

Lessons for Protecting and Promoting Mental Health and Well-Being in Conflict settings

Evidence Review on Humanitarian Protection

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Armed conflict damages mental health and well-being through several channels: direct exposure to violence, abuse, and loss; the collapse of livelihoods and social structures; and the sustained uncertainty of forced displacement. Mental health and psychosocial support (MHPSS) is now recognized as an integral part of humanitarian response, yet rigorous evidence on which approaches work, and in which contexts, remains thin. Policymakers and practitioners therefore have limited guidance on where to invest and what to prioritize.

This review synthesizes evidence from randomized evaluations that measure the effects of interventions on the mental health and well-being of populations affected by conflict or forced displacement. It is organized into two sections. The first section covers interventions that aim to improve people's economic or social circumstances: livelihood and economic empowerment packages, cash and voucher transfers, employment programs, and community reconciliation. Many of these were not designed primarily to improve mental health, but their evaluations include mental health and well-being outcomes. The second section covers psychological interventions that address distress and related symptoms directly through structured therapy. Because mental health clinicians are scarce in these settings, these interventions are almost always delivered by trained non-specialists.

The studies in both sections measure one or both of two kinds of outcomes: well-being, such as life satisfaction, happiness, and a sense of self-worth or control over one's life; and clinical symptoms, such as those of depression, anxiety, and post-traumatic stress disorder (PTSD). Appendix A contains further details on the design and implementation of each intervention discussed, and Appendix B describes the instruments used to measure well-being and clinical symptoms.

Inclusion Criteria

Randomized evaluations that took place in conflict settings and measured mental health and well-being outcomes were considered for inclusion. Only studies that took place in an active conflict, post-conflict, or displacement setting were included. Given the challenges of conducting a randomized evaluation in a conflict setting, studies were carefully examined for methodological quality. Studies that met a high-quality bar were classified as "primary evidence," and the conclusions of this evidence review are based on those high-quality papers. Medium-quality methodological studies were

classified as "suggestive evidence" and integrated where their conclusions support the high-quality studies. At the bottom of each section, we summarize the number of studies supporting the conclusions of the section, as well as their quality classification (primary or suggestive evidence), and their conflict setting classification.

Part 1: Economic and Social Interventions

Beyond direct exposure to violence and loss, conflict and displacement harm mental health through their effects on people's material and social circumstances: lost income and assets, insecure livelihoods, and the erosion of trust and social ties within communities. Interventions that improve these circumstances may therefore also benefit mental health and well-being.

This section reviews evidence on four types of economic and social interventions: livelihood and economic empowerment packages, cash and voucher transfers, employment programs, and community reconciliation initiatives. Most were designed to achieve economic or social goals and measure mental health as one of several outcomes.

Economic and Social Empowerment

Limited evidence exists on social and economic empowerment interventions in conflict settings, but four studies provide some foundational knowledge.

In Afghanistan, a Graduation approach program that combined an asset transfer with coaching reduced poverty and improved psychological well-being among households living in extreme poverty (Bedoya et al. 2019). Suggestive evidence from the Democratic Republic of the Congo (DRC) points in the same direction: a livestock transfer program reduced symptoms of PTSD and anxiety (Glass et al. 2017).

Multi-faceted, "big push" programs, often called Targeting the Ultra-Poor or the Graduation approach, give participants a time-limited package of productive assets, cash stipends, skills training, and coaching, with the goal of lifting them out of extreme poverty. They have proven effective in stable contexts at reducing poverty (Banerjee et al. 2015), and emerging evidence suggests they also improve economic outcomes in conflict settings (Bedoya et al. 2019; Leight et al. 2025; Brune et al. 2022).

In Afghanistan, the program targeted ultra-poor women in eighty villages in the Balkh province. The program began in 2016 and endline data was collected in 2018. During this period, Afghanistan was in an ongoing armed conflict between the Afghan government and the Taliban and other insurgent groups.

Two years after the initial asset transfers, the Graduation program had large and positive impacts on consumption and various measures of household members' well-being. Graduation households saw increases in consumption; this directly led to a decrease in the share of households below the national poverty line in the sample. Most importantly for this review, Graduation households had better psychological well-being. The primary woman in the household saw psychological well-being gains of 0.58 standard deviations (SD) relative to the comparison group, while the primary man in the household saw psychological well-being gains of 0.26 SD.

Psychological well-being was measured as an index combining the Center for Epidemiologic Studies Depression (CES-D) scale, World Values Survey questions on happiness and life satisfaction, Cohen's four-item perceived stress scale, and cortisol levels, a neurobiological marker of stress, obtained from saliva samples.

Suggestive evidence from the eastern DRC is consistent with these results. Pigs for Peace, a livestock program in rural South Kivu, gave households a female piglet on credit. Households repaid the loan by passing two piglets from the first litter to other households, and they received training on raising pigs, biweekly home visits, and veterinary support. Eighteen months after the program began, participants reported fewer symptoms of PTSD and anxiety and better self-rated health than the comparison group. These results should be treated as suggestive: program staff helped collect the survey data, which raises the risk that participants over-reported improvements, and the program group already reported lower anxiety before the program began (Glass et al. 2017).

In contrast to the programs above, two training-based, intimate partner violence (IPV) -focused empowerment programs did not improve women's mental health. In Afghanistan, social and economic empowerment training reduced neither IPV nor depression among conflict-affected women (Gibbs et al. 2020). In Liberia, a year of vocational training and psychosocial counseling reduced IPV but did not improve psychological distress or happiness (Park and Kumar 2022).

A twelve-month social and economic empowerment program, Women for Women International, in Afghanistan did not reduce women's experience with IPV or improve their depression symptoms. The program, targeted at the most marginalized women in conflict-affected communities, included training on a variety of topics on economic and social empowerment, including numeracy, business skills, money management, and referrals to health, legal, and financial services. Notably, the content did not contain information specific to preventing IPV. The intervention instead was formulated on the theory that women's economic and social status in the household may be a root cause of IPV. The researchers also expected that reducing IPV and poverty could improve women's depressive symptoms.

The program took place during a similar time as the Graduation approach study above; it began in 2016, and follow-up data were collected in 2018. The program communities were in Kabul and Nangarhar provinces. Some communities in the study were affected by the conflict, forcing the research team to end follow-up surveys early in one village.

After 22 months, women's experiences of past-year physical IPV, past-year severe IPV, and depressive symptoms did not improve. Depression symptoms were measured using the CES-D scale (Gibbs et al. 2020).

In post-conflict Liberia, the Women Training and Integration (WIN) program, run by the Liberian Red Cross, offered vulnerable women in Monrovia's informal settlements a year of daily vocational and business training combined with counseling. Twelve months after the program ended, it had reduced women's experience of physical and emotional IPV, but it did not change psychological distress or happiness. These results should be treated as suggestive, as the study was smaller than planned and the program's business start-up kits and cash grants were not delivered (Park and Kumar 2022).

Primary evidence base: 2 papers (2 Afghanistan, both active conflict settings).
Suggestive evidence base: 2 papers (1 DRC, protracted conflict setting; 1 Liberia, post-conflict setting).

Digital Aid and Cash-Like Vouchers

A systematic meta-analysis of the effects of cash transfers on well-being and mental health in low- and middle-income countries (LMICs) has shown a positive effect. In a review of 45 studies in LMICs, the average effect size of cash transfers on mental health outcomes was 0.07 standard deviations. The effect on subjective well-being was 0.13 standard deviations (McGuire et al. 2022). However, none of these studies took place in active conflict settings, and the effects of cash transfers on mental health and well-being in conflict settings are less understood. The available evidence is reviewed below.

Digital aid and voucher transfers delivered amid acute crisis and conflict may improve self-reported well-being. Evidence on clinical symptoms of mental illness is thinner: only one of the two studies reviewed tested for it and found no effect (Callen et al. 2025; Quattrochi et al. 2022).

Evidence from Afghanistan and the DRC suggests that digital aid and cash-like transfers can improve psychological well-being in both the immediate term and one year later.

In Afghanistan, four digital aid payments of US$45 improved well-being and food security. The digital payments were sent every two weeks for two months and were equal to 3.75 months' average monthly income for the beneficiaries. They were distributed via mobile phone to low-income, female-headed households. Delivery was coordinated by non-state actors in a design intended to limit interference by Taliban authorities, and take-up was near universal despite low tech literacy.

In addition to improving food security, beneficiaries of the payments were 28 percentage points more likely to report being very or quite happy compared to those who had not yet been paid, of whom 15 percent reported the same (an increase of about 180 percent). These gains grew over the two months; after three or four payments, effects were 40 to 100 percent larger than after one to two payments. Because the comparison group began receiving payments as soon as the first group's payments ended, the study cannot show whether these gains lasted after assistance stopped.

The researchers measured well-being using the Cantril Self-Anchoring Striving Scale, a measure of life satisfaction that runs from 1 to 10. While this scale is an established measure, it is not a clinical measure of mental health.

