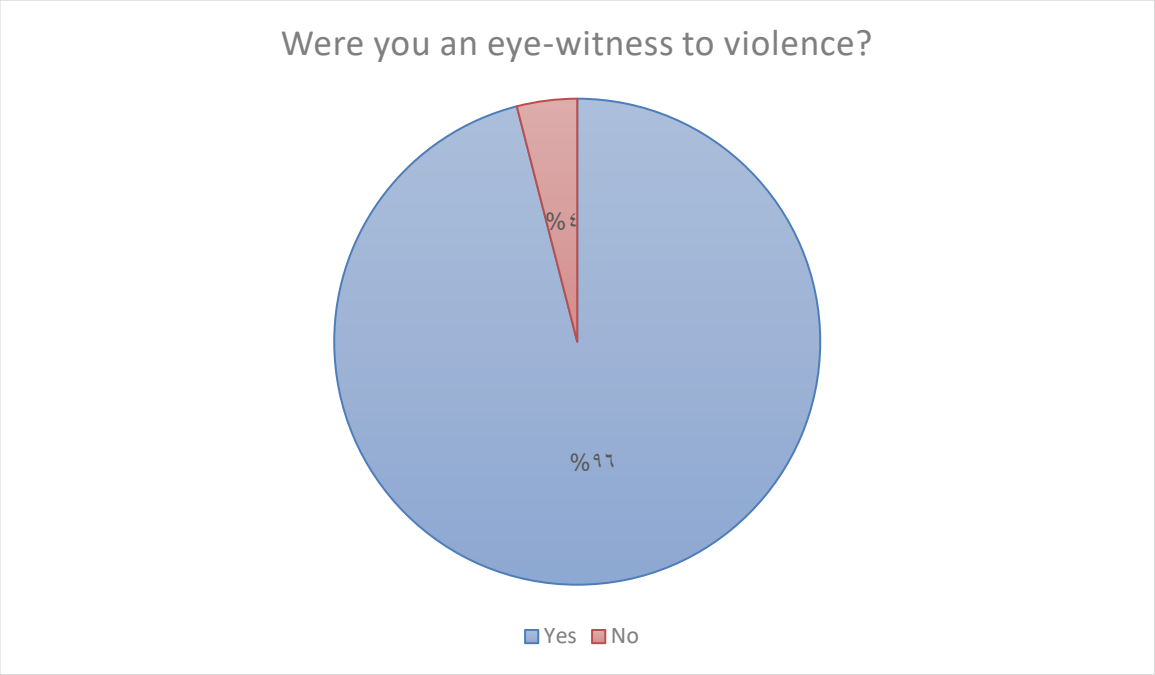

Figure 4.14: Did you witness violence?

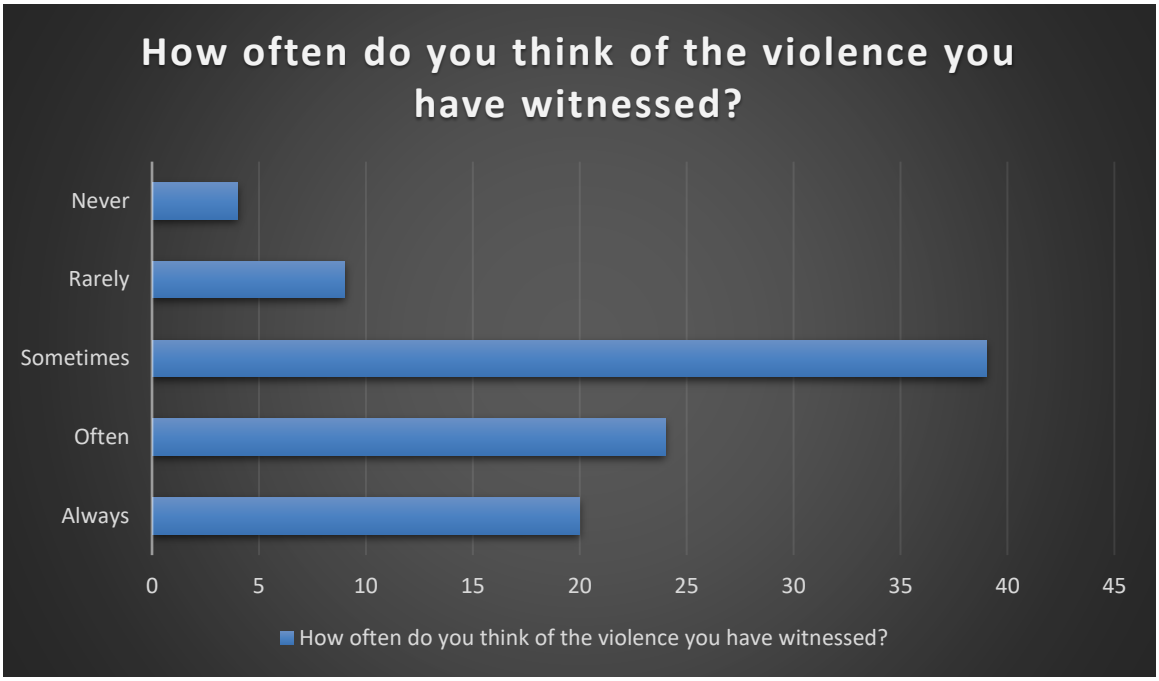

Figure 4.15: How often do you think of the violence you have witnessed?

