

# EVALUATION OF CHILD FRIENDLY SPACES

## Uganda Field Study Summary Report

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## Summary

A Child Friendly Space (CFS) is an intervention frequently used by humanitarian agencies to support and protect children in emergencies. Reflecting priorities of the Global Protection Cluster Child Protection Working Group's 2013-2015 workplan, World Vision International and Columbia University are in the process of conducting a series of structured evaluations of CFS programmes. These are being conducted in various contexts, to document evidence of protective and restorative effectiveness of CFSs, to identify good practice in their design and implementation, and to contribute to the development of better monitoring and evaluation tools for this type of programming. This report presents findings from the second study in this series: an evaluation of CFS programmes for Congolese refugees in Rwamwanja Resettlement Center in Western Uganda. Eight CFSs implemented by the World Vision Uganda and Save the Children in Uganda response teams were evaluated.

The study built upon a structured review of the evidence-base for CFS programmes in humanitarian contexts (Ager, Metzler, Vojta, & Savage, 2013) as well as on learning from the first evaluation of the series, conducted in Ethiopia (Metzler et al., 2013). In addition to targeting the robust design and sampling approach that will characterise all planned evaluations, this second study piloted means of collecting information on community awareness of resources relevant to child protection and the use of mobile phones to administer surveys. Although information was also collected from children aged 13 to 17 years during the course of the evaluation, this report focuses on those findings relevant to younger children (aged 6 to 12), as they were the primary beneficiaries of the CFS programmes.

This study collected baseline survey data from a sample of caregivers residing in the resettlement area in advance of activities beginning at each of the eight CFSs targeted for the evaluation. Baseline data was collected with respect to 689 children. Survey data was supplemented by participatory discussions with children and adults. The same caregivers were then interviewed three months following the start of CFS implementation (follow-up data being collected for 633 children). Parent-reports of CFS attendance (validated by comparison with attendance records) allowed for the comparison between those who had attended and those who had not attended a CFS in that period. Attempts were made to standardize the CFS programme across the resettlement area and emphasized a range of psychosocial activities as well as functional literacy skills. Evaluation tools were selected to assess impact with respect to three key areas: (a) the protection of children from risk, (b) supporting caregivers and communities in strengthening systems of child protection, and (c) the promotion of children's psychosocial well-being.

The CFS programme was found to be well utilized by children aged between 6 and 12. 73% of such children were reported to have attended a CFS: 31% 'occasionally' and 42% 'frequently'. Attendance was similar for boys and girls. Vulnerability did not predict the likelihood of attendance. Caregivers interviewed reported both a greater sense of protection for children and a heightened awareness of support structures for their protection within the resettlement area over time. This trend was observed irrespective of whether the caregiver had a child attending a CFS. Consequently, while changes in sense of protection and awareness of relevant resources within the community were congruent with the broader aims of the CFS programme - which was documented to reach three in four of eligible children -

it is not possible to attribute such changes to this intervention. The stresses that impacted a caregiver's ability to support, care for and protect children, such as a lack of food, shelter, and livelihood among others, were also reported by caregivers (of both those attending CFSs and those not attending CFSs) to have decreased over time in the resettlement area.

Both measures of children's developmental assets (including internal assets such as positive values and social competencies and external assets such as support and empowerment) and of psychosocial well-being showed impact of children's attendance at CFS. CFS attendance was associated with an increase in developmental assets, and a sustained level of psychosocial well-being for children, between baseline and follow-up. This was in contrast to decreasing scores on both measures over this period for children who did not attend the CFSs. In the case of boys attending a CFS, more frequent attendance predicted better protection of well-being. This suggests that CFSs helped to bolster resources supportive of children's development as well as create a buffer against influences otherwise leading to the decline in children's social and emotional well-being.

It was also found that CFSs assessed to meet higher quality standards had greater impact on promoting children's developmental assets and protecting psychosocial well-being than CFSs assessed to meet lower standards. This represents important evidence suggesting that the quality of programming has real influence on the likelihood of CFSs meeting targeted goals regarding children's well-being, with clear implications for the specification and monitoring of quality standards.

These findings are from a single study in a specific setting and as such are not presented as generalizable to other contexts. Learning from this and the first study will inform subsequent evaluations in the planned series, with a view to developing a coherent evidence base from which broader lessons related to CFSs can be drawn upon. Indications from both studies to date, for example, have suggested that in the context of humanitarian emergencies the impact of CFSs may not be in the promotion of well-being, but may be appropriately conceived as protecting well-being from further deterioration.