In the eastern DRC, a one-off voucher worth US$55 to US$90 was shared with participants. The voucher was redeemable for essential household items at a program-organized fair. Participants who received the voucher improved psychological well-being by 0.32 standard deviations six weeks after distribution and 0.18 standard deviations one year later, relative to the comparison group. Unlike most evaluations of cash transfers in humanitarian settings, psychological well-being was the study's pre-specified primary outcome.

The study measured well-being with three cross-culturally validated instruments. Six weeks after the transfer, households that received it scored 1.29 (on a 0–5 scale) on the WHO-5 Well-Being Index, compared with 1.09 in the comparison group, a 19 percent difference. Their life satisfaction was 3.88, compared with 3.29, an 18 percent improvement.

The Hopkins Symptom Checklist (HSCL-25) screening for anxiety and depression did not improve.

Together, these studies suggest that economic transfers can improve how people in crisis rate their well-being, but neither provides strong evidence that transfers reduce clinical symptoms of mental illness.

Both studies measured subjective well-being and found gains, in two different crises and through two different delivery channels. However, only one study administered a clinical screening survey and it found no impact. The evidence that economic transfers shift how people evaluate their lives is therefore stronger than the evidence that they reduce symptoms of depression, anxiety, or PTSD. One possibility is that transfers ease the daily stressors of material deprivation without addressing the trauma and loss that drive clinical disorder in conflict settings. Another is that transfers do affect clinical symptoms, but by less than they affect well-being (as seen in the McGuire et al. 2022 meta-analysis), and by too little for studies of this size to detect. The studies reviewed here cannot distinguish between these explanations.

Of note for practitioners, the two interventions differed in operations but led to similar results. In Afghanistan, female-headed households were given digital payments via mobile phone in an economy that had collapsed under a new de facto government. In the DRC, a single paper voucher, redeemable at a physical fair, was distributed to households displaced by armed groups.
Both programs shared a dependence on functioning local markets. It is unlikely that these interventions would produce improvements in well-being in a setting where supply

cannot respond to a sudden increase in purchasing power, a caveat that applies to some conflict settings.

Primary evidence base: 2 papers (1 Afghanistan, 1 DRC, both active conflict settings).

Employment

Limited evidence exists on whether employment itself improves psychological well-being in conflict and displacement settings. In a Rohingya refugee camp in Bangladesh, a part-time job improved psychosocial well-being more than an equivalent cash transfer (Hussam et al. 2022). A public-works program in the Central African Republic led to a smaller gain in self-reported happiness (Alik-Lagrange et al. 2023).

Rohingya refugees in Bangladesh cannot legally work, and access to informal work in nearby urban centers is sharply limited. Due to these restrictions, researchers estimated that refugees in Cox's Bazaar spent eight hours of a typical day at leisure or idle. Further, 38 percent of this population screened as moderately or severely depressed. Individuals who lacked any paid employment in the previous month were 17 percentage points more likely to qualify as depressed.

Motivated by these conditions, researchers conducted a randomized evaluation to test the impact of cash transfers and longer-duration (two months) employment on mental health. Refugees were randomized into three groups. The first group, the employment group, was offered a part-time survey job that paid US$5.30 per week. The second group, the cash transfer group, received US$5.30 per week as compensation for survey participation. Finally, the comparison group received US$0.60 per week as compensation for answering weekly surveys.

Because the cash and employment arms received identical amounts of money, comparing them allowed the researchers to isolate the impact of work itself.

Refugees offered employment experienced an improvement in psychosocial well-being. They exhibited higher life satisfaction, sociability, beliefs about self-worth, a sense of control over their life, and security in both the present and anticipated long-term future. Participants in the employment group were 6.5 percentage points (or 21 percent) less likely to experience moderate or severe depression relative to the comparison group. Mental health did not improve for participants in the cash transfer group. These differences point to the presence of significant benefits to employment

itself, separate from the money earned via employment. Notably, 66 percent of the employed were willing to forgo cash payments in order to continue working temporarily without pay. The psychosocial distinction between employment and cash appeared most prominent for men (Hussam et al. 2022).

The intervention lasted two months with follow-up six weeks later, so longer-run effects on mental health and well-being are unknown.

This study underscores the non-monetary importance employment plays in the psychosocial well-being of displaced populations. The results suggest that the absence of employment opportunities leads to not only material poverty but also psychological loss, and social protection programs seeking to limit the societal costs of unemployment may be more effective if they attend to both kinds of loss.

A public works program conducted in the Central African Republic provides suggestive evidence that the combination of employment plus an asset increases well-being (Alik-Lagrange et al. 2023).

The Londö public works program in the Central African Republic gave beneficiaries forty days of work at about US$3 per day building and repairing local infrastructure, plus a bicycle they kept afterward. Beneficiaries were chosen by public lottery, and the researchers compared lottery winners to losers two to eighteen months later using a cross-sectional survey of 6,111 applicants. Baseline data was not collected due to security concerns.

When comparing those who were selected in the lottery against those who were not, self-reported happiness rose 0.14 standard deviations. It should be noted that the Hussam et al. (2022) paper above employs a more complete measure of mental health and well-being; this study deployed only a single survey item on a four-point scale to measure happiness. Furthermore, the Londö public works program took place in an active conflict setting, while the Hussam et al. (2022) work took place in a displacement setting where work was illegal for refugees.

Of note for policymakers and humanitarian practitioners, Hussam et al. (2022) provides the stronger evidence. The Londö public works program offers suggestive evidence that employment improves well-being, but it is not strong enough to stand on its own.

Primary evidence base: 1 paper (Bangladesh, displacement setting).
Suggestive evidence base: 1 paper (Central African Republic, active conflict setting).

Dispute Resolution and Reconciliation Efforts

To restore social cohesion after war and conflict, many countries pursue truth and reconciliation efforts. However, a community-level reconciliation forum in Sierra Leone worsened psychological health for participants (Cilliers et al. 2016).

In Sierra Leone, a NGO called Fambul Tok designed and implemented community-level reconciliation forums. The forums were implemented roughly five years after the civil war ended in 2002. Trained community members conducted outreach to encourage victims and perpetrators to participate in the forums and share their experiences. After organizing participants, a two-day bonfire ceremony was held where victims shared their experiences and perpetrators asked for forgiveness.

Researchers studied the impacts of the program by randomizing the areas in which the community-level forums were conducted. While the truth and reconciliation efforts resulted in higher forgiveness of perpetrators and strengthened social capital, psychological health worsened for participants (both victims and perpetrators). A psychological index fell by 0.14 standard deviations, and anxiety, depression, and PTSD all worsened. The indicator for clinical PTSD was 2.9 percentage points higher than the comparison group mean of 8 percent (a 36 percent increase) for participants in the forums.

For a subset of participants, the longer-term effects of the truth and reconciliation forums were measured at nine and 31 months after the ceremonies. The adverse psychological effects did not fade over time.

Although these results come from only one study, they suggest that policymakers working in post-conflict settings should seek to structure reconciliation processes in a way that reduces their negative psychological costs while retaining their positive societal benefits. More evidence is needed to know whether the tradeoff between social cohesion gains and psychological well-being is a feature of truth and reconciliation committees or whether the tradeoff is specific to this program design.

Primary evidence base: 1 paper (Sierra Leone, post-conflict setting).

Looking Ahead: Priorities for Future Research

Executing a high-quality, ethical randomized evaluation in a conflict setting is difficult. The relatively thin evidence base outlined above underscores this challenge. We cannot draw strong conclusions from the evidence above without additional studies that confirm mechanisms, pathways of change, and impact in multiple settings. Despite the caveats, we hope these results provide useful information for humanitarian practitioners. In addition to the need to accumulate more evidence, priority questions for future research include:

- **How long do these mental health and well-being effects last?** Most studies in the section measured outcomes during the program or within a few months of it ending. Thus, little is known about whether effects last once support stops. Two studies do offer a longer view. First, in the DRC, well-being gains from a one-off voucher fell from 0.32 SD at six weeks to 0.18 SD one year later. The gains decreased in size, but they did not disappear. Second, in Sierra Leone, the psychological harms of reconciliation forums had not faded 31 months later. Other studies, including the evaluations of digital aid in Afghanistan and employment for Rohingya refugees, measured effects within a few months of the program ending. Future research should investigate whether improvements in well-being persist after assistance ends, or whether ongoing or repeated support is needed to maintain them.

- **What is the complementarity between mental health support and material support?** Material transfers in this section improved how people rated their lives, but the link to clinical mental health is weaker. In the DRC, vouchers raised life satisfaction but did not reduce symptoms of anxiety or depression, and in Bangladesh, cash on its own did not improve mental health. One possibility is that material support eases daily stressors but does not address the trauma and loss that drive mental illness in conflict settings. If so, pairing material assistance with psychological support could produce gains that neither delivers alone. Future research should test whether combined packages improve mental health, and whether the same package that best raises consumption also best improves mental health.

