Save the Children®

Psychosocial

Care & Protection of Children in Emergencies
A Field Guide • Laura Arntson and Christine Knudsen

Cover photo by Michael Bisceglie:
El Salvador, April 2001: A group of children participate in Save the Children's psychosocial programs.

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FOREWORD

Today's humanitarian crises disproportionately affect children and women. Conflict has moved from the "front line" to the backyard, with more children exposed to extreme violence and loss as their entire community is affected. These events mark children, whether they witness events directly or indirectly, whether they suffer as victims of violence or are pulled into the conflict as perpetrators of violence themselves. While the humanitarian community knows how to meet their survival needs of food, water, and shelter, how do we help children and their communities recover from these other invisible wounds?

In situations that pose a violent, extreme or sudden threat to the survival and well-being of children and women, Save the Children's basic objectives are to *ensure the survival* of the most vulnerable children and women; *assure protection* against violence and exploitation; *support the rehabilitation and recovery* of children, families and communities; and *promote lasting solutions* by creating and strengthening the capacity of families and communities to build an environment in which children can thrive.

Psychosocial care and support in emergencies is an integral component in the rehabilitation of communities and in restoring children's normal and healthy development. This Field Guide has been designed to provide useful strategies in responding to psychosocial needs and a means of operationalizing such an approach. It is an important element in building Save the Children's capacity in this challenging area of emergency response, and as such complements the other program field guides in this series.

We hope that it will prove a valuable tool to all field staff and foster the development of even more effective programming for children in complex emergencies.

Bob Laprade
Director, Emergencies and Protection Unit
Save the Children

INTRODUCTION

Save the Children is pleased to introduce this *Field Guide to Psychosocial Programs in Emergencies*, as one of a series compiled through its Children and War Capacity Building Initiative. Through this initiative, Save the Children has made a clear institutional commitment to providing quality programs that support children's well-being in emergencies and crises, and to ensuring that SC staff have the knowledge and skills they need to continue this important work.

After consultations with staff at both headquarters and in the field, it became clear that there was a need not only for a thematic overview on key protection concerns, but also a quick and practical reference for practitioners when facing new emergencies or designing new programs. With this in mind, the Emergencies and Protection Unit has designed this series of field guides as the basis for in-depth training sessions on priority subjects, while including quick implementation tools, such as checklists of key concerns, sample forms, and rapid guideline references in a portable format.

The field guides have been designed specifically for SC field, headquarters, and partner organization staff members who are involved in the design and management of children and war programs. As such, the series builds on Save the Children's specific approach and programming principles while also bringing in best practices and examples from other agencies' experience. At the same time, however, we hope that these field guides may prove useful to other organizations engaged in similar programming and contribute to the further development of child-focused emergency programs within the international community.

The *Field Guide to Psychosocial Programs in Emergencies* draws heavily on the *Children in Crisis: Good Practices in Evaluating Psychosocial Programming* developed by the International Psychosocial Working Group and International Psychosocial Evaluation Committee. Special mention should be made of those who contributed significantly to the *Good Practices* document; notably Dr. Joan Duncan and members of the Psychosocial Evaluation Committee, which includes academics and practitioners from Save the Children/US, Save the Children/Denmark, Save the Children/Norway, Save the Children/UK, The International Rescue Committee, UNICEF, Christian Children's Fund, the Women's Commission for Refugee Women and Children, Long Island University, Queen Margaret College, Oxford University Refugee Studies Programme, Columbia University, and Johns

Hopkins University. The Field Guide also draws upon the extensive experience and valuable insight of Dr. Neil Boothby, Senior Advisor on Children in Emergencies and Crisis, at Save the Children.

This field guide is an important one for Save the Children to be putting forward at this time, as greater attention is being given to effective psychosocial programming for children in emergencies and crises. It is our hope that this guide will lead to new insights in program design and serve as a useful tool in your work.

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Save the Children

I. OVERVIEW

OVERVIEW OF THE CHILDREN AND WAR FIELD GUIDE SERIES

This field guide is one in a series compiled by Save the Children (SC) as part of its Children and War Capacity Building Initiative. The SC Children in Crisis Unit developed this initiative in order to support SC staff in responding to the priority care and protection needs of children and adolescents during new emergencies and in situations of chronic armed conflict or displacement.

SC recognizes "children" to be any person under the age of 18. Children of all ages are of key concern to SC, and their specific needs and resources are priority considerations in any programming decision. For the sake of brevity, the term "children" will be used in this document to encompass all individuals under the age of 18, while recognizing that the needs and resources of adolescents and younger children may vary significantly and should be considered specifically when designing programs.

The field guides are intended to provide comprehensive, hands-on guidance for program-ming in each of six key thematic areas during emergencies and crisis:

- **Education in emergencies:** analyzes the transition from non-formal to formal educa-tion activities in order to foster sustainability and community involvement.
- **Youth:** outlines an approach to planning non-formal education, vocational training, community mobilization, and other activities for 13-25 year olds.
- **Separated children:** discusses the care and protection of children separated from families as well as steps to take toward reunification.
- **Child soldiers:** focuses on the social reintegration and the prevention of recruitment of girls and boys.
- **Gender-based violence:** examines prevention of violence and support to survivors.
- **Psychosocial care and support:** provides a resource kit applicable to all areas of children and war programming.

The field guides have been cross-referenced and designed as complementary documents. While there are clearly a number of areas of overlap among the themes, repetition has been minimized, while still ensuring that each field guide remains a useful stand-alone document. Each field guide is also accompanied by a CD-ROM, which contains key reference materials and international guidelines for further consideration, as well as practical tools that can be easily modified for use in specific situations.