## Background

World Vision International and Columbia University are partners in carrying out a series of structured evaluations of Child Friendly Spaces (CFSs) over three years in various contexts. This partnership has subsequently expanded to include UNICEF, Save the Children UK, and other members of the Child Protection Working Group (CPWG). The goals are to document the protective and restorative effectiveness of CFSs, to identify good practice in their design and implementation, and to contribute to the development of better monitoring and evaluation tools for this type of programming. Little robust evidence exists related to outcomes and impacts of CFSs even though it is one of the most widely used interventions in humanitarian settings for child psychosocial support and protection (Ager et al., 2013; Global Protection Cluster, Global Education Cluster, INEE, & IASC, 2011).

The first of the structured evaluations was conducted in 2012 with Somali refugees in Buramino Refugee Camp near the Southeast border of Ethiopia. This represented the first attempt at incorporating

rigorous sampling and design in a CFS evaluation. The findings suggested promotive effects of attending the programme in terms of literacy and numeracy acquisition and, amongst younger boys, reduced psychosocial difficulties. In the face of increasing hardship in the camp, there was evidence that attending CFSs supported a greater sense of protection and buffered against the increased stresses of caregivers.

Each study builds upon the next and through the series of planned studies in varying contexts it is anticipated that an evidence base will be established from which broader lessons can be drawn to improve programming. The second structured evaluation introduced the use of mobile phones in survey collection, providing a key innovation towards reducing error and expediting the collection and analysis process in emergency work. The study also piloted some measures to assess community awareness of resources relevant to the protection of children. The experience of implementing the evaluations, as well as developing and using the tools, is being documented in order to create an improved M&E toolkit for child psychosocial support and protection programming in emergencies.

## Intervention

As a result of ongoing and escalating conflict in and around the North Kivu province of the Democratic Republic of Congo (DRC), refugees have been crossing the border into neighboring countries, including Uganda, in large numbers. As of August 2012, over 19,000 refugees had arrived in Rwamwanja Resettlement Center (Humanitarian Initiative Just Relief Aid, 2012; Nyakato, 2012). By the time of the final data collection period in February 2013, the Office of the Prime Minister (OPM) estimated around 35,000 refugees within the resettlement center with the potential to accommodate up to 50,000 (M. David, Resettlement Commandant, Office of the Prime Minister - Uganda, personal communication, February 27, 2013; UNHCR, 2012).

CFSs were implemented across the resettlement area in coordinated operations by World Vision Uganda and Save the Children from late 2012. CFSs were located in several villages<sup>1</sup>, with each agency taking responsibility for a total of 10 CFSs across the resettlement area. Villages varied in population, each being divided into subunits named *nyumba kumi*<sup>2</sup> (a local Congolese community structure normally constituting 10 households, but incorporating as many as 25 in this setting).

Construction of the CFSs began in August 2012, with programme activities commencing in some CFSs by September 2012. All were operational by November 2012. All CFSs consisted of a tented activity area, latrines, a store and a variety of playground equipment.

CFS activities included literacy and numeracy, local dialect and English language acquisition, traditional song and dance, art, storytelling, organized sports, and unstructured free play. Additionally, most CFSs

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<sup>1</sup> Rwamwanja Resettlement Center was divided into 'villages' for ease of demarcation. Each village had an elected village chairman with *nyumba kumi* leaders reporting directly.

<sup>2</sup> This structure was eliminated by OPM before the follow-up data collection period. However, refugees continued to identify their *nyumba kumi* leaders at follow-up.

offered group discussion times where children were able to share experiences with the group or give peer-to-peer support. Although the CFSs were mainly targeted to younger children, older children – mostly girls - participated in vocational activities of sewing and dress design. Each CFS typically provided a four-hour session for children aged 6 to 12 in the morning and a two-hour session for children 13 to 17 in the afternoon. The number of children enrolled varied across the CFSs, ranging from 65 children to 651 children registered at any one CFS.

## Design and Methods

Guided by the CFS programme's specific design, the evaluation framework looked to address the major methodological weaknesses identified by our structured review of the evidence base and by key findings from our first evaluation study (Ager et al., 2013; Metzler et al., 2013). Measurement tools were selected to assess impact with respect to three key areas: (a) the protection of children from risk, (b) supporting caregivers and communities in strengthening systems of child protection, and (c) the promotion of children's psychosocial well-being (including the acquisition of skills and knowledge).

Survey data were collected via mobile phones from interviews with caregivers of children between the ages of 6 and 12 years and from interviews with children aged 13 to 17 (the findings of the latter are reported in a supplement to this report). The survey was comprised of four main sections: questions drawn from the Child Protection Working Group (CPWG) Child Protection Rapid Assessment (CPRA), a pilot, brief measure of developmental assets (the B-DAP) based upon the Search Institute's Developmental Assets Profile, a locally-derived measure of psychosocial well-being, and a vulnerability assessment.