Ongoing Research on Protection in Conflict Settings

The Humanitarian Protection Initiative (HPI) supports research to build our understanding of what works to prevent and mitigate harm caused by conflict. Over the next year, HPI-funded work will shed light on:

Monitoring for Protection: Reducing Workplace Sexual Violence Against Sudanese Refugees in Egypt

Sudanese refugee women in Egypt face high rates of sexual violence and exploitation in informal domestic work, where undocumented status leaves them with little access to legal protection and employers act with little fear of consequences. Building on focus groups and partnerships established with Caritas Egypt and UNHCR Egypt in early 2025, this pilot tests whether third-party monitoring can reduce that abuse.

The pilot examines two possible pathways to protection: whether the prospect of monitoring discourages abusive employers from hiring refugee workers in the first place, and whether alerting current employers to upcoming check-ins reduces mistreatment by raising their sense of accountability. Refugees will be surveyed throughout on gender-based violence (GBV) exposure, psychosocial well-being, and labor conditions.

Growing Stronger Together: A Family Strengthening Approach to Reduce Child Engagement With Armed Forces

In partnership with the International Rescue Committee, researchers in the Central African Republic are evaluating "Growing Stronger Together" (GST), a family strengthening program designed to prevent children from being recruited into armed forces and armed groups, and to support the reintegration of children who have already been involved with them. GST pairs group-based parenting curricula with individualized support tailored to caregivers whose children have been recruited or are at risk.

The evaluation aims to test the ability of GST to prevent child recruitment by armed groups and support reintegration of former child soldiers back into their communities. It will also untangle the mechanisms that lead to these changes: promoting parenting skills, improving caregiver-child relationship quality, child resilience, and/or mental health.

Online Ambulance – Empowering Women and Girls Against Technology-Facilitated Gender-Based Violence

In Myanmar, military junta and pro-State Administration Council accounts are the primary drivers of a damaging campaign of Technology-Facilitated Gender-Based Violence (TFGBV) against women opposing the regime. TFGBV, including doxxing, non-consensual image circulation, threats, and coordinated smear campaigns, is used to silence women's political participation during the ongoing conflict. Online Ambulance is a survivor-led platform that helps people targeted by TFGBV access psychosocial support and digital security assistance.

A pilot study lays the foundation for a future impact evaluation by testing practical questions, including: How prevalent is TFGBV among Myanmar Facebook users and university students, and how much demand is there for support services? Which outreach and messaging strategies are most effective at encouraging people to take up support?

Part 2: Psychological Interventions

Part 1 of this review speaks to the ties between people's economic and social circumstances and their mental health and well-being. This section turns to interventions that aim to improve mental health directly through structured, time-limited therapies delivered by trained non-specialists, individually or in groups.

The largest body of evidence comes from programs informed by cognitive behavioral therapy (CBT), some of which were combined with education subsidies or cash grants. Five other approaches have each been tested in one or two studies with conflict-affected or displaced populations: Narrative Exposure Therapy (NET), Interpersonal Psychotherapy (IPT), Problem Management Plus (PM+), the Common Elements Treatment Approach (CETA), and Self-Help Plus (SH+). The section closes with evidence from Jordan on how stigma can keep people from using mental health services.

As in Part 1, we distinguish between effects on well-being and daily functioning and effects on clinical symptoms of depression, anxiety, and PTSD.

Cognitive Behavioral Therapy (CBT) -Informed Interventions

Cognitive behavioral therapy (CBT) is a structured, short-term form of psychological treatment that focuses on solving problems by helping people identify and change unhelpful patterns of thinking and behavior. Through practice both in and between sessions, people learn new coping skills. CBT is an established treatment for depression, anxiety, and post-traumatic stress (Beck 2020).

CBT-informed programs delivered by trained non-specialists improved participants' daily functioning and/or well-being in the short run across four different conflict-affected settings. In Chechnya and the DRC, CBT also led to improvements in depression, anxiety, or post-traumatic stress symptoms. Evidence on whether these effects last is limited and mixed. Improvements faded within six months in Sierra Leone, while in Liberia, therapy followed by a cash grant improved mental health up to ten years later (Betancourt et al. 2014; Blattman et al. 2017; Blattman et al. 2023; Lenglet et al. 2018; O'Callaghan et al. 2013).

The four programs summarized here varied in who they served and how they were delivered, but all showed some positive results:

- In Sierra Leone, war-affected youth with elevated distress attended a ten-session group program.
- In Chechnya, adults with elevated anxiety and depression symptoms received an average of four individual counseling sessions.
- In Liberia, young men involved in crime and violence attended an intensive eight-week group program, and some also received a US$200 cash grant.
- In the DRC, adolescent girls who had experienced sexual violence attended a fifteen-session trauma-focused group program.

In every case, trained counselors or facilitators—rather than psychiatrists or clinical psychologists—led the sessions. The trained facilitators included local health workers, social workers, or former combatants. The studies also measured different outcomes. Some focused on daily functioning and well-being and others on clinical symptoms. As in Part 1, this section distinguishes between improvements in well-being and clinical symptoms.

In post-war Sierra Leone, group-based CBT improved youth functioning in the short run, but not overall distress (Betancourt et al. 2014). In Sierra Leone, war-affected youth aged 15–24 with elevated psychological distress received the Youth Readiness Intervention (YRI), a program combining CBT and interpersonal therapy techniques. YRI was delivered by trained local health workers over ten to twelve in-person sessions. Participants were randomly assigned to one of two groups in two consecutive stages. In the first stage, participants were assigned either to the YRI intervention group or to a waitlist comparison group. After the YRI intervention period ended and outcomes were measured, participants were randomly assigned a second time to either receive the education subsidy or remain on the waitlist. This two-stage design allowed for comparisons of the effects of the YRI intervention, the education subsidy, and their combination.

Immediately after YRI, young people in the program group showed greater improvement than the comparison group in managing their emotions, caring about and helping others (prosocial attitudes and behaviors), social support, and carrying out their daily activities, with effect sizes ranging from 0.29 to 0.39 standard deviations.[1] In

[1] Emotion regulation improved by 0.31 standard deviations from the comparison group's baseline mean of 3.40. Prosocial behavior improved by 0.39 standard deviations from a comparison group baseline of 1.79. Social support improved by 0.29 standard deviations from a comparison group baseline of 1.11. Functional impairment decreased by 0.32 standard deviations from a baseline of 0.57.

contrast, an education subsidy alone did not improve young people's mental health or daily functioning, and combining it with YRI did not produce additional benefits. For young people affected by war and experiencing distress, lowering the cost of school may not be enough to improve well-being.

The gains from YRI did not last. Six months after the program ended, young people who had taken part in YRI were no longer different from the comparison group on any of these outcomes. Psychological distress and PTSD symptoms did not improve relative to the comparison group at either time point.

In Chechnya, individual counseling using CBT techniques reduced psychological distress among conflict-affected adults (Lenglet et al. 2018). Grozny, Chechnya has experienced years of conflict and ongoing insecurity. In 2015, researchers provided individual counseling to adults with elevated levels of anxiety and depression symptoms. The counseling drew on brief trauma-focused therapy and CBT techniques; it was delivered by non-specialists, averaging four sessions over one month. These sessions led to improvements in health and daily functioning, including self-rated health, how much physical pain limited daily activities, how health problems interfered with social activities, and how much emotional problems interfered with daily activities, with effect sizes of 0.35 to 0.91 standard deviations, compared to the waitlisted comparison group.[2] Counseling also produced reductions in anxiety, depression, and overall psychological distress, with effect sizes of about one standard deviation. PTSD prevalence in the program group fell from 38.1 percent to 6.4 percent (an 83 percent decrease), compared to a smaller decline in the waitlisted group, from 46.4 percent to 38.8 percent (a 16.5 percent decrease).[3] Counseling did not affect coping strategies as much: while there was improvement in perceived social support, reliance on avoidance worsened over the course of the program, and there was no meaningful improvement in problem-solving or social-support seeking coping strategies.

[2] Each outcome was measured on a 0–100 scale, where higher scores indicate better health or functioning. Relative to the waitlisted comparison group, counseling improved self-rated health by 0.52 standard deviations (12.1 points, a 38 percent increase relative to the comparison group's score of 31.9 at the end of the waitlist period), limits on daily activities due to physical pain by 0.35 standard deviations (10.3 points, a 22 percent increase from 47.1), interference of health problems with social activities by 0.69 standard deviations (16.1 points, a 31 percent increase from 51.2), and interference of emotional problems with daily activities by 0.91 standard deviations (16.9 points, a 30 percent increase from 56.4). Effects compare the change in scores during counseling for the program group with the change over the two-month waitlist period for the comparison group.

[3] This analysis was not intention-to-treat (ITT); about 5 percent of participants in each group were missing follow-up data. The rest of reported results from Lenglet et al. are ITT.