OVERVIEW OF THE FIELD GUIDE TO PSYCHOSOCIAL PROGRAMS IN EMERGENCIES

The *Field Guide to Psychosocial Programs in Emergencies* is intended as a reference for SC staff and partners in designing and implementing psychosocial care and support programs in situations of crisis.

This field guide is meant to be useful both for staff who have limited experience with psychosocial programming in emergency situations and for staff who are experienced in such programs but wish to improve their understanding of particular concepts.

The field guide is composed of five sections and appendices, supplemented by a CD-ROM. Section I, *Overview*, provides a guide to the document. Section II, *The Issues*, introduces and defines psychosocial care and support in emergencies and explains why it is a priority in situations of crisis and displacement. Section III, the *International Framework*, presents a discussion of the applicable international laws and policy instruments as well as the role of relevant UN agencies. Section IV provides a *Programming Framework* that includes SC's principles as well as a discussion of child development and cultural issues in psychosocial programming. Section V, *Programming Process*, presents assessment tools as well as a discussion of operational issues to be considered when planning psychosocial care and support programs in emergencies. Section VI, the *Conclusion*, includes a summary of issues and approaches which should guide all psychosocial interventions.

II. THE ISSUES

In many parts of the world, wars, epidemics, and natural disasters have created complex emergencies that lack well-defined endpoints and have a sustained impact on children's development, both in terms of immediate survival as well as long-term recovery. Over the past several decades, the nature of conflict has changed dramatically, increasingly targeting civilians—principally women and children. The "front line" during periods of conflict has moved into backyards, main streets, and neighborhoods. In contexts where children's lives are already threatened by chronic malnutrition and ill health, the eruption of war exacerbates illness, family stresses, poor educational and health services, and crumbling social support systems.

Such conflict often leads children and families to flee dangerous areas and make difficult choices, often without any advance warning or preparation. Children are forced to flee all they know and love, as they see schools, churches, mosques, and entire neighborhoods destroyed. Often, they are separated from parents and families who could help them to understand the upheaval and adapt to new and threatening environments. Even if children are not forced to flee their homes, they still may experience violence, withstand fear and humiliation, and face extreme deprivation. In all of these situations, children's development is interrupted, security and trust are threatened, and a sense of hope or confidence can be severely affected.

Children who experience armed conflict carry the heavy emotional, social, and spiritual burdens associated with death, separation from and loss of parents, attack and victimization, destruction of homes and communities, sexual assault, economic ruin, and disruption of the normal patterns of living. Psychosocial programs seek to limit these effects on children, prevent further harmful events, and strengthen the coping mechanisms of children, their families, and their communities.

SC's field experience has shown that it is most useful to take a holistic approach to humanitarian efforts so that the psychological and social developmental needs of children are an integral part of programming from the outset of an emergency situation. SC believes that addressing these factors as part of a relief project not only promotes psychosocial recovery but also enhances the overall effectiveness of any intervention.

The concept of psychosocial recovery describes a process of coming to terms with the wide range of emotionally traumatic events most children face in emergency situations. Each individual child goes through this process in his or her own unique way depending on multiple factors, including the nature of the child's family environment, peer relationships, age, previous experiences, and family and peer group reactions.

WHAT IS "PSYCHOSOCIAL PROGRAMMING"?

The term "psychosocial" has been developed to encompass the complex nature of child development, building upon the close interplay of the *psychological* and *social* aspects of cognitive and emotional growth. Children's psychological development includes the capacity to perceive, analyze, learn, and experience emotion. Social development includes the ability to form attachments to caregivers and peers, maintain social relationships, and learn the social codes of behavior of one's own culture. Psychosocial programming, therefore, recognizes that there is an ongoing connection between a child's feelings, thoughts, perceptions, and the development of the child as a social being within his or her social environment. Children's reactions to extreme events will vary according to *individual* characteristics and *environmental* factors.

Psychosocial programs support the child's cognitive, emotional, and social development holistically, and strengthen the child's social support systems. Emphasis is placed on strengthening social environments that nurture children's healthy psychosocial development at various levels, with the family, community, and children themselves. At all levels, psychosocial programming must keep in mind the best interests of the child.

SC, along with many international and national governmental and nongovernmental organizations, now considers the psychological and social aspects of humanitarian assistance to children and their families as necessary components in responding to the overall developmental needs of children in complex emergency situations. The fundamental aim of SC's psychosocial programming is to improve children's well-being by:

• Restoring the normal flow of development;
• Protecting children from the accumulation of distressful and harmful events;
• Enhancing the capacity of families to care for their children; and
• Enabling children to be active and positive agents in rebuilding their communities.

CHILD DEVELOPMENT

Globally, societies have different interpretations of what is meant by "child development." There are variations within geographical regions and cultures, and significant differences exist across lines such as North and South, East and West, urban and rural. Views of children are culturally and historically constructed, and they reflect the values, needs and practices of each society.

Nonetheless, some features of child development do apply across cultural boundaries. In all cultures, child development is a complex and dynamic process that involves growth and change at many levels. And, while it is possible to talk about the various aspects of development (physical, cognitive, emotional, social, and spiritual) as separate facets in the developmental process, in reality these aspects are interdependent and mutually reinforcing. For example, a relationship exists between the development of speech and the ability to walk; emotional stress can reduce disease resistance and damage health. Nutritional deficiencies can impair cognitive, speech and motor development and functioning as well as cause overall developmental delays. Chronic physical illness can create a host of emotional and social problems.

Additionally, children's development is inextricably connected to their social and cultural environments, particularly the families and communities that are their life-support systems. Through social interaction, children acquire gender and ethnic identities, internalize culturally-constructed norms and values, participate in formal education and other social institutions, and learn to become functional members of their societies. Children's development is a significant part of the process of becoming socially integrated and connected to the wider social world. This is no less true in crisis situations than in normal daily life.