Several items of the CPRA were used to assess protection risks and vulnerabilities as well as to identify key child protection actors and resources within the community. The B-DAP was used to gauge reporting of internal and external assets that support healthy behaviours and well-being and allow children to develop and thrive into adulthood. The locally derived measure of well-being was based upon indicators of psychosocial well-being suggested by extensive ethnographic fieldwork in Uganda (CPC, 2011). This measure provided a means of assessing different outcome areas related to social and emotional well-being of children including: engagement at home, at school and in the community, social relations, problem solving skills and behaviors, self esteem, and the reduction in troubling thoughts and feelings. The vulnerability assessment screened children with respect to the following criteria: primary caregiver aged 65 or above, member of female-headed household, family with over 5 members residing more than 4 nights per week in the home, physical disability, and mental disability. A Vulnerability Index (VI) for each child was compiled by collating survey data, and children with 3 or more vulnerabilities were designated as 'vulnerable' for the subsequent analysis.

In addition to survey interviews, participatory discussions with children, caregivers and community members were conducted to identify formal and informal systems of protection as well as further define vulnerability in the refugee context. Designation of 'higher' and 'lower' quality CFSs were made based on two assessments of quality using an abbreviated World Vision quality standards monitoring checklist

drawing upon established inter-agency criteria (World Vision International, 2006; Global Protection Cluster, 2011) which was completed during site visits. Higher quality CFSs were defined as those receiving an average score of 60% or above on the checklist.

Baseline data were collected using these tools, prior to any participation in CFS activities. Interviews were conducted on a house-by-house basis, using a random survey cluster methodology (all houses were visited within a series of *nyumba kumi* randomly selected from across the areas to be served by eight designated CFSs). Caregiver interviews were completed with respect to 689 children at baseline. The same caregivers were re-interviewed after approximately three months of operation of the CFS programme. Follow-up data was successfully collected for 633 of the children reported on at baseline (a 92% retention rate). Collecting baseline and follow-up data from caregivers of children aged 6 to 12 who attended a CFS and also those who did not attend a CFS provided a basis for determining the impact of programme attendance. At baseline, scores of children aged 6 to 12 attending and not attending CFSs were equivalent on most measures.<sup>3</sup> Differences in scores at follow-up may, therefore, reasonably be attributed to attendance patterns in the period between baseline and follow-up.

All data were collated and analysed using a range of bivariate and multivariate tests. In the description that follows only trends that are statistically significant at the  $p < 0.05$  level or above are reported.

## Findings

### ***CFSs were widely utilized by children***

Caregivers reported 73% of children between 6 and 12 having attended CFS, with similar proportions for girls (75%) and boys (71%). For most analyses that follow the comparison is between attenders and non-attenders; for others the distinction is made between frequent attenders (42%), occasional attenders (31%), and non-attenders (27%). Validation of caregiver reports of attendance with respect to a sample of 100 children listed on CFS attendance registers indicated an average attendance at 68% of available sessions for frequent attenders, 54% of available sessions for occasional attenders and less than 12% of available sessions for reported non-attenders.

The vulnerability of children was not a significant predictor of their likelihood of attending a CFS. Overall, 18% of children were indicated to be vulnerable on the Vulnerability Index. 22% of children frequently attending CFSs, compared to 16% of children occasionally attending CFSs and 15% of children not attending CFSs, were designated as vulnerable on this measure. There is no evidence here of a statistically significant trend for CFSs to disproportionately reach vulnerable children, but it does suggest that CFSs were broadly accessible to such children.

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<sup>3</sup> No significant differences in baseline scores on vulnerability, protection concerns, caregiver stresses or well-being were identified. At baseline, however, children who subsequently proved to be non-attenders were reported as significantly higher than attenders on developmental assets.

**Protection concerns and caregiver stresses were perceived to reduce over time**

CPRA questions were selected to identify concerns regarding specific child protection risks or vulnerabilities. Table 1 identifies the 11 distinct protection risks for children aged 6 to 12 reported by caregivers during interviews. An index was compiled of identified protection concerns for children at both baseline and follow-up periods. This ranged from zero (no protection concerns reported) to 11 (all protection concerns reported).

Forced recruitment	Attacks
Abductions	Sexual violence
Not being able to go back to school	Losing their belongings
Not being able to return home	Tension within the family
Being separated from their friends	Nightmares or bad memories
Being separated from their families	

Table 1. Caregiver-reported Protection Concerns of Children 6 – 12

Caregivers of children both attending and not attending CFSs reported marked decreases in protection concerns over time (from 5.46 to 4.84 and from 5.55 to 4.76, respectively). There were similar trends for both boys and girls (see Figure 1).

