Hope Groups: Parenting and Mental Health Among Refugees in the Middle East

Study Protocol

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Title {1a}

Hope Groups for Palestinian Refugees Experiencing Multigenerational Displacement in Jordan: A Study Protocol for a Staircase Randomised Controlled Trial

Names of protocol contributors {3a}

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Abstract

Background

The Palestinian population from the West Bank and the Gaza Strip face the longest protracted displacement globally. In 2025, approximately 6 million Palestinians were displaced, with over 2.39 million Palestinians living in refugee camps in Jordan – making Jordan the largest host country of Palestinian refugees. To address the global need for effective approaches to protect children in protracted war and displacement, we adapted and contextualised Ukrainian *Hope Group*s for Palestinians experiencing protracted displacement in Jerash Camp, Jordan. This study seeks to evaluate whether the intervention can effectively strengthen families experiencing multigenerational displacement in the Middle East.

Methods

This protocol describes a randomised roll-out trial (N=490) using a staircase design across five cohorts. Consistent with staircase randomised controlled trials (RCT), participants will be randomly selected to one of five staggered roll-out timepoints (also referred to as "cohorts"). Within each cohort, participants will be individually randomised with a 1:1 allocation ratio to either the Hope Groups intervention or wait-list control, who will receive the intervention after the cohort's trial endline. Primary outcomes include caregiver mental health and violence against children. Secondary outcomes include parenting practices and child behavioural issues. Tertiary outcomes include caregiver well-being and caregiver stress, measured via blood pressure and heart rate. Outcomes will be assessed at baseline and one-week post-intervention (endline) for all participants. Among participants who were randomly selected into early cohorts of the staircase trial, follow-up surveys at 6- and 12- months post-intervention will be completed, which will be compared with baseline surveys of participants in later cohorts.

Discussion

The staircase design may be a useful tool RCTs in humanitarian settings, where reducing participant survey burden and prioritising expedited delivery of potentially beneficial interventions are ethical imperatives. This staircase trial among Palestinians experiencing multigenerational displacement in Jordan will yield findings on post-intervention and long-term follow-up effectiveness, while reducing participant burden and control arm wait-times compared to traditional stepped wedge trials. Additionally, if results demonstrate effectiveness, this intervention may be a useful tool to strengthen the millions of families facing protracted displacement globally.

Trial Registration

This trial was prospectively registered on Open Science Framework on January 26, 2025. (https://osf.io/qy5jh)

Keywords

Protracted displacement, refugee, parenting, mental health, psychosocial, violence against children, war

Structured summary {1b}

Item	Description
Primary Registry and Trial Identifying Number {4}	This trial was prospectively registered on Open Science Framework on January 26, 2025. (https://osf.io/qy5jh)
Secondary Identifying Numbers	NA
Source(s) of Monetary or Material Support	Global Parenting Initiative and donations from an anonymous foundation to World Without Orphans, World Relief, and Sanadak.
Primary Sponsor and contact information {3b}	University of Oxford. Corresponding author: Sydney.tucker@spi.ox.ac.uk
Role of sponsor and funder {3c}	No funder was involved in the study design, data collection, or analysis of data.

Contact for Public Queries	Corresponding author: Sydney.tucker@spi.ox.ac.uk
Contact for Scientific Queries	Corresponding author: Sydney.tucker@spi.ox.ac.uk
Public Title	Hope Groups: Building Hope Among Palestinians to Strengthen Caregivers and Protect Children
Scientific title	Hope Groups: A Randomised Controlled Trial Of Psychosocial And Parenting Support Groups for Palestinian Caregivers Experiencing Multigenerational Displacement in Jordan
Countries of Recruitment	Jordan
Health Condition(s) or Problem(s) Studied	Mental Health and violence against children
Intervention(s)	A 10-session psychosocial, mental health, and violence prevention group-based intervention for parents/caregivers delivered via lay-trained facilitators.
Key Inclusion and Exclusion Criteria	1. Aged >=18; 2. Parent or caregiver for >=1 child under age 18; 3. Palestinian refugee living in Jerash Camp, Jordan.
Study Type	This study is a staircase randomised controlled trial, rolled out across five staggered timepoints (referred to as 'cohorts'). Consistent with a staircase design, participants will be randomly selected into one of five cohorts. Within cohort, participants will be subsequently randomised with a 1:1 allocation ratio to the intervention arm, which involves participating in Hope Groups immediately, or a wait-list control arm. Consistent with superiority trials, intervention effects are estimated through comparing Hope Groups and wait-list control participants.
Date of First Enrollment (planned)	Trial recruitment began February 5, 2025.
Sample Size	490 participants
Primary outcome(s)	Caregiver mental health and violence against children
Key Secondary outcome(s)	Parenting practices and child well-being
Ethics Review	Ethical approval was obtained from the University of Oxford (Reference Number: 760866).
Individual Trial Participant Data sharing statement	Deidentified participant data will be made publicly available on Open Science Framework after trial results are published. Researchers are welcome to contact Sydney.tucker@spi.ox.ac.uk for data usage requests prior to data being made publicly available.

Protocol version {2}

This is version 1.3. The OSF preregistration has been updated with all changes to the protocol.

Introduction

Background and rationale {9a}

According to the United Nations, 2 billion people – 25% of the world's population – live in war-affected countries (*For People, for Peace*, 2024). More people are displaced than ever before in history, including 122 million people forcibly displaced by war, of which 48.8 million are children (Global Trends Report, 2024; UNICEF, 2024). Globally, the Palestinian population from the West Bank and the Gaza Strip are facing the longest protracted displacement (Hill et al., 2004; United Nations, 2023). In 2025, approximately 6 million Palestinians are displaced (UNRWA, 2025), with over 2.39 million Palestinians living in refugee camps in Jordan (UNRWA, 2025), making Jordan the largest host country of Palestinian refugees.

Parents suffer from a variety of traumatic exposures amidst war and displacement, including war exposure, psychological distress, poverty, diminished ability to meet their children's needs, loss of support systems, dangers during travel, and distress from macro-level policies in the host-countries (Khraisha et al., 2024; Sousa et al., 2025). A scoping review of parental resilience in war from 1974-2024 emphasises, "one of the biggest tragedies of political violence is the destabilization of parents, right at the time when children most need them" (Sousa et al., 2025). As parents suffer from traumatic exposures during war and displacement, they exhibit less warmth and more harshness toward their children (Eltanamly et al., 2021), and greater exposure to war is associated with further decreases in warmth and increases in harshness (Eltanamly et al., 2021).

Research demonstrates that caregivers can buffer the grave effects of traumatic exposures on children and help children build resilience, when they utilise positive, supporting parenting amidst war and displacement (Betancourt & Khan, 2008). Across humanitarian contexts, interventions aiming to support caregivers with parenting programmes have demonstrated effectiveness on

improving caregiver mental health, reducing violence against children, and improving child well-being (Backhaus et al., 2025). As Palestinians endure one of the longest displacements globally (Hill et al., 2004), parenting interventions specifically adapted for the Palestinian context are urgently needed.