A holistic approach to child development, then, emphasizes the importance of viewing children as members of a dynamic social system, focusing not on the individual child but on the child interacting with the family, clan, community, ethnic group, and society. If, for example, war erupts and community destruction and family deaths result, there is a profound impact on children. Similarly, if families experience intense poverty and children are driven into armed banditry and crime, this fuels turmoil in the wider society. In settings where children's lives are already threatened by malnutrition and ill health, the occurrence of war or natural disaster disrupts the world as children know it.

Child development theory is an important component in considering psychosocial programming, as children will react to events and have differing needs depending upon their developmental status and stage. Development is guided by biological, temperamental, and cultural differences that are influenced by their environment. Babies and young children share a basic need to form a fundamental bond with their caretaker and receive adequate nutrition; children aged 6-11 years are developing feelings of empowerment and competence; children aged 13 years and older are seeking ways to form their individual identity distinct from their family.[1]

It is important to note that the two phases of most rapid cognitive, physical and emotional growth and development are *early infancy* and *adolescence*. In early infancy, children must have consistent care, adequate nutrition, and an attachment to a primary caregiver in order to survive. In adolescence, the critical period of transition from childhood to adulthood, children's earlier development is consolidated and life-long attitudes, beliefs, values and behavior patterns are established. With this understanding of child development, two emergency programming priorities emerge: ensuring that infants have a primary caregiver and adequate nutritional support; and ensuring that the special needs, vulnerabilities, and capacities of adolescents are supported.

Children who have a healthy psychosocial status have been found to have certain capacities throughout their development that allow them to function normally even in environments of extreme duress. They include the ability to:

• Form stable and secure attachments to caregivers
• Develop meaningful peer attachments, friendships, and social ties
• Maintain a sense of belonging
• Feel a sense of self-worth and value
• Trust others
• Seek opportunities for intellectual, physical, and spiritual development
• Maintain physical and economic security
• Have hope, optimism and a belief in the future

Enabling children to develop these capacities forms the basis of sound psychosocial programming. This approach will be further explored in Section IV, *Programming Framework*.

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[1]Action for the Rights of Children (ARC). (2002). <u>Child and Adolescent Development</u>. "Notes on Developmental Stages." Geneva: Save the Children and UNHCR. See the accompanying CD-ROM for a copy of the ARC module.

ROLE OF THE FAMILY

The family is the fundamental social unit in almost all societies and plays a critical role in meeting basic human needs. Children depend on their families for their survival and for their well-being. A caretaker's illness, death, or separation deprives the child of the many developmental benefits of parental care. Every step should be taken during a crisis therefore to prevent families from being separated, or to reunite separated family members.[2]

Providing support to families allows them to offer stability and improved care to their children. It helps parents to feel confident and secure in their care-giving, which also improves children's psychosocial well-being. As a result, psychosocial interventions may provide support which targets not only children directly, but also their caretakers through parenting peer support, early childhood development (ECD) activities[3] or livelihoods support such as skills training. Ensuring that caregivers have the time to care for themselves and their families in threatening environments is also integral to children's psychosocial well-being, as caregivers under extreme stress will not be able to provide essential support to their children. Establishing regularly scheduled activities for children and youth is therefore important not only for the child's own development and psychosocial recovery, but also to allow caregivers time to tend to other important activities such as getting rations, engaging in social activities, or just relaxing.

ROLE OF THE COMMUNITY

In all societies, families are the first to protect their children and help them grow into strong and healthy adults. But children also interact beyond the family circle through a range of social activities with friends, teachers, religious leaders, and other community members. This broad community interaction helps them build their identities and understand the cultural norms and values which enable them to become functioning members of their societies.

A child's understanding of the world is not only influenced by her direct experience of events, but also by her family, friends, and her community which help to interpret or "mediate" these events. A child's well-being and healthy psychosocial development are, then, dependent upon how she interacts within the broader social context of family,

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[2]For more discussion of this issue refer to *Field Guide to Separated Children Programs in Emergencies* by A. Hepburn, T. Wolfram and J. Williamson in this series.

[3]For more discussion of this issue refer to *Field Guide to Education Programs in Emergencies* by C. Triplehorn in this series.

community, and culture. It is the rules, ideas, and explanations that accompany a child's experience which guide her behavior and inform her understanding of the world.
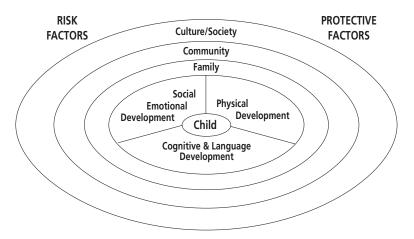
When conflict erupts, there are far-reaching consequences at the community level as traditional structures erode, authority figures weaken, cultural norms and coping mechanisms disintegrate, and traditional support relationships disappear. In times of crisis, distrust and isolation become more common, making children even more vulnerable to psychosocial harm.

The social environment or "ecology" in which children develop plays an important role in their behavior, attitude, and sense of self. The diagram on page 9 shows the inter-related levels of support. Children interact within the nested social systems of family (including clan and kinship group) and wider society (including community institutions and religious and ethnic networks). A child's well-being and healthy development require strong and responsive social support systems at the family and societal level.[4]

Children develop and bring their own ways of understanding and adapting to a situation, but the degree to which they can find or draw on these coping mechanisms depends on internal as well as external resources. During times of crisis, these social support systems may break down temporarily. As children try to cope with extreme violence, loss, fear, and social upheaval, it is important to understand that their usual resources may no longer be at their disposal. To promote psychosocial recovery, it is essential, therefore, to not only support the child directly, but also attempt to restore these social and community mechanisms in order to provide the child with additional external resources and support.