4.3: Associations:

Indicators of mental health disruptions (PTSD and/or depression) in our questionnaire were:

1) How often participants felt sad

This was correlated with:

1) Exposure to violence, and
2) Displacement duration

Feelings of sadness amongst our participants were found to be highly correlated with both exposure to violence and increase duration of displacement. This is shown in Tables 4.1 and 4.2 below

.

Table (4.1):- Feelings of sadness * Exposure to violence

		P-value
Feeling sad	Exposure to violence	0.04

Table(4.2):- Feelings of sadness *
Displacement

		P-value
Feeling sad	Increased duration of displacement	0.03

Chapter Five:

Discussion

The relationship between exposure to war trauma and development of acute stress disorder and posttraumatic stress disorder (PTSD) is well documented in the literature (1, 3, 6, 9, 10). This is shown in our findings.

Following the 9/11 attacks and the Oklahoma City bombing in the USA, children who watched more television coverage of the traumatic events experienced more posttraumatic stress symptoms (8, 11). This is similar to our findings as well.

When children are exposed to war and conflict directly, the number of conflict-related traumatic events (11), the duration of the threat (13), and the severity and nature of the threat mediate psychological outcomes and distress. Our data indicates that increased displacement duration was associated with mental health disturbances.

Chapter Six:
Conclusions and Recommendations

Conclusion:

In conclusion, our research has shown that there exists a significant rate of mental health disorders amongst our participants. This is significant as it further cements the notion that war not only has an effect on the physical and mental well-being of adults, but also that of children.

Recommendations:

Reducing the impact of war on children's mental health requires a multi-faceted approach that involves immediate intervention, long-term support, and systemic changes. Here are some evidence-based recommendations to help mitigate the mental health effects of war on children**:**

.1 **Immediate Psychological First Aid (PFA)** :

- Training Caregivers and Educators: Train parents, teachers, and community leaders in Psychological First Aid (PFA) to provide immediate emotional support to children after traumatic events**.**

- Safe Spaces: Establish safe spaces where children can feel secure and express their emotions. These can be in the form of child-friendly spaces within refugee camps or community centers**.**

- Crisis Counseling: Deploy mobile mental health teams to provide crisis counseling and support for children and families in conflict zones**.**

.**2 Access to Mental Health services :**

- School-Based Mental Health Programs: Implement school-based mental health programs that provide counseling, group therapy, and psychoeducation. Schools are often the most accessible points for children in conflict zones**.**

- Integration of Mental Health into Primary Care: Ensure that mental health services are integrated into primary healthcare systems so that children can receive care as part of routine health visits**.**

- Telehealth and Remote Counseling: Utilize telehealth platforms to provide remote counseling and therapy to children in areas where access to in-person services is limited due to conflict**.**

.**3 Psychosocial Support Programs**:

- Community Support Groups: Organize community support groups where children can share their experiences and receive peer support. These groups can be led by trained mental health professionals or community members**.**

- Art and Play Therapy: Implement art therapy, play therapy, and other creative therapeutic approaches to help children process their trauma in a non-verbal and accessible way**.**

- Resilience-Building Activities: Engage children in activities that promote resilience, such as sports, music, and drama. These activities can help rebuild self-esteem and foster a sense of normalcy.

4 .**Family and Caregiver Support :**

- Parental Education: Provide education and training for parents and caregivers on how to support their children's mental health during and after conflict. This includes teaching stress management and positive parenting techniques.

- Family Therapy: Offer family therapy sessions to help rebuild and strengthen family bonds that may have been strained due to the war.

- Economic Support: Provide financial and livelihood support to families to reduce stressors related to poverty, which can exacerbate mental health issues in children.

5 .**Reintegration of Child Soldiers :**

- Specialized Rehabilitation Programs: Develop specialized rehabilitation programs for former child soldiers, focusing on trauma recovery, education, and skills training.

- Community Acceptance and Reintegration: Work with communities to facilitate the reintegration of former child soldiers, addressing stigma and promoting acceptance.

- Legal and Social Protection: Ensure legal protection for former child soldiers and provide access to social services that support their reintegration.

6 .**Education and Awareness :**

- Mental Health Education: Include mental health education in school curriculums to teach children about emotional regulation, coping mechanisms, and when to seek help.

- Awareness Campaigns: Launch awareness campaigns that destigmatize mental health issues and encourage communities to support children's mental health needs.