Research designs to evaluate such interventions in war and displacement contexts are also urgently needed. Staircase designs, which are an innovative adaptation of stepped wedge trials (Grantham et al., 2024), may be a potential solution in humanitarian settings. Traditional two-armed parallel-group randomised controlled trials (RCTs) require withholding the intervention from the comparison group throughout the study period, which may not be ethical in war and displacement, especially when the trial is evaluating the long-term effectiveness of an intervention. Stepped wedge trials can be a solution to address the ethics of wait times, but traditional stepped wedge trials require repeated measurements from wait-list participants prior to receiving the intervention (Brown et al., 2025; Grantham et al., 2024), which may not be acceptable or feasible in war or displacement contexts. Staircase trials may be a useful tool in humanitarian contexts, when there is often community hesitance to involving participants in extensive data collection without intervention delivery, as staircase trails meaningfully reduce participant measurement burden (Grantham et al., 2024). Consistent with stepped wedge trials, the intervention is still randomly rolled out to participants across staggered timepoints (also sometimes referred to as “cohorts”), which is especially desirable in contexts when the intervention cannot be delivered to everyone simultaneously. However, unlike traditional stepped wedge trials, all participants are not required to complete outcome assessments at each timepoint (Grantham et al., 2024), which drastically increases the feasibility of the design amidst war and displacement contexts.

Therefore, this study uses a staircase randomised controlled trial (RCT) to evaluate the effectiveness of an intervention called Hope Groups among Palestinians experiencing protracted displacement in Jordan. The Hope Groups intervention is a psychosocial, mental health, and parenting intervention to support parents to protect children affected by war and displacement. It was first evaluated through a randomised controlled trial among Ukrainians (2023-2024) and demonstrated statistically significant effects across parental mental health, parenting practices, reductions in violence against children, and child well-being (Tucker et al., 2023, 2026a). In 2024, following the ADAPT framework, the Hope Groups intervention was adapted for the Middle East and North Africa. This current study aims to evaluate the intervention's potential to strengthen Palestinian caregivers and children from Gaza experiencing protracted displacement in Jerash Camp, Jordan.

Explanation for the choice of comparator {9b}

This staircase randomised controlled trial utilises a wait-list control arm, which ensures all participants will ultimately receive the intervention.

Objectives {10}

The primary objective is to estimate the effectiveness of 10-session Hope Groups among Palestinian parents and caregivers experiencing protracted displacement in Jordan, compared to a wait-list control group, on primary outcomes of caregiver mental health and violence against children post-intervention. The study team hypothesises that the intervention will lead to improvements across both outcomes post-intervention. Secondary objectives include 1) evaluating the effectiveness of the intervention at six- and twelve- months post-intervention and 2) evaluating secondary outcomes of parenting practices and child behavioural issues. Additional exploratory analyses will be conducted on tertiary outcomes of caregiver well-being and stress, including blood

pressure and heart rate.

Methods: Patient and public involvement, and trial design

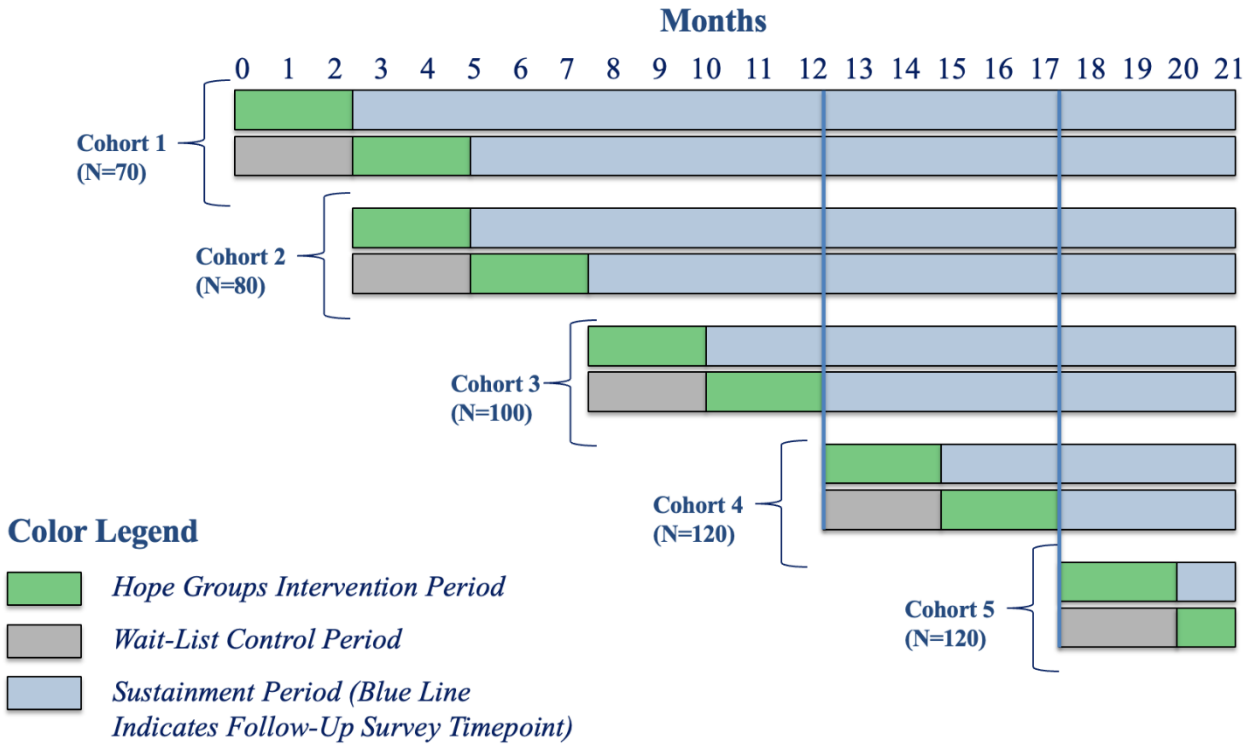
Patient and public involvement {11}

A group of local community leaders co-led, with the Global Hope Groups Collaborative, the adaptation and contextualisation of the intervention for the local context (February 2024-October 2025). Prior to selecting the trial design, the research team met with a group of local implementors and community members to learn what was feasible and acceptable in the local context. Subsequently, the research team proposed trial design options, and the group selected a study design together. A local faith-based organisation with a partnership with the Ministry of Social Development in Jordan, called Sanadak, led the implementation of the RCT. Results will be shared widely with trial participants, local implementors, community members, and local leaders.

Trial design {12}

A staircase RCT was selected to estimate immediate post-intervention and six- and twelve-month post-intervention effects (Grantham et al., 2024). Consistent with a staircase design, participants will be randomly selected into one of five cohorts (Figure 1). After random selection into one of these cohorts, participants are subsequently randomised with a 1:1 allocation ratio to the intervention arm, which involves participating in Hope Groups immediately, or a wait-list control arm, which involves participating in Hope Groups as soon as the cohort's intervention arm completes the intervention (Figure 1). The decision to conduct the trial over five cohorts was made to 1) respect staff capacity relating to the number of participants who could receive the intervention during a set timeframe; and 2) enable six- and twelve- month follow-up assessments among early cohorts (i.e., cohorts 1-3), who will be compared with untreated participants from later cohorts (i.e., cohorts 4 and 5).