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[4]For further discussion of social ecologies, see Bronfenbrenner's work, as cited in Donahue-Colletta, Nancy. (1992). Understanding Cross-Cultural Child Development and Designing Programs For Children. Washington, D.C.: PACT.

Social Ecology of the Child[5]

RESILIENCY

During conflict, emergencies, and other threatening events, some children are able to continue functioning more easily than others. These different reactions are common and the result of many factors including family and community support, past experience, and individual temperament. To describe those children who are able to cope more easily or even flourish in a rapidly changing environment, we use the term "resilient."

Even in the face of extremely stressful circumstances, such as violence, loss of family members, and displacement, resilient children are able to draw on internal resources and external support to help them cope and adapt. Although all children react differently to stress, research has found that resilient children do share certain characteristics or protective factors which seem to protect them in the short term and help them avoid long-term negative psychosocial effects. These factors are:

- Strong attachment to caring adults and/or peers;
- An ability to seek out positive, encouraging role models;

[5]Duncan, Joan and Laura Arntson. (2004). *Children in Crisis: Good Practices in Evaluating Psychosocial Programming*. Washington, D.C.: International Psychosocial Evaluation Committee and the Save the Children Federation, Inc., p.16.

- Easy interaction with adults and peers;
- A level of independence and an ability to request help when necessary;
- Regular engagement in active play;
- An ability to adapt to change;
- A tendency to think before acting;
- Confidence to act or control aspects of his or her life or circumstances; and
- An active interest in hobbies or activities.[6]

By strengthening these protective factors for all children, resiliency will also be strengthened. These are characteristics that can be enhanced through a careful understanding of children's capacities and needs. Children's inherent resiliency can be strengthened by age-appropriate interventions which allow children to develop or augment these characteristics even in emergency settings, thereby creating a more protective environment for the child. The protective factors listed above include internal resources, such as confidence and judgment, as well as external resources, such as an ability to seek out support and role models. This emphasizes that a resilient child is one who can call on a variety of support mechanisms when faced with new challenges.

Adopting the concept of resiliency in programming is extremely powerful for at least two reasons. First, it directs attention to the fact that all children have assets and strengths and leads to program design that builds upon them. Second, the concept of resiliency provides a hopeful perspective from which to work with children and youth. There is a strong tendency, especially in emergencies, to focus exclusively on problems and trauma, and forget that children, families, and communities also have strengths and competencies.

TRAUMA

In the past, early attempts to address the psychosocial needs of children in crisis were largely focused on psychological and clinical terms of post-traumatic stress reactions (sometimes referred to as PTSS or PTSD, Post Traumatic Stress Syndrome or Disorder). This reaction is defined as a delayed or protracted response to an exceptionally stressful event. Key symptoms include intrusive flashbacks of the stress event, vivid memories and dreams,

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[6]Adapted from Donahue-Colletta, N. (1992). Understanding Cross-Cultural Child Development and Designing Programs For Children. Washington, D.C.: PACT.

and reliving the original distress when the person is exposed to similar situations.[7] Although potentially useful in a limited number of individual cases, this emphasis has ultimately proven too narrow to be applied broadly. It is generally not an effective point of departure for psychosocial programming, especially in situations where multiple events continue to influence psychosocial well-being, and where culturally-specific measures of post-traumatic stress are often neither appropriate nor specific enough to be useful for programming purposes.

Psychosocial programs usually focus on emotions, behavior, thoughts, learning ability, perceptions, and understanding.[8] Emotional development is important, but it occurs in a wider context, interacting with cognitive, social, and spiritual development. Too much emphasis on emotional development alone often leads to an approach which fails to take into account the social and cultural context of children's development. In addition, focusing primarily on a trauma orientation tends to lead to a focus on an individual's problematic reactions, and directs attention away from the person's strengths, resources and the current context of his or her life. As such, this kind of "Western" approach can be potentially damaging and stigmatizing.

In conflict settings, the psychological and social functioning of a relatively small proportion of children and adults may be severely compromised. There may be a role for more "intensive" interventions for those most affected; however, they should be culturally appropriate and based on individuals' strengths and resources. SC usually refers this small number of cases to identified mental health specialists and specialized agencies (see discussion of referrals in Section IV: *Programming Framework* below).

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[7]As defined by WHO in: Orley, J. "Health Activities Across Traumatized Populations: WHO's Role Regarding Traumatic Stress." (1996). In International Responses to Traumatic Stress, eds. Yael Danieli, Nigel S. Rodley, and Lars Weisaeth. Amityville, NY: Baywood Publishing Company, p.388.

[8]Duncan, Joan and Laura Arntson. (2004). Children in Crisis: Good Practices in Evaluating Psychosocial Programming, p.24.

BEST INTEREST PRINCIPLE

In all circumstances of assistance affecting children, SC must ensure that the child's best interest is taken into account and respected. The best interest principle is the most fundamental guiding principle of SC's work with crisis-affected children. As discussed in the following chapter, the best interest principle is articulated in international law as part of the Convention on the Rights of the Child and constitutes the basic standard for making decisions with and for children in crisis situations. The principle requires that any international or local agency acting on behalf of children must consider the child's wishes, opinions, and best interests at every stage of the decision-making and programming process.

III. INTERNATIONAL FRAMEWORK

In all situations, and particularly in emergencies and crises, psychosocial programming for children is part of the wider project of advancing children's overall well-being. Ultimately, psychosocial programming advances and protects children's rights, which provide benchmarks for assessing children's well-being. Accordingly, the objectives of effective psychosocial programming follow the human rights framework of the UN Convention on the Rights of the Child.