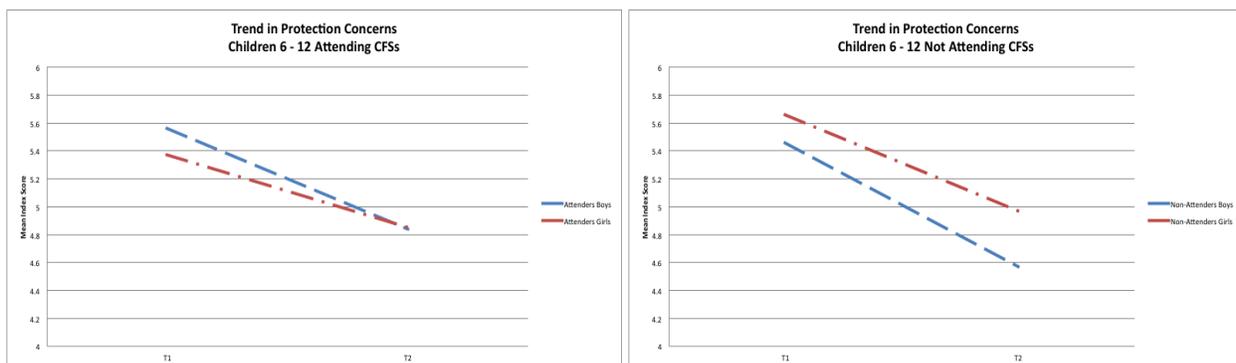


Figure 1: Reporting of Protection Concerns for Girls and Boys (6-12) Attending and Not Attending CFSs

Although this trend is encouraging, participative discussions with children and community members revealed that many protection concerns remained in the resettlement area at the time of follow-up data collection, including issues of child abuse, violence inflicted on children by intoxicated adults, and ethnic discrimination among the refugee population. One parent remarked:

“Our children are being abused when they have not reached years of getting married and we see it very bad. The problem of child abuse is the second because the child who is 12 or 11 you can find her pregnant with no husband another one is at school can leave [because] of pregnancy.”

In discussions with boys 6 to 12 years, one boy reflected:

“Alcohol makes people suffer much, because drunkards get drunk until they sleep at the road and cars knock them. A drunkard reaches at home, he starts beating mammy and children disappear. At least they should take little, even me, I met a drunkard out [and] he beat me.”

An older girl remarked:

“Me, I go to fetch [with] other children. They beat me [because] I am a Tutsi. Reaching home, I tell my mum and she tells me that I leave them and they tell me that they will kill me. In Congo, they ran from Tutsis. Now they are following them. Others can tell us that we are M23.”



A second CPRA question identified five major concerns as contributing to stresses of caregiving in the resettlement area: lack of food, lack of shelter, lost property, lost livelihood, and children’s safety. Providing daily meals for one’s family was difficult after long hours digging in the fields and long distances traveled to secure food rations. The loss of income generating activities created strains on caregivers in procuring clothes and household items, such as sleeping mats and cooking utensils. Interest in such issues is of relevance to this study to the extent that a caregiver’s stress over providing basic needs affects their ability to care for, support, and protect their child. Reporting of these concerns ranged from zero (no stresses reported) to five (all stresses reported).

Caregivers reported marked decreases in such stresses between baseline and follow-up. Such decreases were reported for caregivers of both children attending and not attending CFSs (from 4.51 to 4.00 and from 4.40 to 3.92, respectively). There were similar trends in such reports whether caregivers were being interviewed about a boy or a girl within their household (see Figure 2).

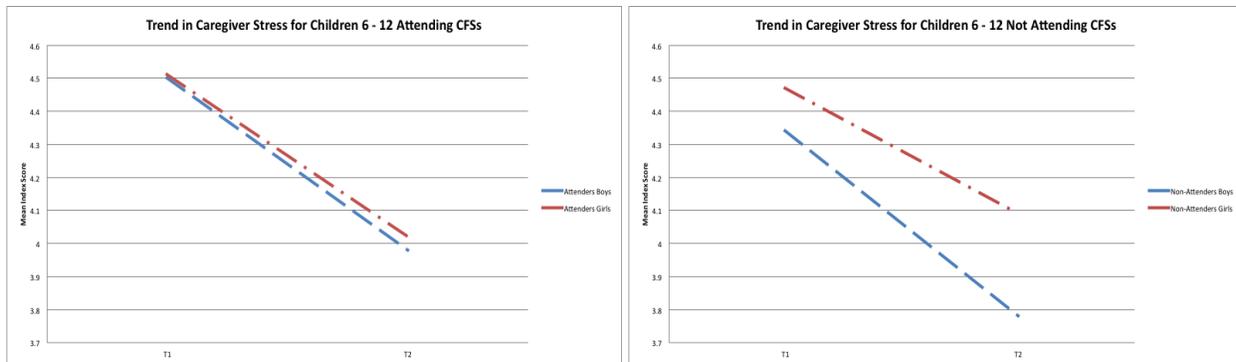


Figure 2: Reporting of Caregiver Stresses for Girls and Boys (6-12) Attending and Not Attending CFSs

Overall, this data suggests an improvement of conditions in the resettlement area from baseline to follow-up. While changes in sense of protection and reduction in concerns over children’s safety (one of five identified caregiver stresses) were in line with the broader aims of the CFS programme – which, as noted earlier, reached three in four of eligible children - it is not possible to attribute such changes to this intervention on the basis of available data.