Figure 1. Randomised Roll-Out Timeline and Study Design Overview



Methods: Participants, interventions and outcomes

Trial setting {13}

Because Jordan is the largest host country for Palestinian refugees, this research takes place in Jordan. Specifically, this trial takes place in Jerash Camp, Jordan, which was created in 1968 for Palestinians refugees displaced from the Gaza Strip. Jerash Camp hosts over 40,000 residents and is the poorest Palestinian refugee camp in Jordan (*UNRWA*, 2023).

Characteristics of the people who are needed for the trial

Characteristic	The people we would expect to see included

Age	It is anticipated that the majority of participants will be aged between 18-50.
Sex	This study aims to recruit at least 20% male caregivers, acknowledging that recruitment among male caregivers is more challenging and thus likely 80% of the study will be female caregivers.
Gender	In the Jordanian context, demographic data will report male and female.
Race, ethnicity and ancestry	All participants will be Palestinians displaced from Gaza living in Jerash Camp, Jordan.
Socioeconomic status	As Jerash Camp is the poorest refugee camp in Jordan, it is expected the majority of participants will report low income.
Geographic location	Jerash Camp, Jordan
Other characteristics relevant to the trial	All participants will be parents or caregivers providing care to at least one child under the age of 18.

Eligibility criteria for participants {14a}

Participant inclusion criteria are as follows: Participants are 1) living in Jerash Camp; 2) a parent/caregiver for one or more child (under 18); 3) aged >= 18; 4) referred via the charitable organisation operating within Jerash Camp; 5) able to provide informed consent.

Eligibility criteria for sites and those delivering interventions {14b}

Facilitator inclusion criteria are as follows: Facilitators are 1) Palestinian with lived experience of forced displacement; 2) Aged >= 18. Facilitators are not required to have any professional mental health training, reflecting the programme's design to mobilise a community-based workforce capable of delivering psychosocial support at-scale in a context of widespread war and displacement related trauma.

Who will take informed consent? {32a}

All participants will complete informed consent prior to their baseline survey during an in-person group session hosted by Sanadak, the implementing partner, within Jerash Camp. Informed consent will occur via a self-administered Open Data Kit (ODK) form. If the participant has a phone, they will complete informed consent on their own device. If they do not have a phone, they will borrow a tablet or phone from Sanadak. If any literacy challenges arise, Sanadak staff or volunteers will facilitate the informed consent process.

Additional consent provisions for collection and use of participant data and biological specimens {32b}

In informed consent, participants consent to making anonymous survey data publicly available. No biological specimens will be collected.

Intervention and comparator

Intervention and comparator description {15a}

This study tests an intervention adapted from the Hope Groups intervention developed for Ukrainians amidst war, which was a 12-session mental health, parenting, and violence prevention support group programme to strengthen Ukrainian parents/caregivers (Hillis et al., 2024; Tucker et al., 2023, 2026). Following the ADAPT framework (Moore et al., 2021), a social worker with the Global Hope Groups Collaborative who co-led the development of Hope Groups in Ukraine met weekly for eight months with a team of Jordanians and Palestinians from Sanadak to thoroughly review each session, make edits, and finalise adapted content. The final adaptation was also reviewed and approved by psychology and psychosocial support experts in the West Bank, from Anar for Empowerment and Psychosocial Support. The adaptation process resulted in a

contextualised 10-session Hope Groups (Table 1) for families affected by war, displacement, and crisis in the Middle East and North Africa (MENA). The MENA Hope Groups intervention maintained the same four target aims of the Ukrainian Hope Groups: 1) strengthening parent/caregiver mental health and hopefulness; 2) building parenting skills to improve parent-child relationships, with take-home skills-building activities for children of all ages; and 3) reducing violence against children, especially caregiver-perpetrated violent discipline and child sexual abuse; and 4) improving child well-being, conceptualised as reducing internalising and externalising behaviours.

Key content and implementation adaptations were as follows: 1) Two sessions from Ukraine on strengthening marriages/partnerships during war to prevent violence against women were not included in this initial MENA adaptation, as the cultural adaptations required were more extensive than time permitted; 2) Session content underwent significant changes for all examples to reflect scenarios pertaining to multigenerational displacement in the Middle East; 3) Programme guides were translated into Arabic and redesigned to reflect the Middle East, using drawn images of Palestinian parents/children; 4) To reduce programme delivery costs in MENA, the intervention was planned to be implemented in larger groups of 8-12 participants of the same sex (versus 5-7 Ukrainian participants per group), a size which local MENA advisors suggested would be comfortable for Arab participants. The programme is implemented by a facilitator of the same sex two times weekly across five weeks. The 10-session MENA Hope Groups programme is detailed in Table 1.

Facilitator training consisted of 1) a 14-hour training on session content and principles related to group facilitation, mental health referrals, safeguarding, and child abuse reporting; and 2)

the facilitators personally participating in the 10-session intervention, with each session led by the programme director, over a span of 5-weeks.

Table 1. Hope Groups Session Content: A 10-Session Intervention for Palestinians Displaced in Jordan

Session	Title	Content
1	**Finding Stability - Our Everyday Tools**	This session builds skills on strategies for building hope in transition and crisis; we create discussion around the impacts of trauma and equip participants to begin building a personal "toolbox" for responding to crisis.
2	**Finding Stability - Our Anchoring Tools**	This session focuses on common physical, emotional, behavioural, and cognitive reactions to trauma. We build participant skills in developing stabilisation techniques, such as deep breathing and progressive muscle relaxation, for coping with stress.
3	**Talk About It**	This session builds skills in identifying and sharing emotions participants are experiencing related to war-time and other personal crisis events. We build skills in how to talk with children about war and loss.
4	**Strong Families**	This session builds skills on developing and maintaining strong relationships within families, particularly caregiver/child relationships. Skills are built for positive communication within relationships.
5	**Staying Safe Together**	This session builds skills and tools for staying safe during crises and war, including being physically together as a family, when possible, and awareness of the risks and signs of sexual perpetrators and human trafficking. We provide a guide for caregivers to learn how to talk with their children about abuse and trafficking in age-appropriate terms, and we equip caregivers to safeguard their children's childhood even amidst crisis.
6	**Staying Safe at Home**	This session builds skills to respond to strong emotions (such as anger) in healthy, safe ways – even in stressful moments. We discuss positive discipline of children.
7	**Coping with Loss**	This session teaches participants about the stages of grief, with an aim to normalise and remove stigma from the concept of grieving. Participants build skills for healthy grieving, finding meaning in their new reality, and helping their children honour whom/what they lost.
8	**Building Hope through Understanding Guilt and Secondary Trauma**	This session equips participants to understand 'survivor guilt' and 'secondary trauma'. Facilitators validate the stress of helping others in crisis and help participants build resilience amidst crises.
9	**Learning Together**	This session builds skills for caregivers to support their children's learning, amidst the war crisis, when many children have left their former schools and are attending new schools (even in a foreign language) or are studying at home/online without a traditional education environment.

10	**Resilience**	This final session builds skills in exploring emotions and discerning how to continually care for their own mental health, as well as their children's, as they build hope for the future amidst the war crisis.

