# Evaluation of Child Friendly Spaces

**Jordan Field Study Report:**
**A CFS Implemented by World Vision and partners in Zarqa, Jordan**

**February 2015**


Janna Metzler[1], May Ishaq[2], Sabrina Hermosilla[1], Enala Mumba[2], and Alastair Ager[1]

[1]Mailman School of Public Health, Columbia University; [2]World Vision Jordan

# Acknowledgements

This study is part of a three-year research collaboration between World Vision International and Columbia University, involving the financial support of World Vision Australia, World Vision UK and UNICEF. The work reported was conducted in collaboration with World Vision Jordan.

The authors are grateful for the technical support and collaboration of the World Vision Jordan team, particularly Steffen Horstmeier, Denis Brown, Maha Hawashin, Nidal Qsar, Wesam Mahfouz, Mahmoud Al Karaki, Maen Daqaq, and Jacqueline Rugayo.

The authors are also grateful for the technical support and collaboration of the World Vision Australia, World Vision Global Rapid Response Team, and World Vision International team members, particularly Alison Schafer, Makiba Yamano, Sabrina Pourmand, Mike Weickert, Maria-Luisa Interiano, Noah Ochola, Eric Kitsa, Rachel Carmichael, Kevin Savage, Marisa Vojta, and George Demetriou.

Special thanks to our data collection team for their dedication and hard work in the field: Ahmad alHijawi, Asala Mirweh, Assem alAzzam, Bilal alMomani, Fadi Abdullah, Hiyam Bani Abdo, Isra' Hayajneh, Lubna Malkawi, Mahmoud Mhanna, Mohammad alAzzam, Mohammad alKhateeb, Mo'men Bani Hani, Nasri alAzzam, Nida' Khdeirat, Sabreen alGhabash, Suha Rawashdeh, Taghleb Khdeirat, Tamer alAzzam, Hiba Bani Hani, and Sundus Bani Hani.

## Summary

This evaluation is the fifth in a series of structured evaluations of CFS and was completed as part of three-year collaboration with World Vision and Columbia University. It was conducted with Syrian refugees in an urban setting in Zarqa, Jordan during the months of February to August 2014. The CFS was implemented through partners and supported and monitored by World Vision Jordan. Interviews were conducted during a one-week registration period hosted by partner staff and preceded by awareness campaigns in the community. Measurement tools were selected to assess impact in three areas in line with the programme's key objectives: (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 wellbeing (including the acquisition of skills and knowledge).

A total of 409 children and 346 caregivers were interviewed at baseline. 252 of these children and 236 of these caregivers were traced after completion of the first cycle of the CFS program was completed. 69 of the children interviewed at endline had attended the CFS, and 49 of the caregivers interviewed at endline had had their child attend CFS. There were no major differences on baseline measures between those who subsequently attended and those who did not subsequently attend CFS. This suggests that comparison of endline scores provides a valid basis for judging impact of CFS attendance. However, sample sizes at this stage were lower than anticipated, which reduced the power of the study to identify change.

The evaluation indicated that while some of the objectives of the CFS were achieved, there were a number of areas where future programming could be usefully strengthened to support children's perception of safety and promote their mental health and psychosocial wellbeing, particularly in an urban context marked by significant population movement.

The evaluation suggests that the CFS was most impactful in achieving its intended objectives in relation to linking younger children to resource persons and reporting mechanisms available to support children within the community. However, there is no evidence that the CFS was impactful in reducing or maintaining perceived protection concerns or caregiver stresses over time. For older children, attending CFS was associated with higher levels of reported protection concerns and stresses related to caregiving. It is unclear whether attendance at CFS exacerbated such issues or facilitated the reporting of issues common to all. There is some evidence to suggest that the CFS played a role in supporting and promoting the psychosocial wellbeing of younger children. However, among older children, there is no evidence to suggest the CFS was impactful in promoting resilience, reducing anxiety or depression related symptoms, or acquiring developmental assets beyond what would have occurred without attendance in the programme.

These findings are from a single study, reflecting the opportunities and constraints of a particular, urban setting and target population of both host community and refugee children, and as such are not presented as generalizable to other contexts. Learning from this and other studies will inform subsequent evaluations in the planned series, with a view of developing an evidence base from which broader lessons related to CFS design, implementation and evaluation can be drawn.

## Background

World Vision International and Columbia University began a three-year collaboration in 2012 seeking to document the protective and restorative effectiveness of CFSs, identify good practice in CFS design and implementation, and contribute to the development of better monitoring and evaluation tools for CFS programming. The initiative is endorsed by the global Child Protection Working Group (CPWG) and has engaged several agencies – including UNICEF, Save the Children, and Mercy Corps – towards the robust evaluation of CFS in different contexts.

The first structured evaluation was conducted in 2012 with Somali refugees in Buramino Refugee Camp near the Southeast border of Ethiopia (Metzler et al., 2013a). The second was completed in 2013 with Congolese refugees in Rwamwanja Resettlement Center in Western Uganda (Metzler et al., 2013b). The third and fourth evaluations were conducted in 2014 with Syrian refugees in Domiz Refugee Camp located in the Kurdistan Region of Iraq (Metzler et al., 2014; Lilley et al., 2015). This fifth structured evaluation of CFS was completed in 2014 as part of this collaboration and was conducted with Syrian refugees and the host community in the municipality of Zarqa, Jordan.

## Intervention

As a result of ongoing conflict in Syria, large numbers of refugees have been crossing borders into neighboring countries, including Iraq, Jordan and Lebanon. Although not a signatory of the 1951 Refugee Convention, the government of Jordan recognizes Syrian refugees and over 590,000 Syrians have been registered by UNHCR in Jordan by February 2014 (UNHCR, 2015). This evaluation was conducted during the months of February to August 2014 in Zarqa in Jordan. Zarqa is an urban setting and currently home to almost 52,000 registered Syrian refugees (UNHCR, 2015).