THE CONVENTION ON THE RIGHTS OF THE CHILD

The International Convention on the Rights of the Child (CRC), adopted in 1989, establishes a broad legal and ethical framework to guide the international community in supporting the psychosocial well-being of children during times of stability, as well as during emergencies. The articles of the Convention outline objectives which cross cultural boundaries and advance children's rights, protection, and development. Collectively, the articles establish a range of interventions that encompass, as stated in Article 39, "measures to promote physical and psychological recovery and social re-integration of a child" in the aftermath of complex emergencies.

Several of the articles relate to the psychosocial well-being of children affected by conflict and are summarized here:[9]

Article 3: The *best interests* of the child should be a primary consideration in all programming and protection efforts. A child's best interest should therefore be considered in the context of physical care, safety and security, material support, as well as adequate psychological and emotional support. It recognizes that children have a right to receive care and protection appropriate to the culture and community where they are living.

Article 9: Children should not be separated from parents against their will, except when necessary and in the best interests of the child.

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[9]The full text of the CRC is included in the CD-ROM accompanying this Field Guide.

Article 19: All appropriate legislative, administrative, social and educational measures should be taken to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.

Article 20: Children separated from their families are entitled to special protection and assistance.

Article 22: A child seeking refugee status or who is considered a refugee, whether unaccompanied or accompanied, should receive appropriate protection and humanitarian assistance.

Article 28: Every child has the right to an education.[10]

Article 38: All measures should be taken to prevent children under the age of 15 years from taking a direct part in hostilities.[11] All measures should be taken to ensure the protection and care of all children affected by armed conflict.

Article 39: All measures should be taken to promote the physical and psychological recovery and social re-integration of any child who has been the victim of neglect, exploitation, abuse, torture, armed conflict or any degrading treatment. Such recovery and reintegration should take place in an environment that fosters the health, self-respect and dignity of the child.

In emergency situations, the rights of children are frequently violated or ignored. Efforts to create an enabling environment where children's rights are respected will necessarily improve children's psychosocial well-being.

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[10]See *Field Guide to Education Programs in Emergencies* by C. Triplehorn in this series.

[11]See *Field Guide to Child Soldier Programs in Emergencies* by M. Lorey in this series.
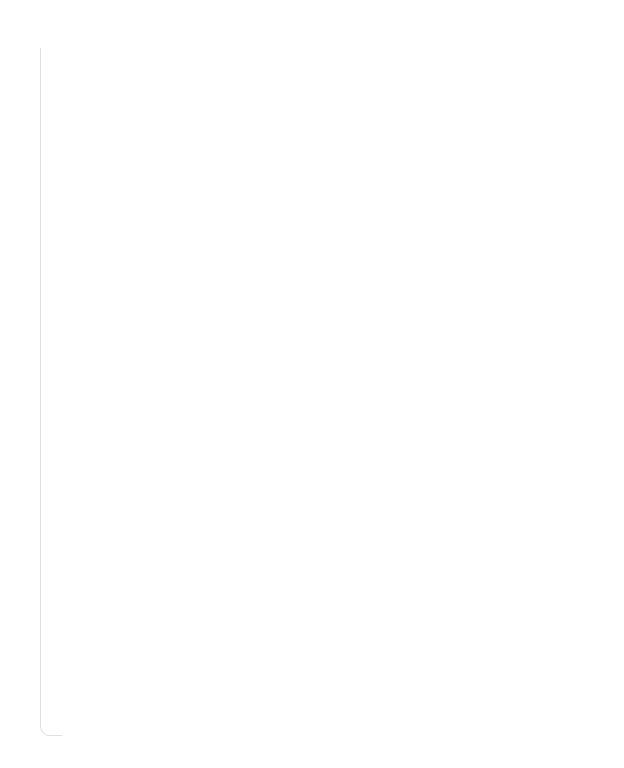
RELEVANT UNITED NATIONS AGENCIES

The United Nations Children's Fund (UNICEF) has, since its establishment after World War II, created a historical framework that anchors current psychosocial programming and strategies for working with war-affected children, families, and communities. While UNICEF originally focused on short-term material assistance through the distribution of food, clothing, and medicine, it increasingly realized that projects needed to consider the whole child within the context of his or her community and culture if the desired benefits were to be achieved.[12]

The United Nations High Commissioner for Refugees (UNHCR) has likewise adopted specific principles which expand basic services to focus on the well-being of refugee children. In their Guidelines for Refugee Children, UNHCR emphasizes a holistic approach to refugee children's developmental needs and a community-based approach to their protection.[13] They further prioritize family unity, access to education, establishment of normalizing child-focused activities, and protection of refugee children's rights. Although specific to refugees, the guidelines provide useful reference in non-refugee settings as well.

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[12]UNICEF. (2003). Working with children in unstable situations: A guiding manual for psychosocial interventions. New York: UNICEF, pp.22-23, 32, 44. A copy of this document is also included on the CD-ROM accompanying this Field Guide.

[13]UNHCR. (1994). Refugee Children: Guidelines on Protection and Care. Geneva: UNHCR, pp.7-16. A copy of these Guidelines is also included on the CD-ROM accompanying this Field Guide.

IV. PROGRAMMING FRAMEWORK

SAVE THE CHILDREN'S PROGRAMMING PRINCIPLES

Save the Children has adopted six principles to guide and strengthen all of its programs worldwide. This section applies these principles to psychosocial programming in emergencies.

1. *Child-centeredness.* Children are central to SC's mission and are the primary beneficiaries of psychosocial programming. Psychosocial program design starts with children as the core, surrounded by family, community and social structures as part of the their "social ecology" which is essential to recovery and resiliency. SC promotes a holistic understanding of the child and respect for children's rights as key to psychosocial well-being.