In post-war Liberia, group-based CBT followed by a cash grant improved young men's mental health in both the short run and ten years later, driven largely by gains in self-esteem and well-being. Therapy without the cash grant did not affect mental health (Blattman et al. 2017; Blattman et al. 2023).

Liberia emerged from fifteen years of civil war in 2003. In the years that followed, the government was concerned about young men involved in crime and violence, including former combatants. Researchers conducted a randomized evaluation to measure the impact of the Sustainable Transformation of Youth in Liberia program (STYL), an intensive eight-week CBT program targeting high-risk young men to reduce criminality and other destructive behaviors. The men who participated were actively involved in crime and violence; thirty-eight percent had previously belonged to an armed group. The intervention, facilitated mostly by former combatants and offenders themselves, focused on improving self-control and self-image, managing anger and violence, and helping participants recognize harmful thoughts and behaviors and practice alternative responses. The program also encouraged participants to see themselves as members of mainstream society rather than as outcasts or criminals.

Participants were randomly assigned to four groups: therapy only, a US$200 cash grant only, therapy followed by the cash grant, or a comparison group that received neither. This design allowed researchers to compare the effects of therapy alone, cash alone, and the two combined. Outcomes were measured about one month after the program ended (the short-run outcomes), one year later, and roughly ten years later.

The researchers measured mental health using an index that combines six outcomes: neuroticism, self-esteem, locus of control, subjective well-being, depression, and distress. Those who received both therapy and cash reported improved mental health. After one month, the mental health index improved by 0.34 standard deviations. After one year, the mental health index improved by 0.22 standard deviations and by 0.21 standard deviations after ten years, largely through improvements in self-reported well-being and self-esteem. These are large changes by the standards of most therapeutic interventions. Neither therapy alone nor cash alone had an effect on the mental health index at any point in the ten years after the program.

In addition to the mental health outcomes, therapy and cash made participants more patient and forward-looking after ten years, improving forward-looking time preferences by 0.25 standard deviations. After ten years, both therapy alone and

therapy plus cash reduced antisocial behavior by 0.20 and 0.25 standard deviations, respectively.[4] Both effects were concentrated among the men with the highest levels of crime and violence at the start of the study.

A preliminary evaluation of trauma-focused CBT (TF-CBT) provides suggestive evidence of reducing PTSD, depression, and anxiety (O'Callaghan et al. 2013). TF-CBT is an adaptation of CBT developed for individuals who have been exposed to trauma. In a small study in the DRC, a group-based, culturally-adapted version was delivered by trained social workers to war-affected adolescent girls exposed to sexual violence. The five-week program reduced post-traumatic stress symptoms by 57 percent compared to a waitlisted comparison group (the comparison group scored 42.9 points on average on an 88-point scale, while the TF-CBT group scored 18.4 points on average). It also reduced combined depression and anxiety symptoms by 65 percent (the comparison group scored 40.0 points on average, while the TF-CBT group scored 14.0 points). Due to the small scale of the evaluation, these results should not be taken as conclusive, and the effect size may be inflated. However, the directional effects are promising and warrant further research on trauma-focused adaptations of CBT for conflict-affected populations.

Taken together, these four evaluations suggest that brief CBT-informed programs led by trained counselors or facilitators, rather than psychiatrists or clinical psychologists, can improve how people in conflict-affected settings function and feel in the short run. It is less certain whether these programs reduce clinical symptoms or produce lasting gains in mental health. The two studies that reduced symptoms of depression, anxiety, and post-traumatic stress, in Chechnya and the DRC, both drew on trauma-focused techniques. However, neither study measured whether the effects lasted. The evaluations in Sierra Leone and Liberia measured symptoms of distress, depression, and post-traumatic stress, but their clearest gains were in functioning, self-esteem, and well-being. The evidence from Liberia showed promising long-term effects in improving self-esteem and well-being, but more research is needed to determine how to make lasting improvements in clinical mental health.

Primary evidence base: 3 evaluations, 4 papers (Sierra Leone and Liberia, post-conflict settings; Chechnya, post-conflict with ongoing insecurity).
Suggestive evidence base: 1 paper (DRC, active conflict setting).

[4] Therapy alone reduced antisocial behavior by 0.20 standard deviations, while therapy followed by cash reduced antisocial behavior by 0.25 standard deviations. However, the authors could not differentiate these two effect sizes, so we can't say if one treatment was more effective than the other.

Narrative Exposure Therapy (NET)

Narrative Exposure Therapy (NET) is a short-term psychotherapy developed to treat PTSD and other trauma-related conditions among survivors of multiple or prolonged traumatic experiences, such as war and organized violence. It involves patients constructing a chronological narrative of their life, with detailed processing of traumatic events, and can be delivered by trained non-specialists. Narrative Exposure Therapy for Forensic Offender Rehabilitation (FORNET) adapts this approach for people who have both experienced and perpetrated violence, such as former combatants. It integrates narration of the patient's own violent acts into the life narrative, with the aim of reducing both trauma symptoms and violent behavior.

In the eastern DRC, FORNET reduced PTSD symptoms, depression, the desire for violence, and violent behavior among female former child soldiers (Robjant et al. 2019). Many children recruited into armed groups experience violence, witness violence, or are forced to commit violence. When they return home, they often live with lasting mental health problems, especially PTSD, and face stigma and rejection from their families and communities.

In the eastern DRC, trained non-specialist counselors delivered FORNET to women aged 16–25 who had been forcibly recruited by the M23 rebel group, most of them as children. All participants met the diagnostic criteria for PTSD. They were randomly assigned either to FORNET, which combined individual trauma-focused therapy with group sessions on managing aggression, or to a comparison group that continued to receive a local NGO's usual services, including vocational training, empathic listening, basic counseling, and practical support.

At the nine-month follow-up, PTSD symptom severity had fallen by 68 percent for women in the FORNET group relative to 23 percent in the comparison group. Thirty-five percent of women who received FORNET still had PTSD compared with 86 percent of the comparison group (a 51 percentage point difference, or 59 percent lower). FORNET also reduced the women's desire for violence (what psychologists call appetitive aggression), depression, and self-reported violent behavior. The treatment also increased participants' sense of social acknowledgement as survivors. However, feelings of guilt related to violence committed were not meaningfully different between groups.

In post-conflict northern Uganda, former child soldiers had fewer PTSD symptoms and less difficulty in daily life after receiving NET from trained community members (Ertl et al. 2011).

From 1987 to 2006, northern Uganda was the site of a civil war between the rebel Lord's Resistance Army (LRA) and Ugandan government forces. The LRA relied on abducting children and forcing them to serve as helpers, fighters, and sexual slaves. About 1.8 million people were displaced into camps. Fighting subsided after a 2006 ceasefire, and people began leaving the camps in 2008.

Between 2007 and 2009, researchers evaluated NET among 85 former child soldiers aged 12–25 with PTSD. All were still living in camps for internally displaced persons. Participants were randomly assigned to one of three groups: 1) eight individual sessions of NET; 2) an equally intensive academic catch-up program that included supportive counseling but did not address traumatic experiences; or 3) a waiting list, whose members received no therapy during the study. Trained local lay counselors delivered both programs in participants' homes.

Young people who received NET had fewer PTSD symptoms than those in either comparison group. Symptoms fell in all three groups over the following year, possibly in part because the conflict was easing, but they fell further for NET participants. A year after treatment, 80 percent of NET participants had a drop in symptoms large enough that clinicians consider it meaningful. In comparison, 48 percent of the academic catch-up group (a 32 percentage point difference, or 67 percent higher) and 50 percent of the waiting-list group (a 30 percentage point difference, or 60 percent higher) did.

NET also helped young people manage daily life with family and friends, at school, and at work better than either comparison group. NET participants felt less guilt about things they had done or survived than those on the waiting list, though not less than those in the academic catch-up group. Researchers were unable to detect differences between NET and either comparison group in depression, thoughts of suicide, or feeling stigmatized by others.

Taken together, these two evaluations suggest that NET and its adaptations can reduce PTSD symptoms among former child soldiers in post-conflict settings. In both studies, young people who received the therapy had fewer PTSD symptoms than those in comparison groups, including groups that received other support such as counseling. NET's benefits also extended beyond PTSD in some cases: in the DRC, FORNET reduced

the desire for violence (appetitive aggression) and violent behavior, outcomes with direct implications for community reintegration and safety. In Uganda, NET improved daily functioning, which is also central to former child soldiers' readjustment and reintegration. However, effects on depression and guilt were mixed and inconsistent. These inconsistencies could reflect the populations, settings, or adaptations studied, or the studies may have been too small to detect effects on these outcomes.

In both studies, community members without mental health qualifications delivered the therapy. This makes NET promising for low-resource humanitarian settings where clinicians are scarce. However, counselors in both studies received intensive training and close supervision from experts, and neither study tested the therapy at a larger scale or measured its costs.

Primary evidence base: 2 papers (DRC, post-conflict setting; Uganda, post-conflict setting).