### ***Knowledge of community mechanisms of support and referral improved over time***

CPRA questions were asked to assess the access to and utilization of resource persons available to protect, support and care for children. The following seven categories of resource persons were identified by caregivers as providing support and protection for children in the resettlement area: peer groups, social workers, school teachers, religious leaders, political leaders, community leaders, or ‘other resource persons’. ‘Other resource persons’ identified included World Vision staff, CFS facilitators, medical workers, and operational partners working in the resettlement area. An index was compiled ranging from a score of zero to seven depending on the number of categories of resource persons identified.

Caregivers of children aged 6 to 12 demonstrated significant increases from baseline to follow-up in their capacity to identify key resource persons in the community that provide support and protect children. There were similar increases for both caregivers of children attending and not attending CFSs (from 0.47 to 1.12 and from 0.66 to 1.25, respectively).

While this increase in awareness of resources is welcome, barriers to accessing these resource persons continued to be identified by surveyed caregivers during the follow-up data collection period. In order of frequency, these barriers were: not thinking the people who work there will listen to me or believe me; not trusting the services or the people who work there; not having enough money to pay for transportation or the services; not speaking the same language; believing it to be against religious or cultural practices; or being scared of what family or friends would say or do if they found out. Other barriers included a lack of awareness of services, hours of operation of service providers and long distances to procuring services.

Participative discussions with caregivers and children elaborated on some of these issues. For example, one parent reported:

“Misunderstanding of language between [us] Congolese and nurses leading to us being given the drugs which are not the [right] ones...when the national reaches there they give him or her the real drugs. They discriminate us.”

Another parent noted how:

“We had diseases and we reach at the health centre when we are very sick and the ambulance cannot come to get a child.”

In discussions with girls aged 10 to 14 years, one girl mentioned:

“The problem of medication, when we arrived at the hospital, they gave us a bad medication and some of us children are dead because of that. Now, we would like that the social worker have a place at the hospital because it’s through them we have a voice.”

It is not clear how frequent such challenges to effective access of health services are, but they clearly concerned many refugees.

Additional CPRA questions were asked to assess knowledge of and access to child protection reporting mechanisms and services for survivors of physical and sexual violence in the resettlement area. Knowledge of child protection reporting structures in the resettlement area was reported in 69% of baseline caregiver interviews. The most frequently cited structures included the police, the village chairman, the resettlement commandant (OPM), and the *nyumba kumi* leader. At follow-up, there was a modest increase to 77% of caregiver interviews identifying reporting structures in the resettlement area. Although the creation of Child Protection Committees (CPCs) was a component of the CFS programme, only six interviews identified this structure as a source of reporting and referral for services at follow-up.

Knowledge of services for survivors of physical and sexual violence in the resettlement area was reported in 58% of interviews with caregivers at baseline. At follow-up, this had fallen to 47% of caregiver interviews documenting knowledge of these services. It is uncertain how best to interpret this finding. The decline in reporting may be attributable to a loss of awareness of, or decrease in, services available in the resettlement area. However, it may be that with greater access to information specifying the types of services offered by operating partners over time, caregivers were more discriminating and focused in their responses at follow-up.

Again, overall, this data suggests a welcome improvement in the knowledge of community mechanisms of supports and referrals from baseline to follow-up. While this trend is in keeping with the goals of the CFS and may have been supported by the work and outreach of CFSs, attribution of such impact cannot be definitively ascertained on the basis of current data. CFSs did not, for example, keep records of

referrals to other services, which would have provided a potential means of identifying the role of CFSs in wider protection mechanisms.

### ***Attending CFSs strengthened the developmental assets of children***

Figure 3 shows trends in scores on the B-DAP scale as a measure of 10 developmental assets of children aged 6 to 12 years. For those children not attending CFSs, average reported developmental assets decreased from baseline to follow-up (from 15.33 to 14.01). For children attending CFSs, however, there was an increase in reported developmental assets (from 14.02 to 15.33) over the same period. Gains were more pronounced in girl attenders (from 13.84 to 15.41) than boy attenders (from 14.21 to 15.24). Children designated as most vulnerable attending CFSs maintained similar levels of developmental assets over time.