Criteria for discontinuing or modifying allocated intervention/comparator {15b}

All participants will be informed they can stop participating in the intervention at any time, without giving a reason. Facilitators will be trained by Sanadak to identify and report adverse events or harms to the programme director, including any psychological discomfort from the intervention or data collection.

Strategies to improve adherence to intervention/comparator {15c}

A facilitator manual outlines all 10 sessions of the intervention, including content, skills-building activities, and prompts to facilitate discussion. Following each session, facilitators complete monitoring forms to report content completion. During baseline data collection, the programme director will emphasise the importance of full attendance and will instruct participants to either 1) attend all sessions or 2) attend a one-on-one session with their facilitator following any missed session to learn programme content, prior to the subsequent session. The programme director will meet weekly with facilitators to review challenges (e.g., incomplete content delivery) and to support the maintenance of high intervention fidelity.

Concomitant care permitted or prohibited during the trial {15d}

We have no restrictions on participants receiving other mental health, psychosocial, and parenting support during our study. Because there is insufficient access to mental health and parenting programming in Jerash Camp, it is unlikely participants are receiving similar interventions during the trial period, although not prohibited.

Ancillary and post-trial care {34}

If participants are identified as needing more intensive support, such as a participant facing a severe mental illness, referrals will be made for ongoing one-on-one support with a psychologist, who is partnering with Sanadak to offer sessions at reduced costs for intervention participants.

Outcomes {16}

Primary, secondary, and tertiary outcomes are described in Table 2. Primary outcomes include: 1) caregiver depression and anxiety symptoms measured via Patient Health Questionnaire-4; and 2) violence against children, including caregiver self-report of physical and emotional violence, measured via ICAST-Trial (Table 2). Two primary outcomes were selected as both were considered crucial for strengthening families amidst displacement. Consistent with a pragmatic trial design, effectiveness will not be defined as requiring effects across both primary outcomes; each outcome will be evaluated individually to assess effectiveness.

Secondary outcomes include: 1) child behavioural issues, measured via the internalising and externalising subscales from Child and Adolescent Behavioural Inventory (CABI), including items to measure oppositional-defiant disorder and conduct disorder, depression, and irritability; 2) parenting practices, measured via six questions from Alabama Parenting Questionnaire (APQ), as done in the Ukrainian Hope Groups evaluation (Tucker et al., 2026b) (Table 2). This abbreviated APQ scale was selected due to local guidance that the full APQ scale was too lengthy and burdensome for participants. Adaptations required for the local context for primary and secondary outcomes are detailed in Supplementary Materials (SM) Table 1.

To explore a broad range of potential outcomes which could be improved through family strengthening, tertiary exploratory outcomes include 1) caregiver well-being, including domains such as quality of life and post-traumatic growth; and 2) caregiver stress, measured via blood

pressure and heart rate (Table 2). Full details on the survey questions included in tertiary outcomes are included in SM Table 1.

All outcomes will be collected at T0 (baseline), T1 (post-intervention endline), and T2 (follow-up), except for blood pressure which will only be collected at T0 and T1 for the first two cohorts (due to limited funding). Outcomes were translated by a Palestinian-Jordanian local, then reviewed by two other Arabic speakers, and discussed in English to assure high-quality translations.

Table 2. Primary, Secondary, and Tertiary Outcomes

Outcome Level	**Domain**	**Outcome**	**Source / Measure Description**	**No. of Items**	**Range** *(response option labels)*
Primary Outcomes					
	Caregiver/ Parent Mental Health	Depression and Anxiety	Patient Health Questionnaire (PHQ) – 4 (Carroll et al., 2020)	4	0–12* *(Not at all, Several days, More than half the days, Nearly every day.*
	Violence Against Children	Physical and Emotional Child Maltreatment	ICAST-Trial – Parent Version - Physical Abuse and Emotional abuse subscales (Meinck et al., 2018)	10	0–30*** *(Multiple times per week, once per week, once in the past TWO weeks, Not at all)*
Secondary Outcomes					
	Parenting Practices	Positive Parenting, Parental Involvement, and Parental Monitoring	Alabama Parenting Questionnaire (APQ) (Shelton et al., 1996)	6	0–7** (*Days in the past week)*
	Child Well-being	Internalising and externalising behaviours	Child and Adolescent Behavioural Inventory (CABI) (Cianchetti et al., 2013)	17	0–32† (*Not true, Sometimes true, Somewhat true, or Very true)*
Tertiary Outcomes					

	Caregiver Physical Health	Blood pressure	Average of two BP readings	4	Systolic: Continuous; Diastolic: Continuous
		Heart rate	Average of two heart rate readings	2	Continuous
		Caregiver sickness	Direct report of number of days caregiver was sick in past week	1	0–7** (*Days in the past week)*
	Caregiver Well-Being	Post-traumatic growth	Post-Traumatic Growth Inventory (Cann et al., 2010)	3	0–12 § *(Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree.)*
		Quality of life	WHO Quality of Life Scale (The WHOQOL Group, 1998)	3	0–12‡ *(Not at all, A little, Moderately, Completely.)*
		Suicidal thoughts	PHQ-9 (Carroll et al., 2020)	1	0–3* *(Not at all, Several days, More than half the days, Nearly every day.)*
		Coping with grief and hopeful-ness	Locally developed in Ukraine	2	0–7** (*Days in the past week)*
		Self-care	Locally developed in Ukraine	1	0–7** (*Days in the past week)*
		Hope and purpose in community: Beliefs about improving community	Locally developed in Jordan	2	0–8‡ *(Not at all, A little, Moderately, Completely.)*
		Hope and purpose in family: Belief in ability to care for self and children	Locally developed in Jordan	1	0–4‡ (*Not at all, A little, Moderately, Completely.)*

Harms {17}

Facilitators will be trained to identify harms or adverse events during the trial, including psychological distress, disclosures requiring mandated reporting, or any other harms. Harms or adverse events will be reported to the local program director within 24 hours, who will inform the research team within 24 hours. All harms or adverse events will be recorded in trial publications.

Additionally, an interim analysis is scheduled to be conducted after the first cohort reaches the post-intervention timepoint to quantitatively assess harms, defined as worsening outcomes associated with the intervention. If harms are detected, all activity will be paused to investigate and make needed changes. All harms or adverse events will be reported in publication.

Participant timeline {18}

The trial will conclude after approximately 21 months (Figure 1). Participants will be randomly selected into one of five cohorts. Within cohort, participants will be subsequently randomised to intervention or wait-list control arm (T0). All cohorts complete informed consent and baseline surveys after randomisation (T0) (Figure 2 and 3). Following baseline data collection, the intervention arm will receive the 10-session intervention. One-week after completion of the 10-session intervention, intervention and wait-list control arms will complete a trial endline survey (T1) (Figure 2 and 3). The wait-list control arm will begin the intervention following completion of the endline survey (T1). This procedure will be followed for all cohorts. At the time of randomisation and baseline survey collection for Cohort 4, participants from Cohort 1 and 2 will additionally complete six- and twelve- month long-term follow-up assessments (T2), to be compared with untreated participants in Cohort 4 (T0) (Figure 1 and 2). Similarly, at the time of randomisation and baseline survey collection for Cohort 5, participants from Cohort 2 and 3 will additionally complete six- and twelve- month long-term follow-up assessments (T2), to be compared with untreated participants in Cohort 5 (T0) (Figure 1 and 2).