The CFS was implemented through partners and supported and monitored by World Vision Jordan. The CFS consisted of several rooms and toilet facilities for use in a local community center within the town. Children were grouped by age (5 to 12 years and 12 to 17 years) for activities and these activities were offered three days per week, two hours per day for each group. Activities consisted of drawing, handicrafts, puzzles, games, storytelling, singing, drama, and informational videos. Children were also engaged in sessions dedicated to life skills, such as hygiene, community mapping, and the importance of volunteerism. Reflecting governmental policy, activities targeted children from the local Jordanian population as well as Syrian refugees.

## Design and Methods

Measurement tools were selected to assess impact in three areas in line with the programme's key objectives: (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 wellbeing (including the acquisition of skills and knowledge). The survey was comprised of five main sections: 1) questions drawn from the Child Protection Working Group (CPWG) Child Protection Rapid

Assessment (CPRA), 2) a section on developmental assets, 3) the Middle East Psychosocial Measure, 4) the Arab Youth Mental Health Scale, and 5) a vulnerability assessment.

Several items of the CPRA were used to assess protection risks, vulnerabilities and coping mechanisms as well as to identify child protection actors and resources within the community. The Emergency Developmental Assets Profile (EmDAP) was administered to children to gauge reporting of internal and external assets that promote healthy behaviours and well-being that support children in their development into adulthood. A Caregiver Rating of Development Assets was administered to caregivers of children to assist in a validation process with the SEARCH Institute. The Middle East Psychosocial Measure was initially developed by an inter-agency consortium led by UNICEF and Columbia University for use amongst Palestinian children living in West Bank and Gaza in 2011 (UNICEF, 2011). The Middle East Psychosocial Scale provided both a resilience score (relating to positive adaptation) and an assessment of troubling thoughts and feelings. The measure showed low levels of internal consistency of the subscale related to troubling thoughts and feelings (suggestive of difficulties in the comprehension of items) and has been omitted from subsequent analysis. Higher resilience scores are indicative of more positive adaptation. The Arab Youth Mental Health Scale was initially developed as a screening tool for depression and anxiety symptoms for use with Lebanese adolescents. Higher scores are indicative of more reported symptoms.

Vulnerability criteria were developed with the programme team in line with agency standards for beneficiary reporting. These included: the number of individuals residing in the same house; the child or their primary caregiver having a mental or physical disability; the child or their primary caregiver having a chronic disease; being from a single-headed household. Additional information related to survey measures is located in the Annex.

CFS outreach workers conducted awareness campaigns in the area in the week prior to registration in February 2013. Caregivers of 6 – 9 year old children were interviewed at the time they registered their child with the CFS, in advance of opening of the programme. Likewise, children aged 10 – 18 being registered with the CFS were themselves interviewed. Caregivers and children interviewed at baseline were traced between three and six months after the opening of the programme, and interviews repeated. This allowed comparison of scores on all measures for those where the child had attended the CFS after initial registration, and those children remaining on the waitlist that had not attended.

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

## Sample Description

Of the 234 caregivers with children aged 6 – 9 interviewed at baseline at the time of registration, 168 were traced and interviewed at follow-up. Follow-up interviews with these caregivers indicated that 37 of their children had attended and 128 of their children had not attended the CFS in the

period since the baseline assessment. 3 children were found to have previous exposure to programming equivalent to CFS in the area and were discarded from the final analysis. 5 children who had attended and 22 children who had not attended CFS met the designated criteria of vulnerability at baseline. 70% of caregivers interviewed designated their children's nationality as Syrian (the remainder as Jordanian).

Of the 175 children aged 10 – 12 interviewed at baseline at the time of registration, 120 were traced and interviewed at follow-up. This represented a lower proportion than achieved in other studies, and may reflect the influence of significant population movement during the study period. Follow-up interviews with these children indicated that 32 children had attended and 76 children had not attended the CFS in the period since the baseline assessment. 12 children were found to have previous exposure to programming equivalent to CFS in the area and were discarded from the final analysis. Four children who had attended and 4 children who had not attended CFS met the designated criteria of vulnerability. 61% of children interviewed were Syrian and 39% were Jordanian.

112 caregivers of these children aged 10 – 12 were also interviewed at baseline and 68 were subsequently interviewed at follow-up. These interviews were completed to provide validation data on caregiver and child-reported measures. Follow-up interviews with these caregivers indicated that 12 of their children had attended and 52 of their children had not attended the CFS in the period since the baseline assessment. 4 children were found to have previous exposure to programming equivalent to CFS in the area and were discarded from the final analysis. 2 children who had attended and 8 children who had not attended CFS met the designated criteria of vulnerability.

Of the 234 children aged 13 – 18 interviewed at baseline at the time of registration, 132 were traced and interviewed at follow-up (again representing substantial loss of participants, potentially attributable to migration). Follow-up interviews with these children indicated that 37 children had attended and 89 children had not attended the CFS in the period since the baseline assessment. 6 children were determined to have previous exposure to programming equivalent to CFS in the area and were discarded from the final analysis. Two children who had attended and 12 children who had not attended CFS met the designated criteria of vulnerability. 64% of children interviewed were Syrian and 36% were Jordanian.

There was no systematic difference in baseline scores between attenders and non-attenders for children of all age ranges. In consequence, differences in scores at endline may be considered indicative of the impact of CFS attendance. However, as noted, endline sample sizes were lower than anticipated, which reduced the power of the study to identify change.

## Findings

**Reported protection concerns overall showed little change over time, but increased for older children attending CFS**

CPRA questions were selected to identify concerns regarding specific child protection risks and vulnerabilities in communities. Caregivers and children were asked to report which of the 13 prompted protection risks or vulnerabilities (listed in Table 1) were a concern for children in the area at the time of the interview.

| | |
|---|---|
| Not being able to go back to school | Sexual violence |
| Not being able to return home | Lack of jobs/inability to provide an income for family |
| Losing their belongings | Nightmares or bad memories |
| Being separated from friends | Crowdedness within one's living area |
| Being separated from extended family | Lack of safe play areas |
| Tension within extended family | Lack of hope for their future |
| Domestic violence | |

Table 1: Caregiver and Child Reported Protection Concerns

For most age groups of children attending and not attending CFS, the reporting of protection concerns showed little change between baseline and endline (see Figures 1 – 2). However, older children 13 – 18 attending CFS reported on average marked increases in concerns from baseline to end line (from 2.57 to 3.81, see Figure 3).