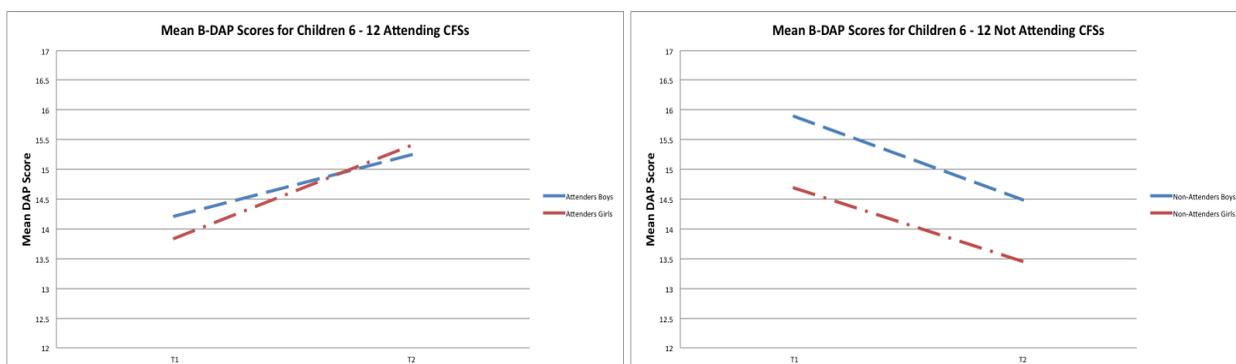


Figure 3: Trends in Developmental Assets for Girls and Boys (6-12) Attending and Not Attending CFSs

These trends suggest that attendance at CFSs served to strengthen internal assets (such as positive values and social competencies) and/or external assets (such as support and empowerment), while those not attending a CFS saw erosion of such assets over time. This is suggestive of both the protective and promotive impacts of CFS programming.

### ***Attending CFS sustained children's psychosocial well-being***

Figure 4 shows trends in scores on the locally-derived measure of psychosocial well-being among children 6 to 12. For children not attending CFSs, average psychosocial well-being reduced from baseline to follow-up (from 13.35 to 11.38). This was equally true for both boy and girl non-attenders (from 13.52 to 11.85, and from 13.16 to 10.88, respectively). For those children attending CFSs, however, psychosocial well-being scores were sustained over time. A sustained level of psychosocial well-being was also observed amongst the sub-group of attending children designated as vulnerable.

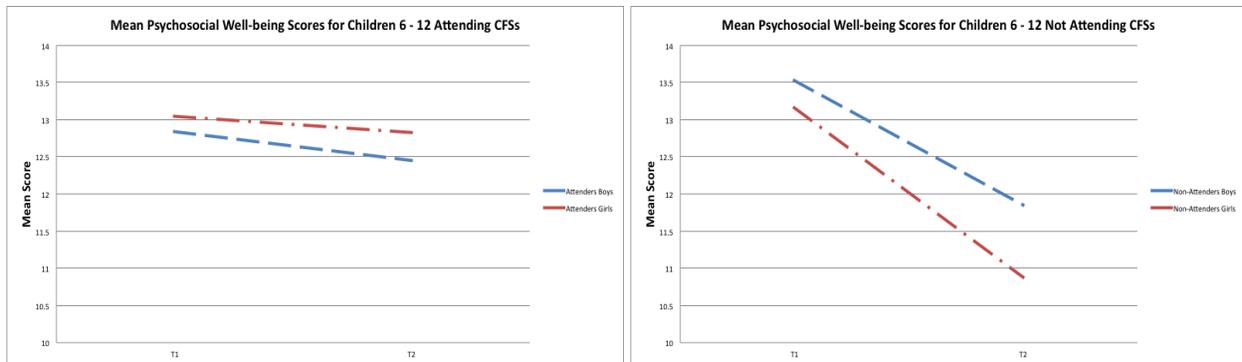


Figure 4: Trends in Psychosocial Well-being for Girls and Boys (6-12) Attending and Not Attending CFSs

There was some evidence of the influence of frequency of attendance on well-being scores in the case of boys. Children frequently attending CFSs generally sustained their psychosocial well-being from baseline to follow-up. This was true for both girls and boys<sup>4</sup>. Amongst children occasionally attending, however, while girls maintained psychosocial well-being over time (with scores of 13.23 and 13.05 at baseline and follow-up respectively), boys showed clear deterioration in well-being over this period (mean scores falling from 12.87 to 11.86).

While not serving to promote increases in reported psychosocial well-being, attendance at a CFS appears therefore to have helped sustain levels of social and emotional functioning. In contrast, those not attending CFS (who, as noted earlier, were equivalent to subsequent attenders on most measures at baseline) showed clear deterioration in well-being between baseline and follow-up. This suggests a potentially important protective influence of CFS attendance. Further, in the case of boys there is evidence that frequent attendance was required to secure this protective effect.