Figure 2. Trial Flow Chart

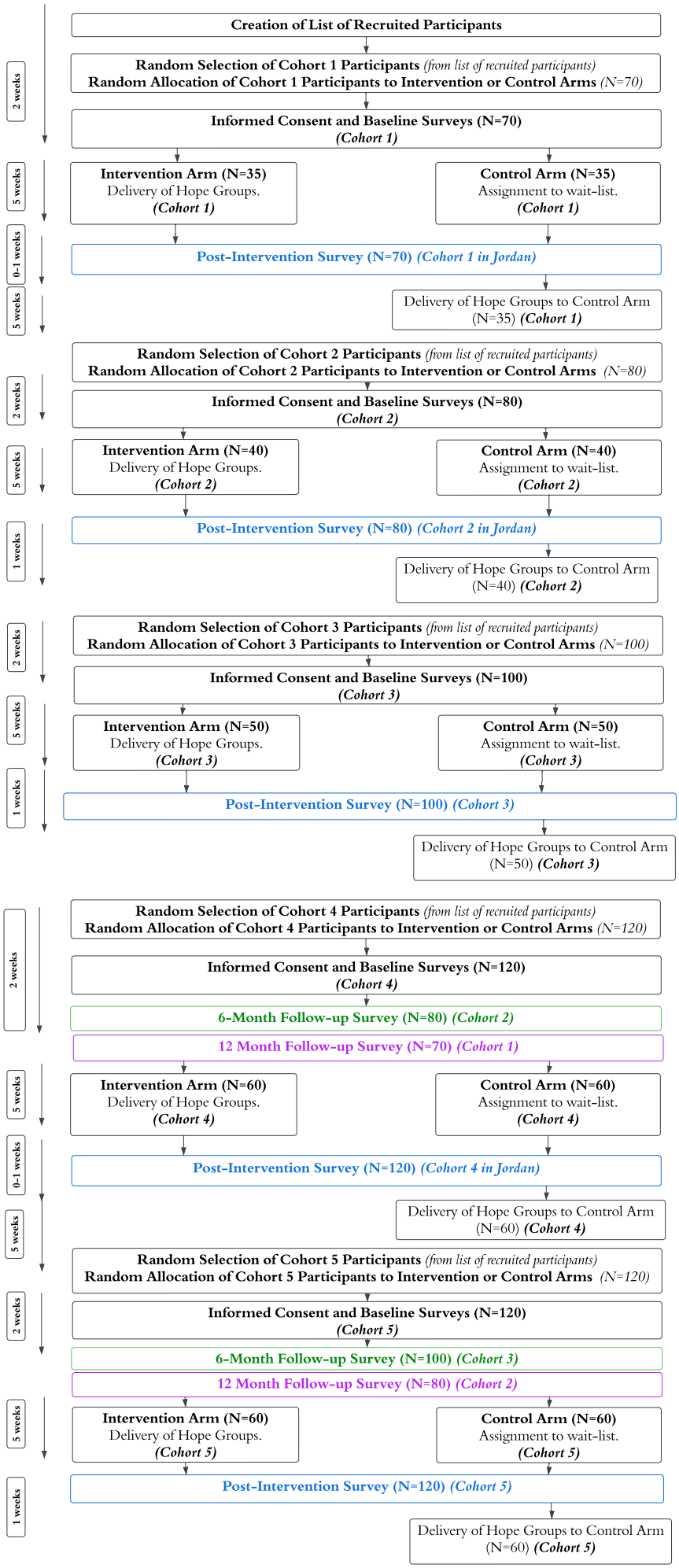

Creation of List of Recruited Participants
2 weeks
Random Selection of Cohort 1 Participants (from list of recruited participants)
Random Allocation of Cohort 1 Participants to Intervention or Control Arms (N=70)
Informed Consent and Baseline Surveys (N=70)
(Cohort 1)
5 weeks
Intervention Arm (N=35)
Delivery of Hope Groups.
(Cohort 1)
Control Arm (N=35)
Assignment to wait-list.
(Cohort 1)
0-1 weeks
Post-Intervention Survey (N=70) (Cohort 1 in Jordan)
5 weeks
Delivery of Hope Groups to Control Arm
(N=35) (Cohort 1)
Random Selection of Cohort 2 Participants (from list of recruited participants)
Random Allocation of Cohort 2 Participants to Intervention or Control Arms (N=80)
2 weeks
Informed Consent and Baseline Surveys (N=80)
(Cohort 2)
5 weeks
Intervention Arm (N=40)
Delivery of Hope Groups.
(Cohort 2)
Control Arm (N=40)
Assignment to wait-list.
(Cohort 2)
1 weeks
Post-Intervention Survey (N=80) (Cohort 2 in Jordan)
Delivery of Hope Groups to Control Arm
(N=40) (Cohort 2)
Random Selection of Cohort 3 Participants (from list of recruited participants)
Random Allocation of Cohort 3 Participants to Intervention or Control Arms (N=100)
2 weeks
Informed Consent and Baseline Surveys (N=100)
(Cohort 3)
5 weeks
Intervention Arm (N=50)
Delivery of Hope Groups.
(Cohort 3)
Control Arm (N=50)
Assignment to wait-list.
(Cohort 3)
1 weeks
Post-Intervention Survey (N=100) (Cohort 3)
Delivery of Hope Groups to Control Arm
(N=50) (Cohort 3)
Random Selection of Cohort 4 Participants (from list of recruited participants)
Random Allocation of Cohort 4 Participants to Intervention or Control Arms (N=120)
2 weeks
Informed Consent and Baseline Surveys (N=120)
(Cohort 4)
6-Month Follow-up Survey (N=80) (Cohort 2)
12 Month Follow-up Survey (N=70) (Cohort 1)
5 weeks
Intervention Arm (N=60)
Delivery of Hope Groups.
(Cohort 4)
Control Arm (N=60)
Assignment to wait-list.
(Cohort 4)
0-1 weeks
Post-Intervention Survey (N=120) (Cohort 4 in Jordan)
5 weeks
Delivery of Hope Groups to Control Arm
(N=60) (Cohort 4)
Random Selection of Cohort 5 Participants (from list of recruited participants)
Random Allocation of Cohort 5 Participants to Intervention or Control Arms (N=120)
2 weeks
Informed Consent and Baseline Surveys (N=120)
(Cohort 5)
6-Month Follow-up Survey (N=100) (Cohort 3)
12 Month Follow-up Survey (N=80) (Cohort 2)
5 weeks
Intervention Arm (N=60)
Delivery of Hope Groups.
(Cohort 5)
Control Arm (N=60)
Assignment to wait-list.
(Cohort 5)
1 weeks
Post-Intervention Survey (N=120) (Cohort 5)
Delivery of Hope Groups to Control Arm
(N=60) (Cohort 5)