Participatory discussions with girls attending CFS[1] revealed additional concerns related to a parent detainment, peer bullying and financial difficulties. In discussions with girls 9 to 12 years, one girl reflected:

"My dad is detained since one year and seven months and I miss him a lot. House rent is expensive and we do not have money. My sister is far from me as well as I am not in school. We cannot afford to buy clothes and medicine as well as my brother is unemployed because Syrians are not allowed to work in Jordan. There are some problems – me and other kids. Sometimes kids hit and mock Syrians. I want my dad to be released from jail."

In discussions with older girls 13 to 15, another girl reflected:

"I am 14 years of age. We came to Jordan from Syria. The hardest thing for me was to be far from home. It was very hard to adapt to the situation in Jordan because I didn't see my relatives and friends living back home (which) made me psychologically uncomfortable. I did not see my cousins. Therefore, I did not practice my full rights. As a kid, I did not play, study, have fun, and smile. I am a kid and I should practice my full rights."

[1] Planned participatory discussions with boys were not completed. It is therefore unclear whether the examples cited show the particular concerns of girls, or children more generally.

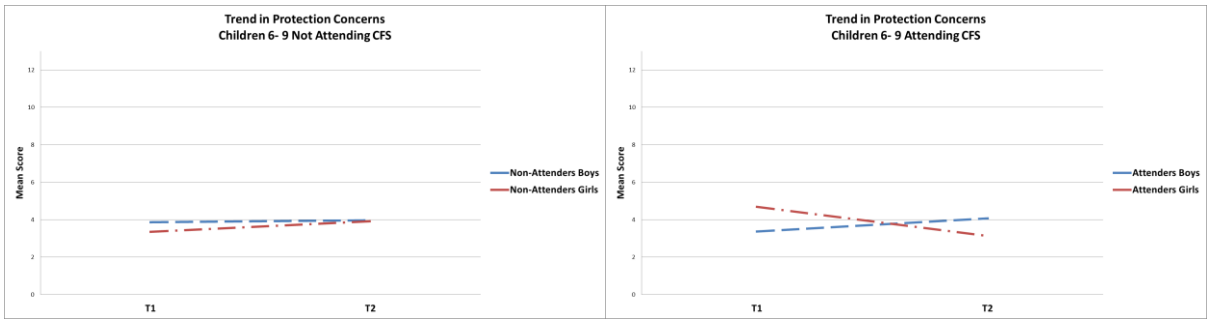


Figure 1: Trend in Caregiver Reported Protection Concerns of Children 6 – 9, disaggregated by CFS attendance and gender of child

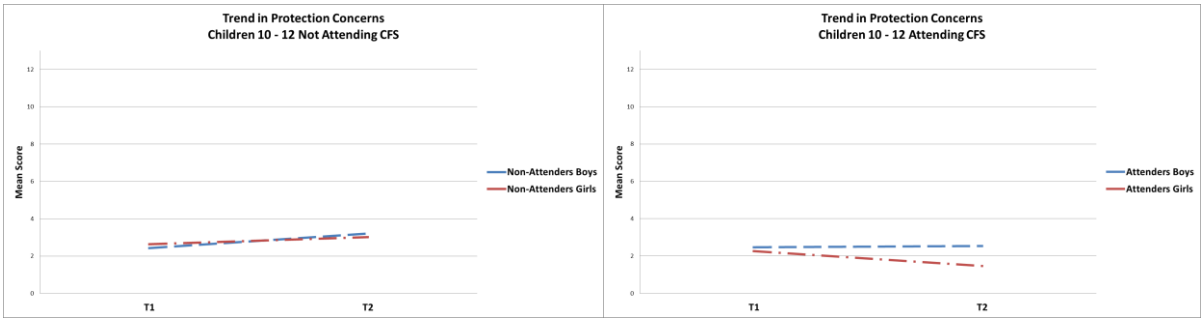


Figure 2: Trend in Self-Reported Protection Concerns of Children 10 – 12, disaggregated by CFS attendance and gender

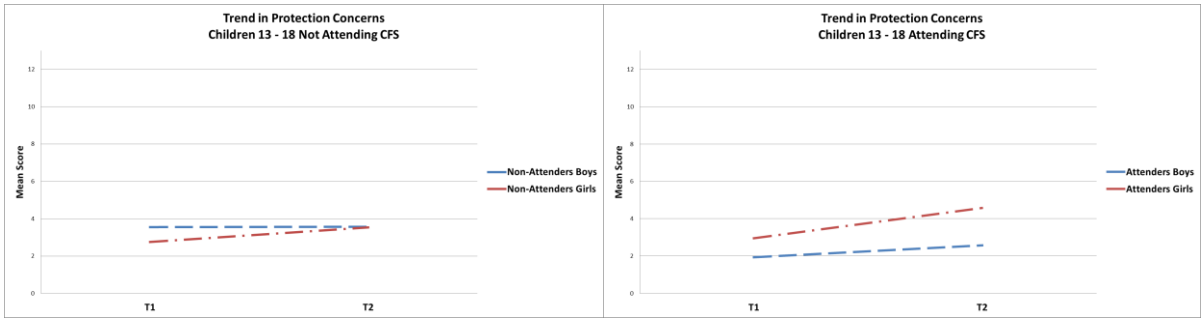


Figure 3: Trend in Self-Reported Protection Concerns of Children 13 – 18, disaggregated by CFS attendance and gender

These findings suggest that attending CFS did not have an impact on reducing perceptions of protection concerns over time. In fact, for older children, attending CFS may have contributed either to the perception of increased risk and vulnerability or an increased awareness of these protection concerns. Additional discussions with older children participating in the programme will provide insight into this increase in concerns and document potential solutions to support and protection children in future programming efforts.