2. *Gender equity.* SC recognizes that girls and boys may have different socially constructed identities, and that understanding these gendered identities is critical to psychosocial programming. SC promotes the equitable access of girls and boys to services, and also seeks equitable hiring of female and male staff in order to best address psychosocial concerns within the generally-affected population.

3. *Empowerment.* SC programs are designed to increase the capacity of disadvantaged individuals and groups, such as those affected by crisis, to make choices and take action on their own behalf. SC psychosocial programs seek to enhance the inherent resiliency of children as well as their families and communities, recognizing that they are the best guarantors of their children's care and protection. As a means of fostering empowerment, SC is committed to meaningful, age-appropriate child participation as a means of constructing positive self identity and enhancing psychosocial recovery.

4. *Sustainability.* SC seeks to make positive changes in institutions, behaviors and policies affecting human well-being, which last beyond SC's direct involvement. Psychosocial programming focuses on building the capacity of families and community members in order to strengthen their own care-giving skills, recognize signs of psychosocial stress, and take steps to strengthen children's resiliency in times of crisis and beyond.

5. *Scaling up.* SC's approach to psychosocial programming focuses on community-based support to the generally-affected and at-risk population, rather than on the small number of children who may require individual mental health care. As such, SC seeks to provide services to the largest population possible, while ensuring that quality and impact are not compromised. Services are often expanded quickly through the forging of partnerships with local or international agencies to increase scope and geographical reach in large-scale emergencies.

6. *Measurable impact.* SC is committed to ensuring that its programs demonstrate a positive impact on children and their communities. Although measurement of psychosocial outcomes is still an emerging field, SC is regarded as a leader in developing replicable tools and approaches that identify attributable changes in psychosocial well-being at an individual and community level. The development of clear objectives, precise indicators, and systematic analysis of program activities are key steps towards measuring these outcomes and impact.

WHAT IS CHILD-FOCUSED PSYCHOSOCIAL PROGRAMMING?

Child-focused psychosocial projects promote the psychological and social well-being and development of children. All psychosocial programs should be informed by a culturally-specific analysis of children's well-being, build upon existing community and individual assets, and emphasize meaningful participation by children, their families, and their communities. SC plays a supportive role in this programming process and believes that a child's well-being and development are promoted most effectively in the context of their family, community, and culture.

It is important to realize that most children—even those who have endured extreme situations—will recover a degree of normal functioning once they feel secure within a supportive family and community context and have developmental opportunities restored. SC's role is to facilitate the general recovery process by providing children the opportunity for healthy development through play and education and to work with parents and communities to restore the web of support that they provided before the crisis. Within psychosocial programming, SC prioritizes targeted outreach to particular "at-risk" groups who may have had particularly traumatic experiences.

One of the greatest challenges in designing successful psychosocial programming is creating an environment in which children feel secure and safe. When addressing this challenge, it is important to understand that *being* secure and safe is not the same as *feeling* secure and safe. Establishing regular routines and reinforcing normal family activities are important first steps to rebuilding trust and creating a sense of security.

SC's framework for psychosocial programming can encompass a range of project strategies, and it is useful to consider three elements when designing an intervention: the *target population*, the *content of the project* itself, and the *project approach* being implemented.
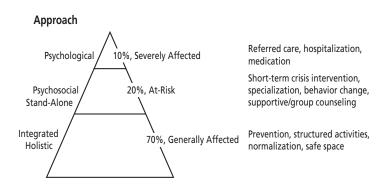
Target Population

When assessing the target population for programming services, it is useful to disaggregate the population according to their risk of developing psychosocial problems if they do not receive community and social support. Once identified, the approach and project content can be tailored to meet the group's needs and support their assets.

> *Severely Affected Group:* In any population, a small percentage of people will require professional mental health care. In a conflict setting, this number may be higher as the psychological and social functioning of some children and adults may be severely compromised. This small group, generally estimated to be ten percent or less of the overall population,[14] requires intensive psychological attention. Children who were mentally ill prior to the conflict and those forced to view, experience, or commit extremely violent acts are likely to fall into this category. For this group, more time-intensive, individualized approaches are likely to be the most appropriate responses, where social and cultural resources permit. For the children who require this special assistance, one-on-one attention should be provided in the form of traditional rituals or other local cultural practices, and should not be limited to Western-derived responses such as psychological counseling. SC generally does not prioritize work with this population; nonetheless, SC staff should ensure that appropriate screening and referral mechanisms to mental health care professionals are available.

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[14]Cairns, E. (1996). <u>Children and Political Violence</u>. Oxford: Blackwell.

At-Risk Group: A second segment of the community (represented as 20 percent in the diagram below) consists of those who have experienced severe losses and disruption. These individuals are significantly distressed, and may be experiencing despair and hopelessness, but their social and psychological ability to function has not yet been overwhelmed. They may have lost family members in the violence, witnessed deaths, or may be victims of violence. This group is at particular risk of psychological and social deterioration if their needs are not addressed through timely community and social support mechanisms. SC focuses efforts on preventing children in this group from moving into the "severely affected" category, and on helping these children decrease their risk so that they can eventually move into the "generally-affected" group.

Generally Affected Group: The third and broadest segment of the population consists of individuals who may not have been directly affected by the crisis and whose families may still be largely intact. Children and adults in this group may be suffering from physical and mental exhaustion, for example, but are not experiencing the level of distress felt by those in the severely affected or at-risk groups. Research suggests that the normal stress and survival responses to violence will fade for the majority of this group over time, even without any direct support.[15] SC typically develops broad-based psychosocial programs such as safe spaces and normalizing activities for this population.

Approach

Psychological — 10%, Severely Affected — Referred care, hospitalization, medication

Psychosocial Stand-Alone — 20%, At-Risk — Short-term crisis intervention, specialization, behavior change, supportive/group counseling

Integrated Holistic — 70%, Generally Affected — Prevention, structured activities, normalization, safe space

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[15]Duncan, Joan and Laura Arntson. (2004). Children in Crisis: Good Practices in Evaluating Psychosocial Programming, p.29.