Figure 3. SPIRIT Participant Timeline

	TRIAL PERIOD			
	Enrolment		Post-randomisation	
TIMEPOINT	**$-t_i$ to 0**	**0**	**t_1**	**t_2**
ENROLLMENT:				
Eligibility screen	X			
Random selection to cohort	X			
Randomization to intervention or control arm				
Informed consent		X		
INTERVENTION/ COMPARATOR:				
Intervention		X →	→ 1-week post-intervention	6- and 12-months post-intervention
Wait-List Control Arm		X →	→	
ASSESSMENTS:				
Baseline Survey		X		
Post-Intervention Survey			X	
6-Month Follow-Up Survey				X
12-Month Follow-Up Survey				X

Sample size {19}

Sample size calculations were initially conducted using the pwr package in R (v 1.3-0). Assuming a two-sided alpha of 0.05, 80% power, 10% loss-to-follow-up, and estimated effect sizes not less than 20% of effects observed in Ukraine, the trial was powered to detect a statistically significant absolute reductions in violence against children and caregiver depression and anxiety symptoms at post-intervention and six- and twelve- month follow-up. Sample size calculations were confirmed using rollout package in R, assuming categorical time effects across each cohort (v 0.1.0).

Recruitment {20}

A list of eligible participants will be created via a two-step process. First, the charitable organisation operating in Jerash Camp will compile a list of adult parents/caregivers, who will be identified as potentially benefitting from mental health or family strengthening resources. Sanadak, the implementing partner, will call participants to screen for eligibility. During this call, the programme director will communicate more information about the study. Participants will be told the intervention would start either immediately or in several months, depending on random allocation. Eligible participants indicating interest will be kept on the list of participants. For each cohort, participants will be randomly selected from the list and subsequently 1:1 randomised to immediate intervention or wait-list control arm. For each cohort, the programme director will call cohort participants again to invite them to attend an in-person meeting in Jerash Camp, where they will complete informed consent and a baseline survey (T0). At the in-person meeting, participants will be given a participant information sheet and time to ask any questions prior to completing informed consent.

Sample sizes will differ across cohorts for implementation purposes, enabling facilitators to begin with smaller group sizes in earlier cohorts then progress to larger group sizes in later cohorts:

Cohort 1 will include N=70 participants, followed by cohort 2 (n=80 participants), cohort 3 (n=100 participants), cohort 4 (n=120 participants), and cohort 5 (n=120 participants).

Across the duration of cohorts throughout the project, Sanadak will continue adding parent/caregiver adults living in Jerash Camp to the list of participants who are identified as potentially benefitting from mental health or family strengthening resources. As this study occurs during displacement, mobility risk may be high, and thus continuing to grow the list to ensure an adequate pool of participants to draw from is deemed critical.

Assignment of interventions: randomisation

Sequence generation: who will generate the sequence {21a}

The study's lead analyst (ST) will use the slice_sample function within the dplyr package in R (v1.2.1) to randomly select participants for each cohort. Subsequently, within each cohort, individual randomisation with a 1:1 allocation ratio to the intervention arm or wait-list control arm will be conducted using the treatment_assign() function within the RCT package in R (v1.1.2), stratified by sex, by the blinded analyst (ST).

After random allocation, individuals will be subsequently randomly compiled into intervention delivery groups of 8-12 participants (separated by sex) and randomly assigned to a facilitator of the same sex.

Sequence generation: type of randomisation {21b}

Randomisation will occur by cohort. Within cohort, individual participant randomisation with a 1:1 allocation ratio will be stratified by sex (female or male).

Allocation concealment mechanism {22}

The analyst will be blinded to participant identity while randomly selecting participants for

each cohort and while individually randomising cohort participants to intervention or control arms. All cohort participants will be randomised to trial arm simultaneously using the treatment_assign() function within the RCT package in R (v1.1.2) to ensure allocation concealment.

Implementation {23}

After the analyst (ST) completes the randomisation, she will send a list of participants for each cohort, along with their intervention arm, to the local programme director.

Assignment of interventions: blinding

Who will be blinded {24a}

Blinding for participants and facilitators is not possible. The analyst remains blind to participant identity during randomisation and is also blinded to trial arm during analyses.

How will be blinding be achieved {24b}

Random ID codes will be generated for participants during randomisation and for trial arm during analyses.

Procedure for unblinding if needed {24c}

Analysts will not be unblinded during randomisation or analysis.

Data collection and management

Plans for assessment and collection of outcomes {25a}

To complete informed consent and baseline surveys (T0), participants will use an online Open Data Kit (ODK) survey form. If participants have a personal phone, they will complete the survey on their device. If not, participants will be given a tablet or phone to complete the survey on. The survey first leads to an informed consent form, then progresses to the baseline survey (taking 25 minutes). If participants are able to read, they will complete the forms independently, to ensure a higher level of anonymity, thereby minimising social desirability bias. If participants need

assistance, a facilitator will read the questions to them, then turn the device back to the participant for them to answer the questions privately, aiming to still reduce social desirability bias. After the intervention arm completes the intervention, another in-person data collection event will be held in Jerash Camp for both arms to complete an endline survey (T1). Endline surveys will be completed in ODK, with procedures consistent with T0. Data collection procedures for long-term follow-up survey completion (T2) will be identical with T1. All outcomes and measurement tools are described in the Outcomes section. Programme fidelity will be monitored via forms submitted by facilitators after each session recording completion of sessions and content.

Plans to promote participant retention and complete follow-up {25b}

To increase participant retention, a reimbursement of 5 JD per endline (T1) survey and follow-up (T2) survey will be offered, which local stakeholders advised was an appropriate amount to be appreciated but not coercive.

Data management {26}

All data will be collected electronically utilising Open Data Kit (ODK), which requires access and a password to enter. Survey data downloaded during the trial is stored on password-protected SharePoint. No paper-based consent forms, surveys, or datasets exist.

Confidentiality {33}

All information participants share within Hope Groups sessions is confidential, with the exception of mandated reporting that is essential for safety (e.g., abuse of a child). At the end of the study, only fully de-identified data will be made publicly available by researcher request and via OSF.

Statistical methods

Statistical methods for primary and secondary outcomes {27a}

As is standard in staircase trials (Grantham et al., 2024), the post-intervention treatment effect will be estimated by pooling together the treatment effects across all intervention and control arm post-intervention comparisons across the five cohorts. An intention-to-treat approach with a binary exposure variable indicating if the participant was randomised to the intervention or control group will be used. The primary method of analysis will be a generalised linear mixed-effects model, estimating the difference between intervention and control participants (i) post-intervention (T1), controlling for baseline level of the outcome, cohort, facilitator, and sex. The regression link function will be based on consideration of outcome distributions at baseline, and the appropriate link function will be used for each outcome. Where an ideal link function is not available (e.g., limited range variables where Poisson, ordered logit, and identity links are inappropriate), we will use wild bootstrapping. If a bootstrap method is used, percentile-based 95% confidence intervals will be reported. We will use two-tailed tests for all models with statistical significance thresholds of 0.05. Adverse event risk differences were estimated using the Newcombe (Wilson-based hybrid) method.