### ***CFSs meeting higher quality standards had greater impact on children's developmental assets and psychosocial well-being***

Measures of CFS programme quality enabled comparison of reports regarding children attending four 'higher quality' CFSs and four 'lower quality' CFSs. As indicated by Figure 5, when disaggregated by CFS quality level, children attending higher quality CFSs showed greater improvement (from 13.38 to 15.57) than those children attending lower quality CFSs (from 14.58 to 15.16, not significant) regarding developmental assets. This suggests that the quality of the CFS programmes as measured had a clear influence on the effectiveness of the intervention in securing targeted developmental gains.

<sup>4</sup> Who saw a marginal, non-significant reduction (from 12.93 to 12.68) and marginal, non-significant increase (from 12.81 to 13.00) in average psychosocial well-being scores respectively.

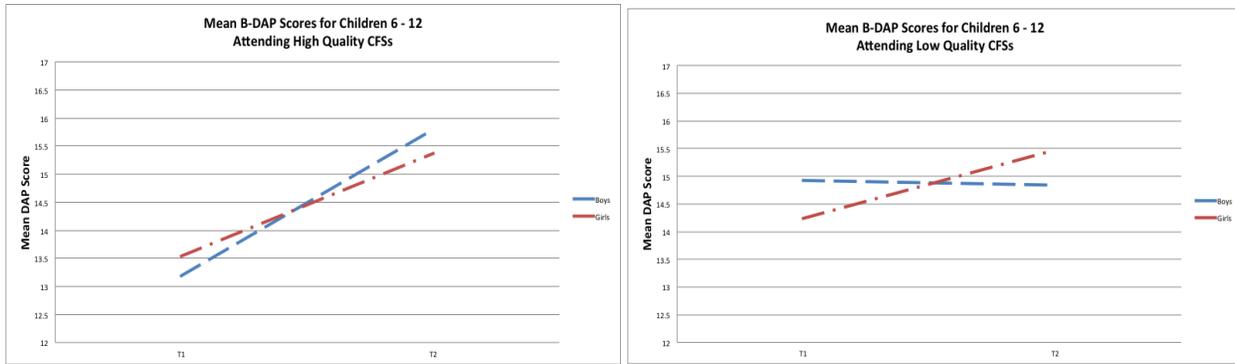


Figure 5: Trends in Developmental Assets for Girls and Boys (6-12) Attending CFSs Disaggregated by CFS Quality Level

Maintenance of psychosocial well-being was also predicted by level of CFS quality. Figure 6 shows how children attending high quality CFSs showed a marginal increase in average psychosocial well-being scores from baseline to follow-up (from 12.60 to 12.94, not significant), while those children attending low quality CFSs showed a significant decrease in psychosocial well-being (from 13.17 to 12.37). This latter trend, it should be noted, still represents a better maintenance of well-being than displayed by non-attenders (see Figure 4).

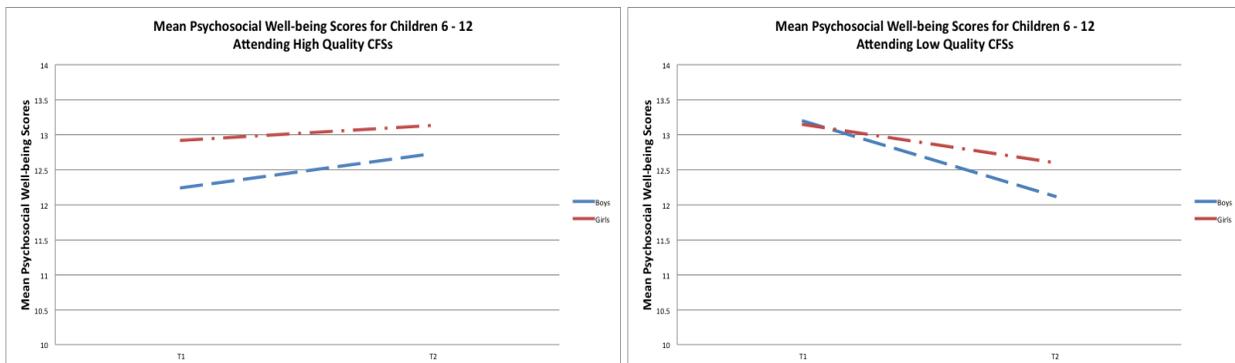


Figure 6: Trends in Psychosocial Well-being for Girls and Boys (6-12) Attending CFSs Disaggregated by CFS Quality Level

Taken together, Figures 5 and 6 provide strong evidence of the quality of CFS programming having real influence on the likelihood of such interventions meeting targeted goals regarding children’s well-being, with clear implications for the specification and monitoring of quality standards.