Project Content

Since children and adults experience and react to complex emergencies in different ways, the types of projects designed to address their needs will also differ. SC may develop and implement a range of psychosocial projects including those that are *curative*, *preventive*, and those that *promote* psychosocial well-being.

- *Curative* projects address the diagnosed psychological effects of complex emergencies on children and families, such as the treatment of trauma. Due to the clinical nature of this work, SC does not generally work in this area, but will refer to other specialized agencies.

- *Preventive* projects seek to prevent further psychosocial deterioration, strengthen individual and community coping mechanisms, and rebuild protective social networks. This will usually include targeted work with the "at-risk" population. Examples include identifying foster families for unaccompanied children, establishing life skills and education programs for former child combatants, and providing day care for adolescent mothers so that they can continue their education.

- Projects that *promote* psychosocial well-being generally support and reinforce positive activities within the generally-affected population, by providing children opportunities to engage in educational, social, and spiritual activities.

> One of the most basic psychosocial interventions is to support and foster the connection that exists between caregivers and their children. When working with unaccompanied children, several steps can be taken to prevent further psychosocial distress and promote well-being:[16]
> - Identify a caregiver who will be able to provide ongoing emotional support and consistent care;
> - Establish a regular daily schedule to begin a return to a sense of order and security;
> - Encourage the child to return to positive, familiar activities such as play, school, and household chores;
> - Ensure children know what changes will happen in their daily lives and what is planned for them. A child as young as two years old needs to know that he or she will be moved, cared for by a new person, or returned to his or her family.

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[16]Donahue-Colletta, N. (1996). Understanding Cross-Cultural Child Development and Designing Programs for Children. For more discussion of this issue refer to *Field Guide to Separated Children Programs in Emergencies* by A. Hepburn, T. Wolfram and J. Williamson in this series.

Project Approach

There are three approaches for designing psychosocial programming for a target population: psychological, psychosocial stand-alone, and integrated/holistic. The choice of program approach will depend upon the population being targeted and the specific project to be implemented. The approaches roughly correspond to the population pyramid noted above, with the psychological approach adopted most often for severely affected children, the psychosocial stand-alone approach adopted for the at-risk groups, and the integrated approach adopted for the generally-affected population. SC primarily uses the psychosocial and integrated approaches in designing its psychosocial interventions.

Psychological: This approach focuses more on psychological factors than on social factors. For example, some projects may provide individual counseling to children who have had traumatic experiences or provide training to key community members to identify, refer, or counsel children. These projects target children and caregivers who have been most severely effected by crisis events.

Psychosocial "Stand-Alone": This approach has self-contained objectives and goals, and is usually not integrated into other projects such as food distribution or shelter programs. Projects may include training and monitoring of foster caregivers, establishing recreation groups, or art therapy. SC has worked with the Center for Trauma Psychology to pioneer such a stand-alone approach through the Classroom-Based Initiative in the West Bank/Gaza, Nepal, and Indonesia.[17] Psychosocial "stand-alone" projects target their activities toward generally affected and at-risk populations, and provide screening and referral (to individualized mental health services or counseling programs) for those more severely affected.

Integrated/Holistic: In this approach, psychosocial interventions are integrated into a project designed to meet the holistic needs of a community and therefore, the "psychosocial" elements may not be as visible. For example, income generation or vocational training projects are not typically thought to be psychosocial. Yet, addressing the economic livelihood of families is fundamental to psychosocial health both in terms of reducing the daily stress of how a family will feed itself, and in terms of providing a pathway to stability and hope for the future. Similarly, such an intervention may have

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[17]An independent assessment of this innovative programming approach by Ruth Sanchez-Way and Rabab F. Saab for Management Sciences for Development, Inc. (2003) can be found in the CD-ROM accompanying this Field Guide.

an educational component that supports cognitive development and at the same time fosters good peer relationships and social skills. An income generation project or vocational training project may be a conduit for improved self-esteem and self-worth and the establishment of peer friendships if designed with psychosocial elements. These projects are most likely to focus on those in the at-risk or generally affected group.

RECOMMENDED PRINCIPLES FOR TARGETING PSYCHOSOCIAL PROJECTS

In an evaluation of a group of psychosocial projects funded by the Norwegian Ministry of Foreign Affairs, the evaluative team recommended a number of principles for future project design.[18] These include:

Focus on Human Rights: Policies that guide psychosocial projects should be anchored in the UN Universal Declaration on Human Rights and the Convention on the Rights of the Child.

Focus on Integrated Approach: Projects should promote human rights, reconciliation, and psychosocial well-being by being integrated into a comprehensive approach to address the range of people's needs in complex emergencies.

Focus on Resources of Beneficiaries: Interventions should be carried out with the participation of members of the affected community, recognizing the personal and professional resources that exist. However, caution should be exercised to ensure that some groups are not singled out for more or less assistance—which may stigmatize the benefited group, cause jealous reactions, or create new conflicts. Avoid "pathologizing" individuals by focusing on their trauma and problems, and instead work with them as "clients" or survivors of human rights violations.

Focus on Needs of the Whole Community: Interventions should be preventive while also providing support to those who have been exposed to severe human rights violations.

Focus on Several Levels of Psychosocial Intervention: A wide range of interventions potentially affect the psychological and social well-being of people, from community development to mutual support building, to counseling. These may be implemented at the same time, and their collective purpose should include the facilitation of peace-building processes, the reduction of tensions between groups, and the diminishing social marginalization of human rights survivors.