Interpersonal Psychotherapy (IPT)

Interpersonal Psychotherapy (IPT) is a short-term talk therapy for depression. Therapists follow a standard, step-by-step guide, so the treatment is delivered the same way each time. IPT is based on the idea that depression is closely tied to what is happening in a person's relationships. It helps people work through common relationship problems that can trigger or worsen depression. IPT was first developed for mental health specialists to deliver. It has since been adapted into a group format that trained non-specialists can deliver in low-resource settings (WHO and Columbia University 2016).

A group version of IPT (IPT-G) reduced depression symptoms among adolescents affected by active conflict and displacement in northern Uganda (Bolton et al. 2007). In 2005, during the conflict between the Ugandan government and the Lord's Resistance Army (LRA), researchers tested IPT-G in two camps for internally displaced people in northern Uganda. Study participants were adolescents aged 14–17 with symptoms of depression. More than 40 percent had been abducted by the LRA.

Researchers randomly assigned adolescents to one of three groups: sixteen weekly sessions of IPT-G, a creative play program, or a waitlist comparison group. IPT-G groups were separated by gender and had a facilitator of the same gender who had received two weeks of training.

About one month after the program ended, adolescents who received IPT-G had fewer depression symptoms than those in the comparison group. Girls drove this improvement. There was no change in depression among boys. The study's design does not allow reliable conclusions about the creative play program.

These findings come from a single study with only one follow-up survey, taken shortly after the program ended, so it is not clear whether the effects lasted.

Suggestive evidence base: 1 paper (northern Uganda, active conflict and displacement setting).

Problem Management Plus (PM+)

Problem Management Plus (PM+) is a brief psychological program developed by the WHO for adults whose distress makes it hard to manage daily life in communities affected by adversity such as conflict, displacement, or chronic poverty. Rather than targeting one specific condition, PM+ uses a single set of techniques to address common problems such as depression, anxiety, and stress. Because PM+ is designed to be delivered by trained non-specialists rather than mental health professionals, it is well suited to settings where specialist care is scarce, including conflict-affected settings (WHO 2018).

PM+ delivered by non-specialists reduced depression and anxiety symptoms in two studies in Pakistan, while its effect on PTSD symptoms was less consistent (Rahman et al. 2016; Rahman et al. 2019).

In Peshawar, Pakistan, lay health workers delivered five weekly, ninety-minute individual PM+ sessions to adults with high psychological distress and difficulty functioning in daily life. The trial took place during active conflict, including bomb blasts and attacks on health workers in the study area. The comparison group received "enhanced usual care," meaning standard primary care plus a short refresher training for doctors on anxiety and depression, and basic information for participants about their symptoms and where to seek help.

Three months after starting treatment, anxiety scores in the program group were 28 percent lower than in the comparison group (effect size of 0.74 SD) and depression scores were 32 percent lower (effect size of 0.85 SD). Both differences were roughly twice the smallest change considered clinically meaningful. Post-traumatic stress symptoms were 33 percent lower (effect size of 0.63 SD), and participants also reported

less difficulty functioning. The share of participants meeting criteria for depression was 32 percentage points lower than in the comparison group, where 59 percent of participants had depression (a 54 percent reduction) (Rahman et al. 2016).

A separate study in post-conflict rural Swat, Pakistan tested a group-based adaptation of PM+ for women with psychological distress and difficulty functioning. Local female facilitators with no prior mental health experience delivered five weekly sessions, working in partnership with community health workers.

Three months after the program ended, combined anxiety and depression scores in the program group were 31 percent lower than in the comparison group (effect size of 0.58 SD): 31 percent lower for anxiety (effect size of 0.57 SD) and 30 percent lower for depression (effect size of 0.52 SD). Women in the program group also reported less difficulty functioning and less severe personal problems. Post-traumatic stress symptoms were lower one week after the program (effect size of 0.39 SD), but after three months, this effect faded.

The authors suggest two explanations. Participants had lower PTSD symptoms at baseline, and their distress may have stemmed more from ongoing daily hardship than from trauma. In addition, PM+ does not include the trauma-focused emotional processing found in specialized PTSD treatments (Rahman et al. 2019).

Taken together, these two studies suggest PM+ can be delivered effectively by non-specialists in both individual and group formats in active-conflict and post-conflict settings. Both studies followed participants for about three months, so it is not clear how long the effects last. For populations where PTSD is the main concern, policymakers should note that the evidence on trauma symptoms is mixed, and trauma-focused approaches may be more appropriate. The group format may also be more efficient, since each facilitator works with several participants at once, but neither study reported cost data.

Primary evidence base: 2 papers (Pakistan in active conflict setting and in post-conflict setting).

Common Elements Treatment Approach (CETA)

The Common Elements Treatment Approach (CETA) is a transdiagnostic talk therapy, meaning it uses a single approach to treat several common mental health conditions such as depression, anxiety, and post-traumatic stress, rather than a separate treatment for each one. It was designed for delivery by community members with little or no prior mental health training. Rather than training counselors in a separate therapy for each condition, CETA teaches them a small set of techniques that proven therapies for depression, anxiety, and trauma have in common. These include learning about common reactions to stress and trauma, relaxation, "getting active" through enjoyable or meaningful activities, "thinking in a different way" about upsetting situations, and gradually facing painful memories or feared but safe situations (Murray et al. 2014)

In Thailand, CETA reduced post-traumatic stress, depression, and anxiety among Burmese refugees in the short-term (Bolton et al. 2014).

Decades of military rule in Myanmar, including the imprisonment of political prisoners, attacks on ethnic minority groups, and forced labor, have driven around two million people to seek refuge in Thailand since 1984. Many are survivors of torture and other systematic violence. In Mae Sot, a Thai town on the border, most Burmese refugees lacked documentation, few mental health services were available to them, and many avoided clinics and other public places for fear of arrest and deportation.

Researchers randomly assigned 347 Burmese adults who had experienced trauma and had moderate to severe symptoms of depression or post-traumatic stress to receive CETA immediately or to join a waitlist. Twenty Burmese refugee counselors, only two of whom had prior counseling experience, delivered an average of about ten weekly sessions in places where clients felt safe, such as their homes or community organizations. Counselors adapted the content to local culture, for example by using Burmese folktales and building on coping practices clients already used, such as meditation.

Shortly after treatment ended, CETA reduced depression symptoms by 1.16 standard deviations, post-traumatic stress symptoms by 1.19 standard deviations, and anxiety symptoms by 0.79 standard deviations.[5] It also reduced difficulty with daily tasks and

[5] Effects compare the change in scores from baseline to follow-up for the CETA group with the change over the waitlist period for the comparison group. Depression fell by 1.16 standard deviations (0.49 points on a 0–3 scale; comparison group's score was 0.74 at the end of the waitlist period). Post-traumatic stress fell by 1.19 standard deviations (0.43 points on a 0–3 scale; comparison group's score was 0.62). Anxiety fell by 0.79 standard deviations (0.48 points on a 0–4 scale; comparison group's score was 0.61).

aggressive behavior. However, outcomes were measured once, so it is not clear whether these effects lasted. The waitlist group had no contact with counselors, so the study cannot separate the effect of CETA's techniques from the effect of regular support from a counselor. The trial also relied on intensive remote supervision by US-based experts, which may be hard to sustain at scale. CETA is a promising option for lay-delivered care in displacement settings, but more evidence is needed before it can be considered proven.

Primary evidence base: 1 paper (Thailand, displacement setting).

Self-Help Plus (SH+)

Self-Help Plus (SH+) is a group-based intervention developed by the World Health Organization (WHO) to help people cope with adversity such as violence, armed conflict, and displacement. It is based on acceptance and commitment therapy (ACT), a form of CBT that teaches people to accept difficult thoughts and feelings, mainly through mindfulness, rather than trying to suppress them, and to act in line with what they value. SH+ is delivered to groups of twenty to thirty people over five two-hour sessions. Briefly trained non-specialists can lead the sessions, so SH+ can be used where few mental health specialists are available (Epping-Jordan et al. 2016).

In Uganda, SH+ reduced psychological distress, post-traumatic stress, and depression among South Sudanese refugee women. Effects were largest right after the program ended and smaller three months later (Tol et al. 2020).

Rhino Camp, a settlement in northwestern Uganda, hosted more than 250,000 refugees fleeing renewed conflict in South Sudan, mostly women and children in 2017. Researchers randomly assigned fourteen villages either to SH+ plus enhanced usual care or to enhanced usual care alone, and enrolled 694 women with at least moderate psychological distress. A small group of women with no formal mental health training led the sessions after about nine days of training. Enhanced usual care included one thirty-minute session with a community health worker, plus information on where to find mental health services.

Immediately after the program ended, psychological distress was 0.72 standard deviations lower in the SH+ group than in the comparison group. Three months later, the difference had narrowed to 0.26 standard deviations. At three months, women in the SH+ group also had post-traumatic stress symptoms 0.30 standard deviations lower,

depression symptoms 0.31 standard deviations lower, and well-being 0.36 standard deviations higher. These effects were similar regardless of women's past exposure to trauma or gender-based violence.