- Teacher Training: Train teachers to recognize signs of trauma and mental health issues in students and provide initial support or referrals to mental health services.

7 .Policy and Advocacy :

- Advocacy for Children's Rights: Advocate for the protection of children's rights in conflict zones, emphasizing the importance of mental health care as a critical component of humanitarian aid.

- Integration into National Policies: Work with governments to integrate child mental health services into national health and education policies, ensuring that mental health support is part of the broader response to conflict.

- Monitoring and Evaluation: Establish systems for monitoring and evaluating the effectiveness of mental health interventions for children in conflict zones to ensure that programs are meeting their needs.

.8 Long-Term Peacebuilding Efforts :

- Conflict Resolution Education: Integrate conflict resolution and peace education into school curriculums to help children develop skills for peaceful conflict resolution and reduce the likelihood of future violence.

- Community Reconciliation Programs: Support community-based reconciliation programs that address the root causes of conflict and promote healing and social cohesion.

- Support for Displaced Children: Provide long-term support for displaced children, including stable housing, education, and continued access to mental health services.

Key Organizations and Resources:

- UNICEF: Offers various programs and resources aimed at supporting children in conflict zones.

- Save the Children: Provides mental health and psychosocial support to children affected by war.

- International Rescue Committee (IRC): Focuses on education and mental health programs in conflict and post-conflict settings.

- World Health Organization (WHO): Provides guidelines for mental health and psychosocial support in emergency settings.

Recommended Reading:

- *Helping Children Cope with Trauma: Individual, Family and Community Perspectives* by

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Annexes :

Napata College

Questionnaire:

Impact of War on Children's Mental Health in Sudan 2024

Thank you for participating in this survey. The purpose of this questionnaire is to understand the impact of the ongoing conflict on the mental health of displaced children in Sudan. Your responses will help us provide better support and resources. Please answer the questions honestly. Your responses are confidential.

1. Age:

- a) 6-9 years

- b) 10-12 years

- c) 13-15 years

- d) 16-18 years

2. Gender:

- a) Male

- b) Female

- c) Prefer not to say

3. Duration of displacement:

- a) Less than 1 year

- b) 1-2 years

- c) More than 2 years

4. How often do you feel sad or depressed?

- a) Always

- b) Often

- c) Sometimes

- d) Rarely

- e) Never

5. Do you have trouble sleeping? (e.g., difficulty falling asleep, nightmares)

- a) Always

- b) Often

- c) Sometimes

- d) Rarely

- e) Never

6. How often do you feel anxious or scared?

- a) Always

- b) Often

- c) Sometimes

- d) Rarely

- e) Never

7. Do you find it difficult to concentrate or focus on tasks?

- a) Always

- b) Often

- c) Sometimes

- d) Rarely

- e) Never

8. How frequently do you experience physical symptoms like headaches or stomachaches?

- a) Always

- b) Often

- c) Sometimes

- d) Rarely

- e) Never

9. Do you feel safe in your current living environment?

- a) Always

- b) Often

- c) Sometimes

- d) Rarely

- e) Never

10. How often do you have support from friends or family when you are feeling down?

- a) Always

- b) Often

- c) Sometimes

- d) Rarely

- e) Never

11. Do you have access to activities that make you feel happy or relaxed? (e.g., playing, reading, sports)

- a) Yes

-b) No

12. How often do you feel hopeful about the future?

- a) Always

- b) Often

- c) Sometimes

- d) Rarely

- e) Never

13. Have you received any counseling or mental health support since being displaced?

- a) Yes

- b) No

14. If yes, how helpful has the counseling or mental health support been?

- a) Very helpful

- b) Somewhat helpful

- c) Not helpful

15. What are the biggest challenges you face in your daily life? (Select all that apply)

- a) Lack of food

- b) Lack of clean water

- c) Lack of education

- d) Lack of safety

- e) Separation from family

- f) Poor health

16. What kind of activities or support do you think would help you feel better? (Select all that apply)

- a) Talking to a mental health expert

- b) Participating in sports or physical activities

- c) Having more safe places to play

- d) Access to better education
- e) Spending more time with family

17. How often do you feel angry or frustrated?
- a) Always
- b) Often
- c) Sometimes
- d) Rarely
- e) Never

18. Do you have someone to talk to about your experiences and feelings?
- a) Yes
- b) No

19. Have you witnessed or experienced violence during the conflict?
- a) Yes
- b) No

20. If yes, how often do you think about these experiences?
- a) Always
- b) Often
- c) Sometimes
- d) Rarely
- e) Never

21. Do you have access to educational resources and support?
- a) Yes

-b) No

22. How often do you participate in social activities with other children?

- a) Always
- b) Often
- c) Sometimes
- d) Rarely
- e) Never

23. How has your relationship with your family changed since being displaced?

- a) Improved
- b) Stayed the same
- c) Worsened

24. Do you feel that you have enough privacy in your current living situation?

- a) Yes
- b) No