The six-month follow-up treatment effects will be estimated by pooling together the treatment effects across comparisons of participants completing six-month follow-up assessments with untreated participants completing assessments at the same timepoints. Similarly, the twelve-month follow-up effects will be estimated through pooling together participants completing twelve-month follow-up assessments with untreated participants completing assessments at the same timepoints. Across both six- and twelve- month follow-up analyses, an intention-to-treat approach will be used, with a binary exposure variable indicating if the participant is at a follow-up or untreated timepoint. The same statistical model reported for post-intervention analysis will be used for both six- and twelve- month follow-up analyses: The primary method of analysis will be a generalised linear mixed-effects model, estimating the difference between follow-up participants and wait-list control participants (i), controlling for cohort, facilitator, and sex. Exchangeability

across cohorts will additionally be assessed through comparing demographic covariates. If any imbalance is detected, propensity-score weighting to adjust for cohort differences will be utilised in six- and twelve- month follow-up analyses.

Who will be included in each analysis {27b}

Post-intervention analyses will be intention-to-treat, including all randomised participants, across cohorts 1-5 (N=490). Consistent with stepped wedge and staircase trials, six-month follow-up analyses will include all participants completing six-month follow-up surveys with all untreated participants completing baseline surveys at the same timepoint (N=420). Twelve-month follow-up analyses will include all participants completing twelve-month follow-up surveys with all untreated participants completing baseline surveys at the same timepoint (N=390).

How missing data will be handled in the analysis {27c}

If data missingness in any one outcome model exceeds 10%, multiple imputation and inverse probability weighting will be used to account for missingness.

Methods for additional analyses (e.g. subgroup analyses) {27d}

Additional analyses will explore sex, time since displacement, and age as effect measure modifiers across primary outcomes. Additional moderators may be identified and preregistered. A detailed statistical analysis plan will be registered on OSF prior to analysis.

Interim analyses {28b}

A post-intervention interim analysis will be conducted after the first cohort reaches T1, using a Bayesian approach, consistent with the RCT in Ukraine (Tucker et al., 2023). The purpose of the interim analysis is to ensure there are no harms, defined as worsening outcomes in the intervention versus control arm. If harms are identified, all trial activities will be paused for investigation. The Bayesian interim analysis will be conducted using rstanarm (v. 2.32.1). Bias corrections for the interim analysis will not be made, as the Bayesian framework does not use p-

values for inference.

Protocol and statistical analysis plan {5}

The full statistical analysis plan will be published on OSF prior to analysis.

Oversight and monitoring

Composition of the coordinating centre and trial steering committee {3d}

The trial was designed by researchers from the University of Oxford, with input from the local implementing partner on feasibility. The trial is coordinated by the lead implementing partner, Sanadak, who leads data collection and monitoring, intervention implementation, and monitoring for adverse events or harms. A trial steering committee consists of local leaders through the World Without Orphans Middle East and North Africa network, World Relief, and research experts from the Global Reference Group for Children Affected by Crisis. The trial steering committee meets quarterly at minimum or more frequently as needed.

Composition of the data monitoring committee, its role and reporting structure {28a}.

The trial does not have a formal data monitoring committee and rather has an advisory committee of local leaders who provide oversight and guidance to support the safety of participants. The involvement of local leaders with deep understanding of the context was seen as essential. Members reviewed the intervention content prior to initiation of the implementation to ensure the content was deemed as safe, non-triggering, and potentially beneficial. Members also thoroughly reviewed the study plan prior to the initiation of the study to assess whether the trial plan was ethical. Throughout the trial, if any adverse events or harms are reported, the committee will meet within 72 hours to review.

Frequency and plans for auditing trial conduct {29}

After the completion of each cohort, data will be reviewed to ensure the trial was carried out according to the protocol. The interim analysis will be conducted after the first cohort reaches post-intervention to ensure no evidence of harms or adverse events before proceeding with additional cohorts; the interim analysis results will be reviewed by the full trial steering committee.

Protocol amendments {31}

All protocol amendments will be posted on the live OSF preregistration.

Dissemination policy {8}

The authors are highly committed to the broad dissemination of results. Results will be disseminated through conference abstracts, peer-reviewed publications, policy briefs, and an online webinar hosted by the Global Parenting Initiative. The webinar will be offered to local NGOs, the World Without Orphans and World Relief networks, UNHCR, UNRWA, UNICEF, and the Accelerate Hub at Oxford University.

Discussion

This study utilises a staircase RCT to estimate the effectiveness of a mental health, parenting, and violence prevention intervention called Hope Groups among Palestinians experiencing multi-generational displacement in Jerash Camp, Jordan. This study will yield evidence on the intervention's potential to improve caregiver mental health and reduce violence against children using an innovative trial design, which prioritises the estimation of both short- and long- term intervention effects, while reducing participant survey burden and shortening wait-times for control arm participants compared to traditional stepped wedge designs. With over 6 million Palestinians experiencing the longest existing displacement globally (*UNRWA*, 2024), identifying an intervention which effectively strengthens Palestinian parents and protects children both short- and long- term should be a public health priority.

This staircase RCT design was specifically selected to address community feedback, who expressed commitment to ensuring 1) all participants would receive the intervention and 2) no wait-list participants would complete more than two surveys prior to be given the intervention. This precluded a traditional stepped wedge trial. Additionally, to maintain the research priority of estimating the effectiveness of the intervention 6- and 12- months post-intervention, a traditional two-armed parallel trial design was also infeasible, as it would require a year-long delay for the comparison arm with repeated survey measurements. While in some settings, delivering an unrelated intervention to the comparison arm can serve as a feasible solution, this study did not have funding or local interest for developing and implementing a second intervention. This staircase RCT design served as an innovative solution to simultaneously honour local preferences and prioritise rigorous short- and long- term evaluation of the intervention. The staircase design's key limitation is the reduced 12-months post-intervention sample (N=390, 80% of full sample), compared to the complete post-intervention sample (N=490), given all intervention arm participants will not reach the timepoint of 12-months post-intervention during the study period. However, this limitation is addressed through adequately powering the trial to ensure sufficient sample for the long-term follow-up analysis. Furthermore, many traditional two-armed trials also only include 80% of the sample at long-term follow-up timepoints, due to loss-to-follow-up which not only shrinks power but also introduces bias. Thus, especially in war and displacement settings where there is often increased risk of loss-to-follow-up, staircase designs may serve as a useful tool for impact evaluations.

This study builds on strong findings from an RCT testing the Hope Groups intervention among Ukrainians across parental mental health, parenting practices, violence against children, and child well-being. This current study will assess the intervention in a new setting of multigenerational displacement in the Middle East, which will yield valuable insight on the intervention's generalisability across cultures and war contexts. If results of this study demonstrate effectiveness,

the Hope Groups intervention may be a promising tool to strengthen families across diverse cultures and war contexts globally.

Trial status

The trial began in February 2025. Participant recruitment remains ongoing at the time of submission and is expected to complete by June 15, 2026. Trial data collection is expected to conclude in September 2026.