**Irrespective of CFS attendance, similar levels of caregiver stress were reported over time for caregivers of younger children and increased levels for caregivers of older children**

In addition to asking about protection concerns, caregivers and children were asked to report which of the 8 prompted stresses (listed in Table 2) were a stress for caregivers in the area at the time of the interview.

| | |
|---|---|
| Lack of food | Lack of or lost livelihood |
| Lack of or not enough water | Children's safety |
| Lack of shelter | Lack of education |
| Lost property | Lack of or decreased access to healthcare |

Table 2: Caregiver and Child Reported Stresses of Caregivers

For most age groups of children attending and not attending CFS, the reporting of stresses related to caregiving showed little change between baseline and endline (see Figures 4 – 5). Amongst caregivers of the youngest children who had attended CFS, greater stresses has been reported with respect to girls rather than boys at baseline, but this difference was not present at endline.

Among older children 13 – 18, both those who had attended and not attended CFS reported marked increases in caregiver stresses, on average, from baseline to end line (from 1.78 to 2.89 and from 2.00 to 2.64, respectively). Girl attenders aged 13 - 18 reported particularly marked increases compared to boy attenders aged 13 – 18 (an increase from 1.87 to 3.17, $p<0.05$ for girls, compared with a lesser, non-significant increase from 1.64 to 2.43, for boys).

Participatory discussions with younger and older girls attending CFS also revealed their awareness of the financial difficulties in the home. One younger child commented:

"When we ran away from Syria, my mom fell on her back and she needs surgery now. We don't have money to pay for her surgery since the surgery is expensive."

Another younger girl remarked:

"My dad does not work because he is sick as well as the house rent is expensive where we don't have money."

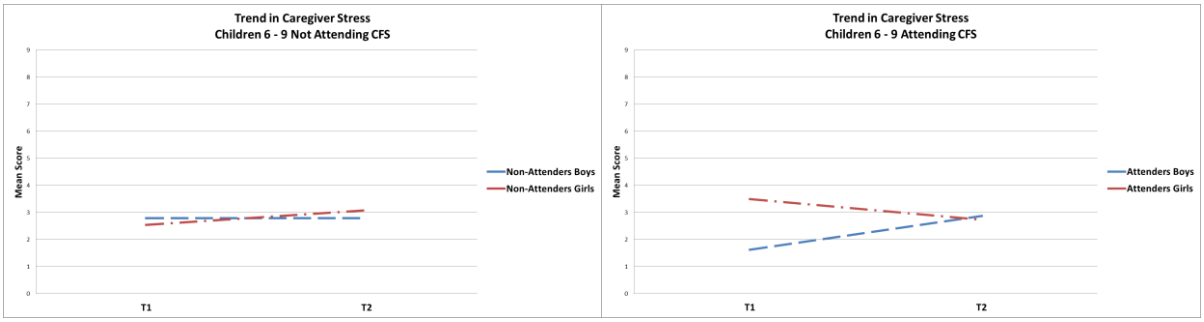


Figure 4: Trend in Caregiver Stresses reported by Caregivers of Children 6-9, disaggregated by CFS attendance and gender of child

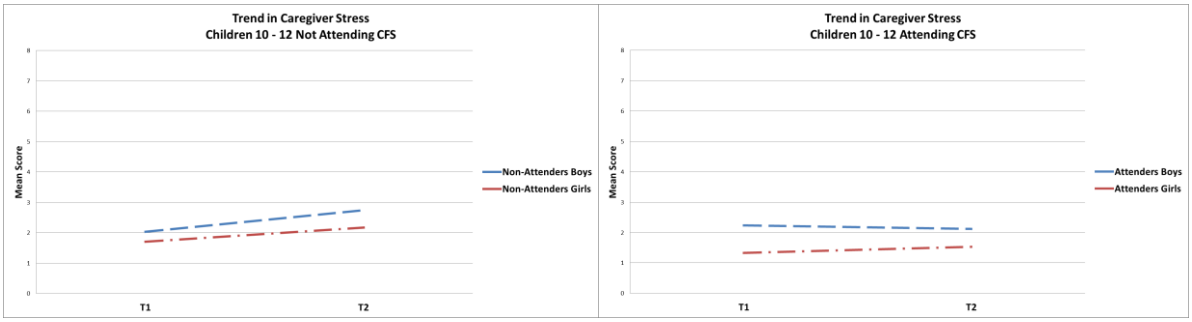


Figure 5: Trend in Caregiver Stresses reported by Children 10 – 12, disaggregated by CFS attendance and gender

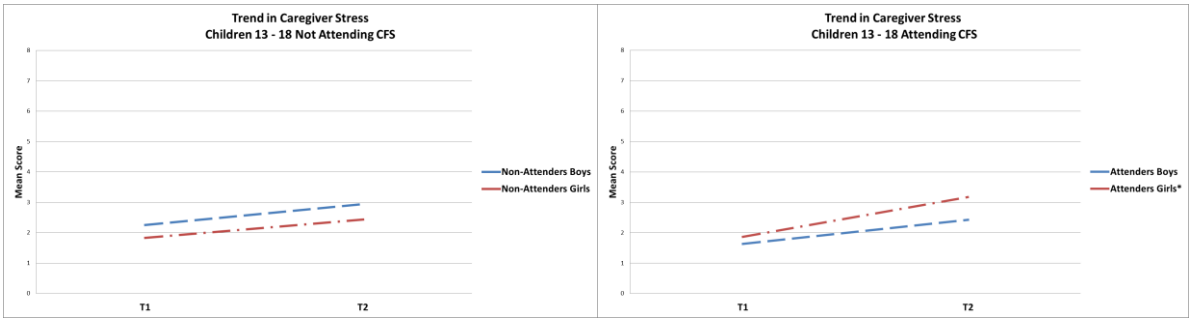


Figure 6: Trend in Caregiver Stresses reported by Children 13 – 18, disaggregated by CFS attendance and gender

These findings suggest the enduring, and in some cases increasing, daily demands of caregiving in the urban context of Zarqa during the evaluation period. A reduction in perceived stresses for caregivers was not secured by attendance in the programme. Among older children, the increased reporting of these stresses may be reflective of growing hardship on caregivers that is either more readily apparent to this age group or more freely articulated to older members of the household.