## Implications for Practice and Future Evaluations

This study indicated that many of the objectives of the CFS programmes studied were achieved. Children were reported to be less vulnerable to protection risks over time and caregivers to have greater knowledge of resources to support children. The stresses that impacted a caregiver's ability to support, care for and protect children, although still relatively high at follow-up, also decreased over time. Although these changes were congruent with the objectives of the CFS programmes at Rwamwanja, given such trends were observed equally amongst caregivers of children attending and not attending CFSs, it is not possible to attribute such change to these interventions.

However, children attending CFSs were more likely to acquire developmental assets and sustain psychosocial well-being compared to children not attending CFSs. Sustaining well-being over time was for boys more likely given 'frequent' rather than 'occasional' CFS attendance. Additionally, promotion of developmental assets and protection of psychosocial well-being were more evident for children attending high quality CFS. Taken together, these findings suggest important potential promotive and protective functions of CFSs, particularly when implemented in line with quality standards and (as suggested with boys) with consistent attendance.

This study highlights three particular areas where programming efforts may usefully be strengthened. First, while enrollment in a CFS programme is indicated to be of potential benefit to children, findings suggest that 'signing up' is only the start of the story. With more regular attendance associated with better psychosocial well-being for boys, active mobilization and outreach to achieve their consistent attendance is clearly warranted (and is likely to be of benefit to girls also). Further, since children attending lower quality CFSs saw poorer outcomes than those attending higher quality CFSs, providing programme activities in line with inter-agency guidelines on quality appears crucial if targeted benefits are to be secured.

Second, it was noted earlier that CFSs failed to keep records of referrals to other services, which would have provided a potential means of identifying their role in wider protection mechanisms. The formal recording of such referrals would not only assist documentation of - but also likely promote - the role of CFSs in identifying children's particular needs and responding appropriately to them.

Third, community ownership and creation of Child Protection Committees was seen as a key outcome of CFSs in Rwamwanja Resettlement Center. As protection concerns for children and the stresses of caregivers decreased over time, there was little mention of these formal structures as a resource or support and referral mechanism. Instead, most participants identified traditional structures of support, such as *nyumba kumi* and village leaders, or formal coordination structures as key links to services and referral networks. This suggests the value of CFS programmes supporting existing structures of protection and strengthening local ability to provide referrals and services for survivors of physical and sexual violence.

As noted at the outset, this study is the second in a series of structured evaluations planned over a three-year period. Each study builds upon the next and will establish an evidence base, on which to

draw broader lessons for practice and implementation of operational research in the field of CFSs and other psychosocial programming in emergencies.

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## Appendix

### An In-Depth Look at Tools

#### Brief Developmental Assets Profile (B-DAP)

The Developmental Assets Profile was designed to measure the presence (and change over time) of internal asset categories (Positive Values, Social Competencies, Positive Identity, Commitment to Learning) and external asset categories (Support, Empowerment, Constructive Use of Time, Boundaries & Expectations). These developmental assets help support healthy behaviours and well-being that allow children to develop and thrive into adulthood. From December 2011 Search Institute and World Vision International collaborated to pilot a brief 10-item version (B-DAP) of the institute's original 58-item Developmental Assets Profile to help assess the developmental condition of children affected by emergencies around the world. This work has subsequently led to the formulation of a 13-item Emergency Development Assets Profile (EmDAP) not used in the reported work. The DAP was developed and is owned by Search Institute. Special permission was obtained for the pilot use of the B-DAP (including exploration of non-standard use of items for parental completion). For more information, visit: <http://www.searchinstitute.org/developmental-assets> and <http://www.wvdevelopment.org/>.

#### Child Protection Rapid Assessment (CPRA)

The Child Protection Rapid Assessment is an inter-agency tool designed for use following the rapid-onset of an emergency. It provides a means of rapidly identifying the pressing protection needs of children and their prioritization for programmatic response. For more information, visit:

<http://cpwg.net/resource/cpra-guide-english-cpwg-october-2011/>.

#### Psychosocial Well-Being

This locally-derived measure of psychosocial well-being is based upon indicators of psychosocial well-being suggested by extensive ethnographic fieldwork in Uganda (CPC, 2011). It provides a means of assessing different outcome areas related to social and emotional well-being of children including: engagement at home, at school and in the community, social relations, problem solving skills and behaviors, self esteem, and the reduction in troubling thoughts and feelings. For more information, visit the CPC Network website at <http://www.cpcnetwork.org/>.

#### CFS Quality Standards Checklist

The Quality Standards for Children's Activities and CFS Programmes Assessment – specified within the World Vision Children in Emergencies Manual - provides quality standards for 17 areas of CFS programming including (but not limited to): awareness of protection issues, activities content, playground equipment, record keeping and planning, and visitor information. This assessment was used as the basis for the CFS Quality Standards Checklist, comprising 10 items to guide observational assessment during site visits. Data were combined from two site visits to make the determination of 'higher' and 'lower' quality CFSs.