The study followed women for three months and did not report costs. Effects were smaller than those of the more intensive therapies reviewed above. However, because each session reached twenty to thirty people and was led by non-specialists, SH+ may be a useful first step in a "stepped care" approach, where people who need more support are referred to more intensive treatment.

Primary evidence base: 1 paper (Uganda, displacement setting).

Delivery of Mental Health Services and Social Stigma

Effective mental health treatment can only help people who are willing to access services. Evidence from an intervention with Syrian refugees in Jordan suggests that stigma stops people from telling their friends about mental health services, even when they know those friends are struggling. When people had a socially acceptable reason to share information, or a "social cover," they shared it more often (Smith 2026).

The studies we outlined above show that brief therapy delivered by non-specialists can improve mental health in conflict-affected settings. However, stigma around mental health may prevent individuals from seeking beneficial care. Among Syrian refugees in Jordan, about half of adults likely have depression. Yet researchers estimated that fewer than seven percent of households in this population sought mental health care recently. Over 40 percent of refugees surveyed said they would not marry someone who had sought professional mental health care. In LMIC settings, individuals often learn about services from friends and through word of mouth, so stigma may stop the spread of information on mental health services.

Researchers tested an intervention intended to give individuals "social cover" for sharing information about mental health services. The researchers asked 849 Syrian refugees to share a mental health awareness campaign with their close friends over WhatsApp. The campaign was designed by the International Rescue Committee and promoted a free phone counseling helpline. Every sharer received the same small payment of US$1.40.

To test the effects of social cover, researchers randomly changed one sentence in the message. Some sharers were encouraged to tell friends that an NGO was paying them to share it; others said they simply wanted to share it. Without the social cover, sharers

sent the campaign to 22 percent of their friends and prioritized sending the message to the highest-need friends. When individuals were given the social cover of being paid to share the message, sharing rose by 7.7 percentage points, from roughly 22 to 30 percent of friends, a 34 percent increase. Those who had used mental health services before responded most strongly: with social cover, they more than doubled how often they shared.

While the evidence from this study provides useful information for mental health practitioners in displacement settings, additional research is needed on how to decrease stigma in mental health services.

Primary evidence base: 1 paper (Jordan, displacement setting).

Looking Ahead: Priorities for Future Research

Priority questions for future research include:

- **How long do improvements last, and what is needed to sustain them?** Some interventions may be best suited to reducing acute distress quickly, for example during an emergency response or soon after displacement. Others may be better at producing lasting change. The current evidence cannot tell these apart, because studies rarely followed participants long enough to compare how effects developed over time: only one of the studies in this section measured outcomes more than a year after the intervention ended. This is a critical evidence gap because, in the three studies that included multiple follow-ups, improvements diminished within a few months of program completion: CBT-related functioning gains in Sierra Leone, PTSD symptom reduction under PM+ in Pakistan, and psychological distress reduction under SH+ in Uganda. Future research should therefore plan and budget for follow-up data collection well beyond the intervention period. Where effects are known to fade, trials could test whether booster sessions, extended engagement windows, or maintenance protocols help sustain them.

- **How do different therapeutic approaches compare in effectiveness and cost?** None of the studies reviewed compared any two of the six therapeutic approaches (CBT, NET, IPT, PM+, CETA, SH+) head-to-head in the same population. Given that they target overlapping outcomes, direct comparison is needed to determine which approach is most effective for a given context, and whether the answer differs depending on whether the primary objective is reducing trauma symptoms or improving broader psychosocial functioning. Additionally, most of the studies reviewed did not report cost data. Future trials should collect and report intervention costs systematically to allow decisionmakers to compare the cost-effectiveness of different approaches as well as delivery formats (such as group versus individual). This is especially relevant because many of these approaches were designed for delivery in low-resource settings.

Ongoing Research on Protection in Conflict Settings

The Humanitarian Protection Initiative (HPI) supports research to build our understanding of what works to prevent and mitigate harm caused by conflict. Over the next year, HPI-funded work will shed light on:

Caregiver Mental Health and Early Childhood Development in Conflict-Affected Settings: At Scale Experimental Evidence from Colombia
The study evaluates the national scale-up of Semillas de Apego, a community-based psychosocial program in Colombia that aims to restore caregiver mental health and protect early childhood development for children under five in conflict-affected and displaced communities, including victims of armed conflict, internally displaced persons, and Venezuelan refugees. Using a phase-in randomized design, it tests whether the program's benefits, which previous studies have found to be effective at a smaller scale, hold up when delivered nationally, across twelve municipalities among over 4,200 caregivers annually.

The study will speak to whether the positive effects documented at a smaller scale are preserved when implemented nationally under real-world conditions, and what this reveals about the broader "scale-up effect" in early childhood development programs, that is, whether well-evaluated interventions lose effectiveness or cost-efficiency as they expand, and what that implies for scaling community-based psychosocial models in humanitarian and fragile settings more generally.

Advancing Screening for and Access to Mental Health Services in Eastern DRC
In the DRC, researchers are testing screening and delivery tools for mental health support among conflict-affected women in Bukavu. The study evaluates whether an AI voice biomarker tool can effectively screen participants for depression, anxiety, and PTSD, and whether Problem Management Plus (PM+), a layperson-delivered psychological intervention developed by the World Health Organization, can be delivered over the phone without reducing its effectiveness.

Specifically, the project tests whether a thirty-second voice recording can substitute for costly clinical assessments and self-report surveys as a scalable screening method among non-English speakers in conflict-affected settings, and whether phone-delivered PM+ is as effective as in-person delivery. It also examines whether matching participants with providers of the same gender affects uptake, attrition, and outcomes, a key mechanism question given stigma and gender norms around mental health disclosure in the DRC. Together, these findings will inform the cost-effectiveness and scalability of digital screening and support tools for humanitarian settings more broadly.

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Appendix A. Program and study details

Program design and implementation details for each study discussed in the review, in the order in which they appear. Findings are reported in the body of the review and in Appendix B. Conflict setting and evidence classification follow the review text.

Study	Setting	Conflict setting	Evidence	Population and sample	Intervention	Cost
Part 1: Economic and social interventions						
Economic and social empowerment						
Bedoya et al. 2019	Afghanistan: 80 villages, Balkh province	Active conflict	Primary	1,219 of the poorest households; women were the named beneficiaries. Eligibility included reliance on women's domestic work or begging, no adult male earner, and school-age children working for pay.	Graduation ("big push") package: livestock (cows or goats, approx. US$309-405), a monthly cash stipend of US$15, livestock and enterprise training, a health subsidy worth US$22, and frequent coaching visits.	Benefit-cost ratio of 2.3; estimated internal rate of return of 26 percent.
Gibbs et al. 2020	Afghanistan: six urban and peri-urban communities, Kabul and Nangarhar	Active conflict	Primary	1,461 women aged 18–49 (933 married), one per household, in conflict-affected and economically vulnerable communities. 82 percent retained at endline.	Women for Women International: 12 months of weekly group sessions (90–180 minutes, groups of 25) on numeracy, business skills, money management and rights, with referrals to health, legal and financial services. No IPV-specific content.	Not reported.
Glass et al. 2017	DRC: 10 villages, Walungu Territory, South Kivu	Protracted conflict	Suggestive	833 adults aged 16 and over (84 percent women), one per household; most were married and had never attended school.	Pigs for Peace: a female piglet on credit, repaid by passing two piglets from the first litter to other households, with training on pig rearing, biweekly home visits and veterinary support. Run by a Congolese microfinance organization (PAIDEK).	Not reported.
Park and Kumar 2022	Liberia: informal settlements of Monrovia	Post conflict	Suggestive	395 vulnerable women selected by the Liberian Red Cross; selection criteria included experience of domestic abuse. 359 tracked at endline.	Women Training and Integration (WIN): 12 months, 4–5 hours a day, five days a week, combining psychosocial counseling (individual, group and CBT sessions) with vocational and business training, literacy classes and health check-ups. Planned start-up kits and cash grants were not delivered.	Not reported.
Digital aid and cash-like vouchers						
Callen et al. 2025	Afghanistan: 16 urban neighborhoods in Kabul,	Active conflict	Primary	2,409 extremely poor, female-headed households with limited tech literacy.	Four digital payments of US$45 every two weeks over two months (about 3.75 months of average household income), sent through	Delivery cost under 7 cents per dollar transferred, about 10 cents less than the