Abbreviations

RCT: Randomised controlled trial

MENA: Middle East and North Africa

ODK: Open Data Kit

Declarations

Acknowledgements

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Authors' contributions {3a}

ST, SH, NB, NH, MA, and SG conceptualised the implementation and evaluation of the intervention in Jordan. ST designed the staircase RCT. NB, NH, and SG adapted the intervention for the Jordanian context. JL has provided guidance throughout the trial. NH led the implementation of the intervention in Jordan, including the training and oversight of facilitators, the recruitment of participants, and the monitoring of weekly sessions. MA created all surveys and monitored all data collection across all trial timepoints. ST, GJMT, and OR designed the statistical analysis plan. ST led the writing of this manuscript, with revisions from all co-authors. ICMJE guidelines are used to select co-authors for publications of this study.

Sources of funding and other support {7a}

This study is supported by the Global Parenting Initiative (funded by the LEGO Foundation and Oak Foundation) and private donations to World Without Orphans, World Relief, and Sanadak.

Availability of data and materials {6}

Data dictionaries, statistical code, and deidentified participant data will be made publicly available on Open Science Framework. Researchers are welcome to contact Sydney.tucker@spi.ox.ac.uk for data usage requests prior to data being made publicly available.

Ethics approval and consent to participate {30}

Ethical approval was obtained from the University of Oxford (Reference Number: 760866).

Consent for publication

The research team has included the participant consent form as a supplementary document.

Competing interests {7b}

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: JL is the CEO of Parenting for Lifelong Health (PLH), a charitable organisation based in the United Kingdom. The Hope Groups programme was developed based on content from PLH, which is open access and licensed under a Creative

Commons 4.0 Attribution Share-Alike license. JL participates in a number of research studies involving PLH programmes as investigators; the University of Oxford and University of Cape Town receive research funding for these. GJMT is a National Institute for Health and Care Research (NIHR) Senior Investigator. All other authors declare that they have no competing interests.

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Supplementary Materials

Supplementary Materials Table 1. Primary, Secondary, and Tertiary Outcomes with Adaptation Explanations

Outcome Level	Domain	Outcome	Source / Measure Description	No. of Items	Range *(response option labels)*	Adaptations
Primary Outcomes						
	Caregiver/ Parent Mental Health	Depression and Anxiety	Patient Health Questionnaire (PHQ) – 4 (Carroll et al., 2020)	4	0–12* *(Not at all, Several days, More than half the days, Nearly every day.*	None
	Violence Against Children	Physical and Emotional Child Maltreatment	ICAST-Trial – Parent Version - Physical Abuse and Emotional abuse subscales (Meinck et al., 2018)	10	0–30*** *(Multiple times per week, once per week, once in the past TWO weeks, Not at all)*	- Due to confusion in local setting, 1 item was removed from the physical violence subscale ("Shake him/her"). - Due to locally-deemed inappropriateness in a Muslim or extremely low-resource refugee camp setting, 3 items were removed from the emotional violence subscale, including 1) "Threaten to invoke ghosts or evil spirits, or harmful people"; 2) "Without a meal as a punishment"; and 3) "Lock him/her out of the house".
Secondary Outcomes						
	Parenting Practices	Positive Parenting, Parental Involvement, and Parental Monitoring	Alabama Parenting Questionnaire (APQ) (Shelton et al., 1996)	6	0–7** (*Days in the past week)*	Consistent with the Ukrainian Hope Groups evaluation, 2 items from each of the positive parenting, parental involvement, and parental monitoring subscales were chosen, to reduce participant burden.
	Child Well-being	Internalising and externalising behaviours	Child and Adolescent Behavioural Inventory (CABI) (Cianchetti et al., 2013)	17	0–32† (*Not true, Sometimes true, Somewhat true, or Very true)*	- Oppositional-defiant disorder and conduct disorder subscale: Based on cultural relevance and the low-resource context, 7 items were used, and 3 items from this subscale were dropped, including 1)*"he is domineering and always wants to assert himself", which was viewed as positive by local leaders; 2)"he bothers and intentionally annoys others", which was viewed as less important by local leaders; and 3)"he has committed petty theft", which was viewed as highly common by local leaders.* - Depression subscale: 8 items on depression were used, including all the validated items on mood, aboulia, and suicidal thoughts. Due to local input on prioritisation in the local setting, the 1 item on self-esteem and 1 item on guilt were not included. - Irritability subscale: 2 items on irritability were used. To shorten the survey, 2 items from

						this subscale were dropped, which were deemed by local advisors are highly common in a refugee context, and thus yielding less meaningful information, including 1)*"he has frequent mood changes"; and 2)"he is very irritable"*.
Tertiary Outcomes						
	Caregiver Physical Health	Blood pressure	Average of two BP readings	4	Systolic: Continuous; Diastolic: Continuous	NA
		Heart rate	Average of two heart rate readings	2	Continuous	NA
		Caregiver sickness	Direct report of number of days caregiver was sick in past week	1	0–7** (*Days in the past week)*	NA
	Caregiver Well-Being	Post-traumatic growth	Post-Traumatic Growth Inventory (Cann et al., 2010)	3	0–12 § *(Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree.)*	Due to constraints regarding survey length, 3 of the most-relevant items from the 10-item form were selected by local leaders, including: - *"Hardship has taught me I am stronger than I thought I was"* - *"Hardship has taught me that I can handle difficulties."* - *"Hardship has given me a greater sense of closeness with others."*
		Quality of life	WHO Quality of Life Scale (The WHOQOL Group, 1998)	3	0–12‡ *(Not at all, A little, Moderately, Completely.)*	Due to constraints regarding survey length, 3 questions <u>from spiritual, religious, or personal beliefs subscale</u>, including: - *"How much does spiritual strength help you to live better?"* - *"To what extent do you have inner peace?"* - *"To what extend are you hopeful about your life?"*
		Suicidal thoughts	PHQ-9 (Carroll et al., 2020)	1	0–3* *(Not at all, Several days, More than half the days, Nearly every day.)*	NA. The one item on suicidality from PHQ-9 was used.

		Coping with grief and hopeful-ness	Locally developed in Ukraine	2	0–7** (*Days in the past week)*	Locally developed in Ukraine, and determined to be included in Jordan. Consisting of 2 items, developed to measure constructs related to positive psychology and coping with grief: - *How many days in the past week did you feel hopeful about the future?* - *How many days in the past week were you able to grieve your losses in a healthy way, such as by talking with someone you trust, finding ways to honour who or what you lost, or finding meaning in your new reality?*
		Self-care	Locally developed in Ukraine	1	0–7** (*Days in the past week)*	Locally developed in Ukraine, and determined to be included in Jordan, consisting of: - *How many days in the past week did you take actions to care for yourself, such as relaxation techniques, talking to someone you trust about your feelings, establishing a routine, or eating and sleeping well?*
		Hope and purpose in community: Beliefs about improving community	Locally developed in Jordan	2	0–8‡ *(Not at all, A little, Moderately, Completely.)*	Locally developed in Jordan, including the following questions: - *"Do you believe things in your community can get better?"* - *"Do you believe you can be a part of making things in your community better?"*
		Hope and purpose in family: Belief in ability to care for self and children	Locally developed in Jordan	1	0–4‡ (*Not at all, A little, Moderately, Completely.)*	Locally developed in Jordan, including the following questions: - *"Do you believe you have the skills to take care of yourself and your children, regardless of whether circumstances in your community get better or not?"*