**Knowledge of community mechanisms of support and referral was higher among CFS attenders but knowledge of services was low for all children**

CPRA questions were asked of caregivers of children 6 – 9 and children 10 – 18 to assess the knowledge and utilization of resources and services available to support, protect and care for children. Caregivers and children were asked about the following nine categories of resource persons potentially providing support and protection for children in the community: family elders, community leaders, religious leaders, police, Jordanian military, political parties, employees of international or local NGOs, Community-based Child Protection Committees (CBCPCs), or 'other

resource persons'. 'Other resource persons' identified included teachers, health providers, neighbors and relatives. A follow-up question was asked of caregivers and children to identify barriers to accessing resources persons in the community. The top four barriers reported included 1) fear of what family or friends would say or do should they find out, 2) lack of belief that people will take the problem seriously, 3) lack of money for transportation or services, and 4) lack of trust in services/persons.

When caregivers of children aged 6 – 9 were asked about where to go to report physical and sexual violence, a greater proportion of children attending CFS had knowledge of reporting mechanisms available in the community to support children at the time of follow-up than children who had not attended CFS (57% and 46%, respectively). Amongst children aged 10 – 12 asked the same question, again the proportion of children who had knowledge of reporting mechanisms available in the community to support children at the time of follow-up was higher amongst those who had attended CFS compared to those who had not (50% and 39%, respectively). However, there was no difference in the proportions who had knowledge of such mechanisms amongst older children aged 13 – 18 (43% for attenders and 42% for non-attenders, respectively).

There was little reported knowledge amongst caregivers or children regarding services available for survivors of physical and sexual violence. Knowledge of services available to support survivors of physical and sexual violence declined from baseline to follow-up. At follow-up, less than one-fifth of caregivers and children had knowledge of available services. Further discussions with community members, staff and participants may be required to understand the reduction in reporting, either due to a lack of knowledge of available services or a lack of services available (e.g. due to clinic or hospital closings).

**Amongst younger children, there is evidence from caregiver reports of increased resilience and better maintenance of developmental assets in those who have attended CFS**

Caregivers of children 6 – 9 attending CFS reported marked improvements in resilience levels between baseline and endline (from an average of 6.29 to 7.95) while caregivers of children 6 – 9 not attending CFS reported no change over this period (see Figure 7). However, on average, these caregivers reported no difference in depression and anxiety symptoms over time, regardless of their child's attendance in CFS (see Figure 8). When asked to report on the acquisition of developmental assets of their children, caregivers of children who had attended CFS reported no changes over time while caregivers of children who had not attended CFS reported marked reductions in developmental assets (from 24.99 to 23.30; see Figure 9).

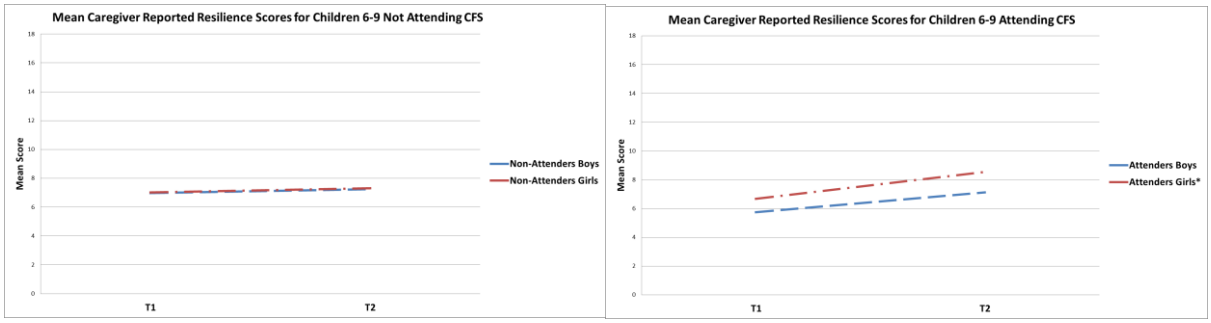


Figure 7: Trend in Mean Resilience Scores, disaggregated by CFS attendance and gender (caregiver-reported)

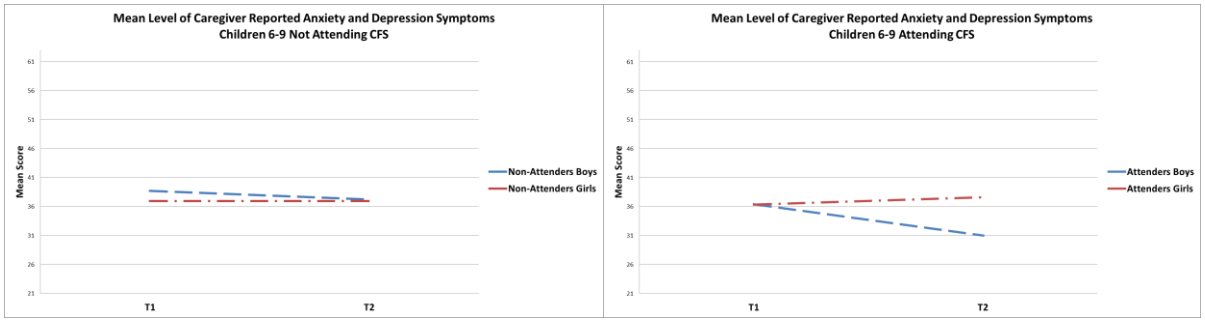


Figure 8: Trend in Mean Reported Anxiety and Depression Symptoms, disaggregated by CFS attendance and gender (caregiver-reported)