	Herat and Mazar-i-Sharif				the HesabPay platform. Beneficiaries were identified by local Community Development Councils working with Uplift Afghanistan.	World Food Programme's global figure for cash transfers.
Quattrochi et al. 2022	DRC: 25 villages across seven sites, North Kivu	Active conflict	Primary	976 internally displaced and vulnerable host-community households. A third of respondents scored above the clinical threshold for anxiety or depression at baseline.	One-off vouchers worth US$55–90 per household, redeemable for essential household items at a temporary fair stocked by 40 to 80 local vendors. Part of the UN Rapid Response to Movements of Population program.	About US$21 per beneficiary, or US$137 per household, including implementation.
Employment						
Hussam et al. 2022	Bangladesh: Rohingya refugee camps, Cox's Bazar	Displacement	Primary	745 working-age camp residents (18–45; 30 percent women) with no recent work. 78 percent screened as depressed at baseline.	Eight weeks of part-time survey work (about 2.5 hours a day, three days a week) paying about US$5.30 a week. A cash arm received the same weekly amount for a survey with no work; the control group received a small survey payment.	Not reported.
Alik-Lagrange et al. 2023	Central African Republic: 12 sous-préfectures	Active conflict	Suggestive	6,111 adult lottery applicants (3,470 selected; 2,826 women).	Londö public works: 40 days of labor on local infrastructure at about US$3 a day, set low so that the poorest would self-select, plus a bicycle kept after the contract.	Direct cost of 177,200 CFA francs per beneficiary; the stipend and bicycle were 72 percent of total costs.
Dispute resolution and reconciliation						
Cilliers et al. 2016	Sierra Leone: 200 villages in 100 sections across five districts	Post-conflict	Primary	2,383 adults, 10 to 12 sampled at random per village, including victims and perpetrators. 54 percent had lost a family member in the war.	Fambul Tok community forums: trained community members encouraged victims and perpetrators to take part, culminating in a two-day bonfire ceremony where victims described atrocities and perpetrators asked for forgiveness. No compensation or prosecution.	US$150–200 per ceremony.
Part 2: Psychological Interventions						
Cognitive behavioral therapy (CBT)-informed interventions						
Betancourt et al. 2014	Sierra Leone: six community sites in Freetown	Post-conflict	Primary	436 war-affected youth aged 15–24 with elevated distress and impaired daily functioning, identified through community screening.	Youth Readiness Intervention (YRI): 10 weekly 90-minute group sessions combining CBT and interpersonal therapy techniques, led in same-sex pairs by local counselors with social work training. A second randomization offered an education subsidy (tuition and textbooks).	Not reported.

Lenglet et al. 2018	Chechnya (Russia): three hospitals in Grozny	Post-conflict with ongoing insecurity	Primary	168 adults seeking care from a Médecins Sans Frontières (MSF) mental health program who scored above the HSCL-25 distress threshold. Most were women.	Individual counseling based on brief trauma-focused therapy and CBT techniques, averaging four 50-minute sessions over one month. Delivered by MSF counselors, most of whom had academic training in psychology.	Not reported.
Blattman et al. 2017; 2023	Liberia: five high-crime neighborhoods of Monrovia	Post-conflict	Primary	999 high-risk men, mostly aged 18–35, engaged in crime and violence; 38 percent had belonged to an armed group. 833 surveyed after ten years.	Sustainable Transformation of Youth in Liberia (STYL): eight weeks of CBT-informed group therapy (three 4-hour sessions a week) plus home and work visits, led by facilitators who were former combatants or offenders. Crossed with a US$200 cash grant in a 2×2 design.	US$530 per person for therapy and cash, US$189 for therapy, US$216 for the grant, US$125 for administration.
O'Callaghan et al. 2013	DRC: Beni, North Kivu	Active conflict	Suggestive	52 girls aged 12–17 exposed to rape or sexual exploitation, enrolled in a World Vision vocational training program.	Culturally adapted trauma-focused CBT: 15 sessions over five weeks (12 group, 3 individual), led by World Vision social workers without clinical training, plus three caregiver sessions.	Not reported.
Narrative Exposure Therapy (NET)						
Robjant et al. 2019	DRC: Kibumba, North Kivu	Post-conflict	Primary	92 women aged 16 and over who had been forcibly recruited by the M23 rebel group, most as children. All met diagnostic criteria for PTSD.	FORNET (NET adapted for offenders): six weekly individual sessions of 90–120 minutes plus six group sessions on managing aggression, delivered by Congolese counselors without mental health qualifications after three weeks of training. The comparison group continued to receive a local NGO's usual services.	Not reported.
Ertl et al. 2011	Uganda: camps for internally displaced persons in three areas of the north	Post-conflict	Primary	85 former child soldiers aged 12–25 with PTSD, drawn from a population survey of 1,113 young people.	NET: eight individual 90–120-minute sessions at home, three times a week, delivered by 14 trained local lay counselors. Compared with an equally intensive academic catch-up program with supportive counseling, and a waitlist.	Not reported.
Interpersonal Psychotherapy (IPT)						
Bolton et al. 2007	Uganda: two camps for internally displaced persons near Gulu	Active conflict and displacement	Suggestive	314 adolescents aged 14–17 with symptoms of depression, identified through community screening.	Group IPT: 16 weekly sessions in single-sex groups led by a facilitator of the same sex with two weeks of training. Compared with a creative play program and a waitlist.	Not reported.
Problem Management Plus (PM+)						

Rahman et al. 2016	Pakistan: three primary care centers in Peshawar	Active conflict	Primary	346 adult primary care patients (79 percent women) with high psychological distress and functional impairment.	Individual PM+: five weekly 90-minute sessions on problem solving, behavioral activation, social support and stress management, delivered by lay health workers with no prior clinical training after eight days of training. Comparison: enhanced usual care.	Not reported.
Rahman et al. 2019	Pakistan: 34 community clusters in rural Swat	Post-conflict	Primary	612 women aged 18–60 with psychological distress and functional impairment.	Group PM+: five weekly sessions led by local female graduates with no mental health experience after seven days of training, held in lady health workers' homes. Comparison: enhanced usual care.	Not reported.
Common Elements Treatment Approach (CETA)						
Bolton et al. 2014	Thailand: Mae Sot, on the border with Myanmar	Displacement	Primary	347 adult Burmese refugees who had experienced trauma, including imprisonment and torture, with moderate to severe depression or post-traumatic stress.	CETA: weekly one-hour individual sessions (9.7 on average), with components selected for each client's symptoms, delivered by Burmese refugee lay counselors. Comparison: waitlist.	Not reported.
Self-Help Plus (SH+)						
Tol et al. 2020	Uganda: Rhino Camp refugee settlement	Displacement	Primary	694 South Sudanese women refugees with at least moderate psychological distress, in 14 villages.	SH+: five 2-hour audio-guided workshops for groups of 20–30, led by briefly trained lay facilitators, with an illustrated self-help book. Comparison: enhanced usual care.	Not reported.
Delivery of mental health services and social stigma						
Smith 2026	Jordan: Syrian refugees across the country, mostly outside camps	Displacement	Primary	849 Syrian refugees nominated by peers as well connected, who listed close friends and agreed to share a campaign with them.	Senders were paid about US$1.40 to share an International Rescue Committee mental health campaign, promoting a free counseling helpline, with friends over WhatsApp. One randomized sentence encouraged some senders to tell friends they were paid ("social cover").	Not reported.

Appendix B. Mental health and well-being measures

Studies differ in whether they measure clinical symptoms, subjective well-being, daily functioning, or a combination, which limits direct comparison across studies. Table B1 shows which outcomes each study measured and what it found. Table B2 describes each instrument once, grouped by the outcome it measures.

B1. Outcomes measured and effects found, by study

Each cell names the instrument used and the effect relative to the comparison group. A blank cell means the study did not measure that outcome. A cell spanning two columns is a single instrument that scores depression and anxiety together. Effect sizes are reported in the body of the review.

Outcome change guide:

- Improved. Outcome better than the comparison group at the latest follow-up reported.
- Improved, then faded. Outcome better at an early follow-up, but not at a later one.
- No effect. Outcome has no statistically meaningful difference from the comparison group.
- Worsened. Outcome worse than the comparison group.
- In index. Outcome measured, but tested only as part of a combined index; see the notes column for the index result.

Study	Depression	Anxiety	PTSD	General distress or stress	Subjective well-being	Daily functioning	Other outcomes and notes
Part 1: Economic and social interventions							
Economic and social empowerment							
Bedoya et al. 2019	CES-D **Improved**			Cohen PSS-4 **Improved**	WVS happiness and life satisfaction **Improved**		Self-esteem: improved for women. Salivary cortisol: no effect. All combined in an index.
Gibbs et al. 2020	CES-D **No effect**						
Glass et al. 2017	HSCL depression subscale **No effect**	HSCL anxiety subscale **Improved**	HTQ (16 items) **Improved**				Self-rated health: improved.

Park and Kumar 2022				HSCL-10 **No effect**	WVS happiness and well-being (5 items) **No effect**		
Digital aid and cash-like vouchers							
Callen et al. 2025					Single happiness item; Cantril ladder **Improved**		
Quattrochi et al. 2022	HSCL-25 (combined score) **No effect**				WHO-5; WVS life satisfaction **Improved**		All three combined in a primary well-being index.
Employment							
Hussam et al. 2022	PHQ-9 **Improved**			Cohen PSS **Improved**	Diener Satisfaction with Life Scale **Improved**		Locus of control, sociability, self-worth, stability: improved. Results are for employment; cash alone had no effect.
Alik-Lagrange et al. 2023					Single happiness item **Improved**		
Dispute resolution and reconciliation							
Cilliers et al. 2016	Zung depression items **Worsened**	Zung anxiety items **Worsened**	DSM-IV PTSD Symptom Scale (11 items) **Worsened**				Harms persisted at 31 months.
Part 2: Psychological Interventions							
CBT-informed interventions							
Betancourt et al. 2014			UCLA PTSD-RI **No effect**	OMPA (internalizing and externalizing) **No effect**		WHODAS II **Improved, then faded**	Emotion regulation (DERS), prosocial behavior (OMPA), social support: improved, then faded by 6 months.
Lenglet et al. 2018	HSCL-25 depression subscale **Improved**	HSCL-25 anxiety subscale **Improved**	HTQ (16 items) **Improved**	HSCL-25 total **Improved**		SF-6; local Chechen functioning scales **Improved**	Perceived social support (SPS): improved. Avoidant coping (CSI): worsened.

Blattman et al. 2017; 2023	Local scale (6 items) **In index**		Local scale (12 items) **In index**		Happiness, absolute and relative **In index**		Mental health index, also including neuroticism, self-esteem and locus of control. Therapy plus cash: improved at 1 month, 1 year and 10 years, driven by well-being and self-esteem. Therapy alone: no effect.
O'Callaghan et al. 2013	AYPA depression and anxiety subscale **Improved**		UCLA PTSD-RI **Improved**				Conduct problems and prosocial behavior (AYPA): improved.
Narrative Exposure Therapy							
Robjant et al. 2019	PHQ-9 **Improved**		PSS-I-5 (clinical interview) **Improved**				Appetitive aggression (AAS), violent behavior, social acknowledgement (SAQ): improved. Guilt (AAGS): no effect.
Ertl et al. 2011	MINI (clinical interview) **No effect**		CAPS (clinical interview) **Improved**			CAPS impairment items **Improved**	Guilt (CAPS items): improved against waitlist only. Suicidal ideation (MINI), perceived stigma: no effect.
Interpersonal Psychotherapy							
Bolton et al. 2007	APAI depression scale **Improved**	APAI anxiety scale **No effect**				Local function scale **No effect**	Depression improved for girls only. Conduct problems (APAI): no effect.
Problem Management Plus							
Rahman et al. 2016	HADS-D; PHQ-9 **Improved**	HADS-A **Improved**	PCL-5 **Improved**			WHODAS 2.0 **Improved**	Self-identified problems (PSYCHLOPS): improved.
Rahman et al. 2019	HADS-D; PHQ-9 **Improved**	HADS-A **Improved**	PCL-5 **Improved, then faded**			WHODAS 2.0 **Improved**	Self-identified problems (PSYCHLOPS): improved. PTSD symptoms lower at 1 week, not at 3 months.
Common Elements Treatment Approach							
Bolton et al. 2014	HSCL-25 depression subscale **Improved**	HSCL-25 anxiety subscale **Improved**	HTQ **Improved**			Local sex-specific scales **Improved**	Aggression (Aggression Questionnaire): improved. Alcohol use (AUDIT): no effect.
Self-Help Plus							
Tol et al. 2020	PHQ-9 **Improved**		PCL-6 **Improved**	Kessler 6 (K6) **Improved**	WHO-5 **Improved**	WHODAS 2.0 **Improved**	Explosive anger: improved. Self-identified problems (PSYCHLOPS), psychological flexibility (AAQ-II): improved, then faded. Relations with other ethnic groups: no effect.

Smith 2026 is not included: it measured willingness to share information about mental health services, not mental health outcomes.

B2. Instruments, by outcome

Each instrument is listed once, under the outcome it mainly measures. Studies are cited by the first author.

Instrument	What it measures	Used in
Depression and anxiety		
CES-D (Center for Epidemiologic Studies Depression Scale)	Self-reported depressive symptoms in the past week.	Bedoya; Gibbs
PHQ-9 (Patient Health Questionnaire)	Nine-item depression screener; also used to classify probable depression.	Hussam; Robjant; Rahman 2016, 2019; Tol
HSCL-25 (Hopkins Symptom Checklist)	25 items with separate anxiety and depression subscales and a total distress score. Widely used in humanitarian settings.	Glass; Quattrochi; Lenglet; Bolton 2014
HADS (Hospital Anxiety and Depression Scale)	14 items with separate anxiety (HADS-A) and depression (HADS-D) subscales.	Rahman 2016, 2019
Zung Self-Rating Depression and Anxiety Scales	Self-reported depression and anxiety symptoms; subsets of items used.	Cilliers
MINI (Mini International Neuropsychiatric Interview)	Structured diagnostic interview; used for major depression and suicide risk.	Ertl
APAI / AYPA (Acholi, later African Youth, Psychosocial Assessment Instrument)	Locally developed in northern Uganda: depression-like and anxiety-like symptoms, conduct problems, prosocial behavior.	Bolton 2007; O'Callaghan
Post-traumatic stress (PTSD)		
HTQ (Harvard Trauma Questionnaire)	Trauma exposure and 16 PTSD symptoms; used as a screening tool.	Glass; Lenglet; Bolton 2014
PCL-5 / PCL-6 (PTSD Checklist)	Self-reported PTSD symptoms (20-item DSM-5 version; 6-item short version).	Rahman 2016, 2019 (PCL-5); Tol (PCL-6)
CAPS (Clinician-Administered PTSD Scale)	Clinician interview for PTSD diagnosis and severity; includes items on functional impairment and guilt.	Ertl
PSS-I-5 (PTSD Symptom Scale Interview for DSM-5)	Clinician interview for PTSD diagnosis and severity.	Robjant
UCLA PTSD Reaction Index	PTSD symptoms in children and adolescents.	Betancourt; O'Callaghan
DSM-IV PTSD Symptom Scale	Self-reported PTSD symptoms (11 items used).	Cilliers
General distress and stress		
Kessler 6 (K6)	Six-item screen for general psychological distress.	Tol
HSCL-10	Ten-item short form of the HSCL, scored as a general distress index.	Park and Kumar

OMPA (Oxford Measure of Psychosocial Adjustment)	Validated in Sierra Leone: internalizing and externalizing problems, prosocial behavior.	Betancourt
Cohen Perceived Stress Scale (PSS)	How stressful and uncontrollable people find their lives (4-item and longer versions).	Bedoya; Hussam
Salivary cortisol	Biological marker of stress, from saliva samples.	Bedoya
Subjective well-being		
WHO-5 Well-Being Index	Five items on positive mood, energy and interest over the past two weeks.	Quattrochi; Tol
World Values Survey (WVS) items	Single questions on happiness and life satisfaction, sometimes combined into an index.	Bedoya; Park and Kumar; Quattrochi
Cantril Self-Anchoring Striving Scale	Respondents rate their life on a ladder from worst to best possible.	Callen; Hussam (adapted)
Diener Satisfaction with Life Scale	Five-item measure of overall life satisfaction.	Hussam
Single happiness item	One question on how happy the respondent is; not a validated scale.	Callen; Alik-Lagrange; Blattman
Daily functioning		
WHODAS 2.0 (WHO Disability Assessment Schedule)	Difficulty with daily activities across domains such as mobility, self-care and participation (12-item version).	Betancourt; Rahman 2016, 2019; Tol
SF-6 (from the SF-36 Health Survey)	Self-rated health and how physical and emotional problems limit daily and social activities.	Lenglet
Locally developed functioning scales	Ability to carry out tasks that local people identify as important, often separate for men and women.	Lenglet; Bolton 2007; Bolton 2014
Other outcomes		
PSYCHLOPS (Psychological Outcome Profiles)	Progress on the problems for which the person sought help.	Rahman 2016, 2019; Tol
Appetitive Aggression Scale (AAS)	Attraction to and enjoyment of violence.	Robjant
Aggression Questionnaire	Aggressive feelings and behavior (12 items).	Bolton 2014
AUDIT (Alcohol Use Disorders Identification Test)	Hazardous alcohol use.	Bolton 2014
Coping, emotion regulation and social support scales	Coping Strategy Indicator and Social Provisions Scale (Lenglet); Difficulties in Emotion Regulation Scale and a social support inventory (Betancourt).	Lenglet; Betancourt
Self-regard measures	Self-esteem, locus of control and neuroticism items.	Bedoya; Hussam; Blattman
Guilt, stigma and acknowledgement measures	Attitudes About Guilt Survey and Social Acknowledgement Questionnaire (Robjant); Perceived Stigmatization Questionnaire (Ertl).	Robjant; Ertl