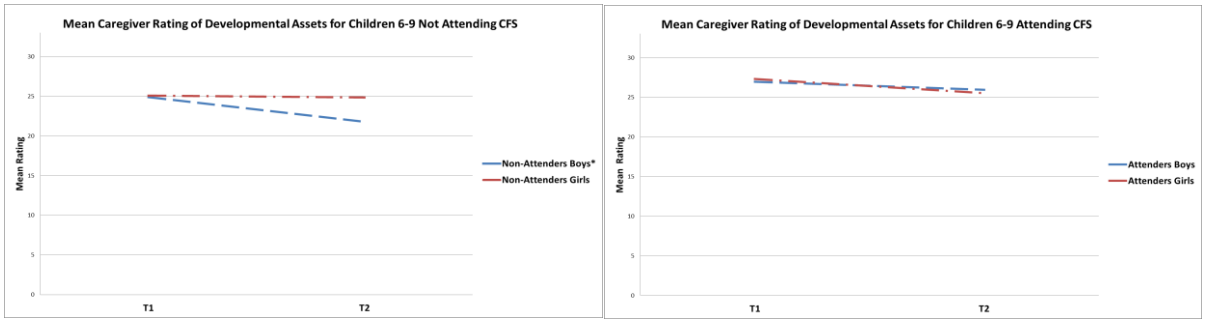


Figure 9: Trend in Caregiver Rating of Developmental Assets, disaggregated by CFS attendance and gender (caregiver-reported)

These findings suggest that from the perspective of caregivers, attending CFS helped support the wellbeing of children and maintain the level of reported developmental assets over time. CFS attendance did not impact caregiver perceptions of their child's symptoms of anxiety or depression.

**Amongst children 10-12, child reports suggest some modest impacts of CFS attendance on well-being; caregiver reports suggest no impact other than a <u>weakening</u> of resilience.**

In general, children 10 – 12 reported no difference in resilience levels over time regardless of attendance in CFS (see Figure 10). Overall, there was a marked reduction in depression and anxiety symptoms amongst all children aged 10 – 12, regardless of CFS attendance (see Figure 11), although this reduction was more pronounced in attenders than non-attenders (from 35.36 to 29.88 and from 35.30 to 31.98, respectively). Children 10 – 12 attending and not attending CFS reported similar levels of developmental assets over time (see Figure 12).

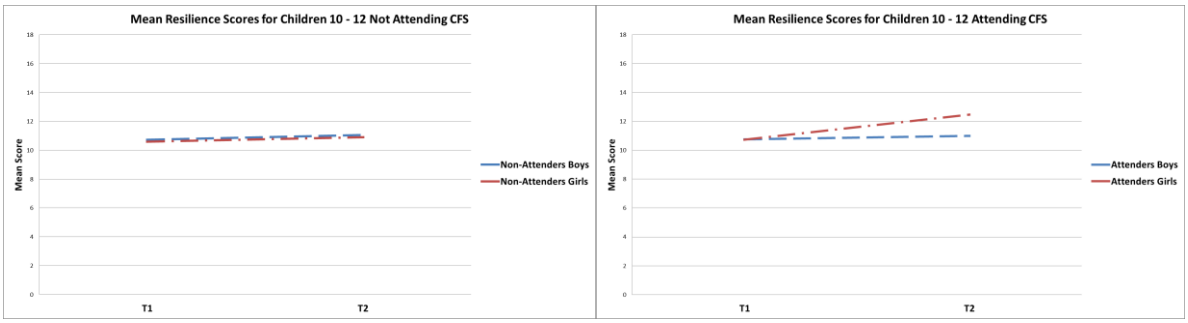


Figure 10: Trend in Mean Resilience Scores, disaggregated by CFS attendance and gender (child-reported)

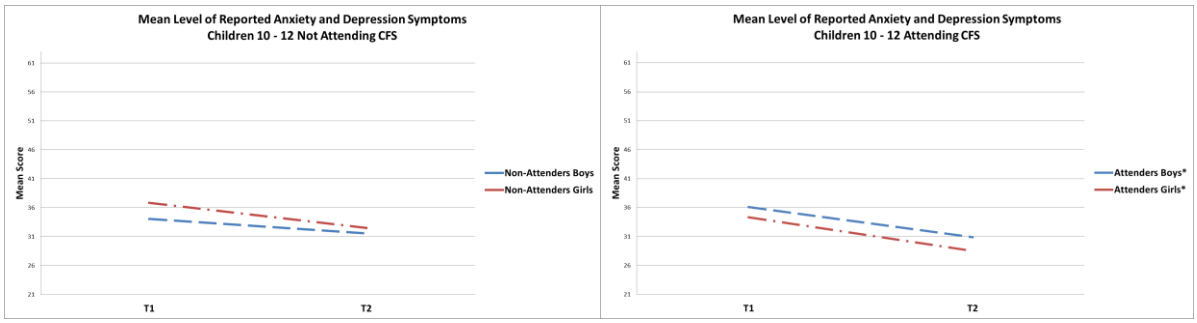


Figure 11: Trend in Mean Reported Anxiety and Depression Symptoms, disaggregated by CFS attendance and gender (child-reported)

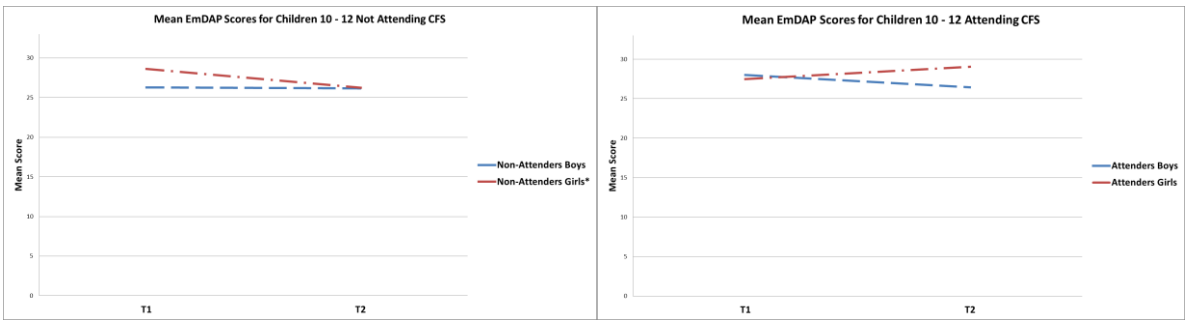


Figure 12: Trend in Mean Acquisition of Developmental Assets, disaggregated by CFS attendance and gender (child-reported)

For this age group, caregiver reports are also available. Caregivers of children who had attended CFS reported marked reductions in their child's resilience over time (from 8.93 to 6.29), while those whose children had not attended CFS reported similar levels at baseline and endline. Caregivers reported little change over time in symptoms of anxiety and depression and in developmental assets over this time period, irrespective of whether children had attended CFS.

Child reports thus suggest some modest impacts of CFS attendance (noting slightly greater gains regarding symptoms of anxiety and depression). However, there are no impacts of CFS attendance observed by caregivers for this age group other than a reduction in resilience following completion of the program. It is unclear whether this trend reflects a perceived loss of adaptation or is a response to the loss of supports provided by CFS provision.

**Amongst older children, those who had not attended CFS generally showed equivalent or better outcomes on well-being measures compared to those who had attended CFS.**

There was no overall change in resilience scores for children 13 – 18 whether they attended or did not attend CFS (see Figure 13). Among children who had attended CFS although there was no overall change, boys showed significant strengthening of assets over time (24.3 to 27.6) while girls tended to report loss of assets. Figure 14 indicates that among older children, there was a significantly greater reduction in anxiety and depression symptoms for those who had not attended CFS than for those who had attended CFS (from 37.27 to 34.81, $p<.05$ and 37.9 to 36.5, not significant, respectively.) Older children reported no difference in developmental assets over time, regardless of their attendance in CFS (see Figure 15).

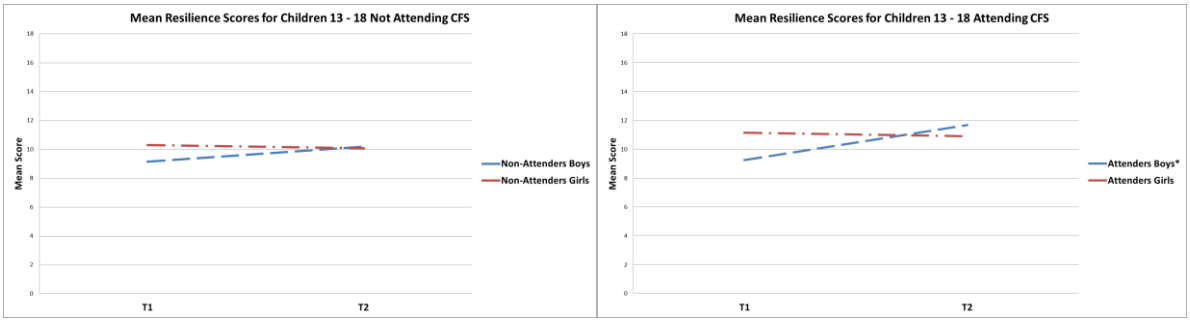


Figure 13: Trend in Mean Resilience Scores, disaggregated by CFS attendance and gender (child-reported)

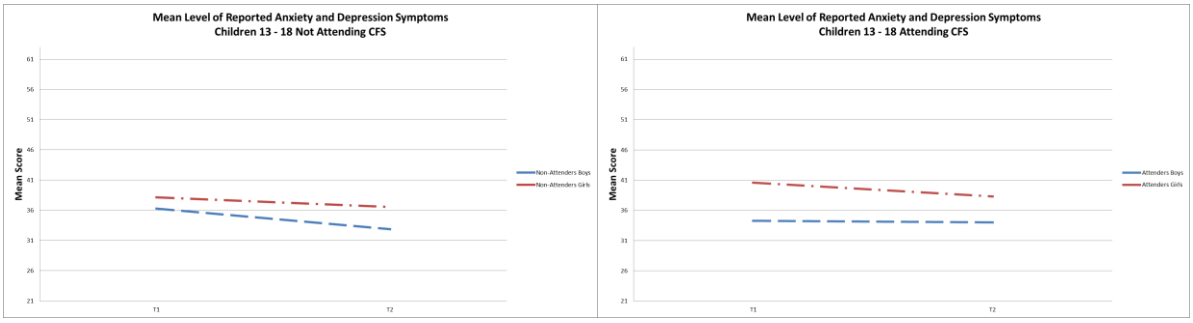


Figure 14: Trend in Mean Reported Anxiety and Depression Symptoms, disaggregated by CFS attendance and gender (child-reported)

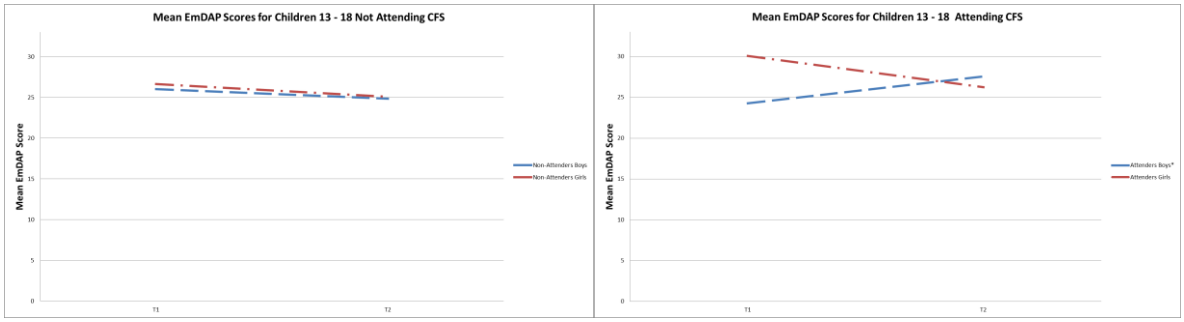


Figure 15: Trend in Mean Acquisition of Developmental Assets, disaggregated by CFS attendance and gender (child-reported)

Other than potentially supporting the acquisition of developmental assets amongst boys, these findings suggest no evidence that attending CFS was impactful in promoting resilience, reducing anxiety or depression related symptoms, or acquiring developmental assets beyond what would

likely have occurred without attendance in the programme. Indeed, in this age group those not attending CFS reported greater reductions in symptoms of anxiety and depression, suggesting that the principal mechanisms of psychosocial and related support for youth lay outside of CFS programming.

## Implications for Practice and Future Evaluations

The evaluation indicated that while some of the objectives of the CFS were achieved, there were a number of areas where future programming could be usefully strengthened to support children's perception of safety and promote their mental health and psychosocial wellbeing. These may particularly be seen as adjustments to programming to reflect the prevailing challenges of a crowded and resource-pressured urban environment characterized by significant population movement. The CFS was generally more impactful among younger children than older children in measured outcome areas, for example, with the latter potentially better equipped to engage with resources available in the town. Additional assessments, inclusive of participatory discussions with staff, community members and children, may bring light to how the CFS: 1) is perceived by the community, 2) can coordinate with other institutions, such as schools, and 3) can better address the needs of older children through different forms of programming, such as vocational and life skills training.

There is some evidence that the CFS was impactful in linking younger children to resources and reporting structures within the community. However, awareness of services available to support and protect child survivors of physical and sexual abuse remained low regardless of the child's participation in the programme. Further discussions with community members, staff and participants is required to understand the low levels of knowledge of services to determine if this is principally linked to challenges in accessing information or to a general lack of services.

There is no evidence that the CFS was impactful in reducing or maintaining perceived protection concerns or caregiver stresses over time. For older children, attending CFS was associated with higher levels of reported protection concerns and stresses related to caregiving. It is unclear whether attendance at CFS exacerbated such issues or facilitated the reporting of issues common to all. Additional discussions with older children participating in the programme will provide insight into this increase in protection concerns and caregiver stresses among older children and document potential solutions to support and protection all children in future programming efforts.

There is some evidence to suggest that the CFS played a role in supporting and promoting the psychosocial wellbeing of younger children. However, among older children, there is no evidence to suggest the CFS was impactful in promoting resilience, reducing anxiety or depression related symptoms, or acquiring developmental assets beyond what would have occurred without attendance in the programme. Revising the current curriculum and approach to better address the needs of older children would be helpful in supporting ongoing and future efforts. Focus group discussions and in-depth interviews with children, parents and staff can provide further support to better tailor activities and programme aims for older children that will promote their mental health

and psychosocial wellbeing and increase knowledge of community mechanisms of protection and support.

Follow-up interviews and participant feedback are critical to the success of any evaluation. Key effects or trends may not be detected in the analysis without a sufficient number of participants traced over the course of the evaluation. With a mobile, urban population such as was targeted here, innovative strategies for follow-up work with community leaders and programme staff in the tracing of participants over time is likely to be critical to its success. For example, maintaining flexible work hours to offer interview times more easily accessible by caretakers and children in the community is one such strategy. It will be important to note for future work that endline data collection periods typically take longer than baseline data collection periods as participants often move or relocate to other areas over the months observed in the monitoring period. Potential strategies to mobilize remaining participants should be creative and may include things such as a brief sports event (e.g. a football game) or a presentation of children's work to caregivers in the CFS or at a community center.

As noted, this study is the fifth 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.

## References


Ager, A., Metzler, J., Vojta, M., & Savage, K. (2013). Child Friendly Spaces: A Systematic Review of the Current Evidence-Base on Outcomes and Impact. *Intervention, 11*(2), 133-147.

Global Protection Cluster, Global Education Cluster, INEE, & IASC. (2011). Guidelines for Child Friendly Spaces in Emergencies.

Lilley, S., Atrooshi, A., Metzler, J., & Ager, A. (2015). Evaluation of Child Friendly Spaces: Iraq Field Study Report - A Save the Children Implemented CFS in Domiz Refugee Camp: World Vision International, Save the Children, & Columbia University Mailman School of Public Health.

Metzler, J., Kaijuka, R., Vojta, M., Savage, K., Yamano, M., Schafer, A., Yu, G., Ebulu, G., & Ager, A. (2013a). Evaluation of Child Friendly Spaces: Uganda Field Study Summary Report. World Vision International & Columbia University Mailman School of Public Health.

Metzler, J., Savage, K., Vojta, M., Yamano, M., Schafer, A., & Ager, A . (2013b). Evaluation of Child Friendly Spaces: Ethiopia Field Study Summary Report. World Vision International & Columbia University Mailman School of Public Health.

Metzler, J., Atrooshi, A., Khudeda, E., Ali, D., & Ager, A. (2014). Evaluation of Child Friendly Spaces: Iraq Field Study Report: A MoLSA-Implemented CFS in Domiz Refugee Camp. World Vision, UNICEF & Columbia University Mailman School of Public Health.

UNHCR. (2015). Syria Regional Refugee Response: Inter-agency Information Sharing Portal. Retrieved 6 January 2015: http://data.unhcr.org/syrianrefugees/settlement.php?id=172&country=107&region=73

UNICEF. (2011a). Interagency Psychosocial Evaluation Report. Shuffat, East Jerusalem: UNICEF.

UNICEF. (2011b). Inter-Agency Guide to the Evaluation of Psychosocial Programming in Humanitarian Emergencies. New York: UNICEF.

# Appendix: Tools

### Developmental Assets

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 wellbeing 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) piloted in this reported work. The DAP was developed and is owned by Search Institute. Special permission was obtained for the pilot use of the EmDAP For more information, visit: http://www.searchinstitute.org/developmental-assets and http://www.wvdevelopment.org/. Additionally, a Caregiver Rating of Development Assets (CRDA) scale was developed to explore ratings of children's development assets by their caregivers.

### 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/.

### Middle East Psychosocial Questionnaire

This locally-derived measure of psychosocial wellbeing was developed by an inter-agency consortium led by UNICEF and Columbia University and administered amongst Palestinian children living in West Bank and Gaza in 2011 (UNICEF, 2011a). Psychosocial wellbeing of children was ascertained on two subscales. The first subscale relates to local conceptions of child resilience including: performance in school, problem-solving abilities, and peer relationships. The second subscale relates to troubling thoughts and feelings experienced by children including: sense of safety, troubles with sleeping, and expression of anger and worry. For more information, visit: http://www.unicef.org/oPt/FINAL_OPT_psychosocial_evaluation.pdf.

### Arab Youth Mental Health Scale

This locally-derived measure was developed in Lebanon by the American University of Beirut for use as a screening tool for depression and anxiety symptoms among Lebanese adolescents. For more information on the development and validation process, visit: http://www.ncbi.nlm.nih.gov/pubmed/20446036 or http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070665/.