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[18] Agger, I., E. Jareg, A. Herzberg, J. Mimica, and C. Rebien. (1999). <u>Evaluation of Norwegian Support to Psycho-Social Projects in Bosnia-Herzegovina and the Caucasus</u>. Oslo: The Royal Ministry of Foreign Affairs.

SOCIAL ECOLOGY AND CULTURE

Any humanitarian intervention should be grounded in a solid understanding of the history, tradition, and culture of the population being served. As discussed above in Section II, the social environment or "social ecology" that surrounds children varies by country, region, and even village. The social environment comprises the socio-cultural, political, and economic contexts within which children learn behavior, attitudes, and a sense of self. A child's development as a social being is embedded in the beliefs, practices, and values of his or her cultural upbringing and environment. Interventions must respect and accommodate local beliefs and practices so that project activities are culturally appropriate and relevant.

In emergency settings, the surrounding chaos, suffering, and time pressures may push humanitarian agencies to act too quickly without learning about local beliefs and practices. When humanitarian agencies disregard or minimize local beliefs and practices, important opportunities are lost and it becomes more likely that culturally inappropriate programming will be imposed as a result. Cultural beliefs and local practices should be viewed as facilitating mechanisms to aid project development and implementation rather than as obstacles. Local people and local perceptions should be drawn upon rather than marginalized.

SC recognizes that each culture has its own manner of caring for their children, and that they would continue to do so whether an outside agency intervenes or not; therefore, it is critical to support and strengthen a community's capacity to care for their children within their own cultural context.

The meaningful participation of project beneficiaries, including children and youth, in the assessment, planning and implementation stages is essential in generating appropriate activities and a sense of ownership. Participation in program monitoring and evaluation also provides a sense of ownership, increases the likelihood of sustainability of supportive practices, and results in a fuller understanding of a project's impact.

To ensure that programming is inclusive and culturally sensitive and appropriate, it is useful to consider the following questions:

• What is expected of men, women, younger/older girls, and younger/older boys in this community? What are they each responsible for?
• What are the child development stages in this culture? Does the concept of "adolescence" exist, for instance? What age do children normally begin attending school? Begin helping in the home? Become an adult? Get married? Have children?

- What rituals, holidays, and celebrations are normally observed? What rituals mark different stages in a child's life?
- What are the traditional methods of caring for children? What behavior is tolerated? What is considered appropriate discipline?
- What does a "happy" or "normal" child act like? What does an "unhappy" or "sad" child act like? How does the family and community usually help children who are "unhappy"?
- What assumptions do you and your staff carry about your own culture and the culture of the community you are assisting?

PROTECTIVE FACTORS AND RISK FACTORS

Psychosocial programs are designed to promote recovery and resiliency. In order to achieve these aspirations, however, it is important to identify and understand what factors pose a risk to children, so that they can be decreased, and what factors serve to protect children, so that they can be strengthened. Such knowledge can be gained through direct observation, as well as through discussion with children, parents, and others who interact with children regularly.

Risks vary according to the nature of the emergency as well as by the age and gender of the child. Complex emergencies are by nature very high-risk environments, due to the violence and subsequent breakdown of social structures. Building on a holistic understanding of child development, it is possible to see how certain risk factors pose a threat not only to a child's immediate survival, but also to the child's psychosocial well-being.[19] These risk factors include:

- Injury, incapacitation, or death of a family member;
- Separation from caregivers;
- Persecution and/or exposure to violence;
- Lack of adequate food, shelter, and medical care;
- Inadequate substitute care;
- Forced displacement from home and community;
- Separation from friends and community;

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[19]Adapted from Donahue-Colletta, Nancy. Understanding Cross-Cultural Child Development and Designing Programs For Children.

- Physical insecurity;
- Exploitation and/or physical or sexual abuse; and
- Denial of educational opportunities, health care, and other services.

The cumulative effect of these risk factors is a disruption of normal patterns of living and the communal or traditional practices that provide a powerful sense of continuity and meaning to daily life; activities that re-establish a sense of security, "normalize" life again, and reduce the risks that children face are important first steps in psychosocial programs.

Cultural, situational, and individual factors all influence the identification of protective factors, but both practice and theory suggest that a number of factors have been shown to protect children across cultures. These factors include:

- Having a close, nurturing connection to a primary caregiver who provides consistent and competent care;
- Having close connections to competent, caring members of one's own cultural group outside of the extended family;
- Participating in familiar cultural practices and routines;
- Having access to community resources, including effective educational and economic opportunities; and
- Having connections to spiritual and religious groups.

All children have assets and strengths. Strong psychosocial programming taps into these assets and builds on them. In conducting assessments and designing projects, it is too common to focus on the problems, deficits and difficulties that children have endured. In order to design effective psychosocial projects that enhance resiliency and community capacity to protect their children, it is essential to identify the assets, strengths, and competencies of children, families, and communities.

RESILIENCY AND PROTECTIVE FACTORS: LESSONS LEARNED

What has been learned about resiliency and protective factors that might be of value in working with children and families in complex emergencies? The following are nine lessons learned.[20]

- Promoting healthy development and competence, not just treating problems, is an important strategy for protecting child development and preventing psychosocial problems from initially appearing.

- There are potential risks, vulnerabilities, assets, and protective factors in all people, families, communities, and societies.

- The greatest threats to human development are those that damage or compromise key resources and protective systems. The corollary is also true: If key resources and protective systems are preserved or restored, children are capable of remarkable resilience.

- Resilience is typically made of ordinary processes and not extraordinary "happenstance"—it is a reachable goal.

- Children who make it through adversity or recover will have more human and social capital in the future, that is they will be in a better position to address future problems. However, no child is invulnerable. As risk and threat levels rise, the relative proportion of resilience among children will fall. There are conditions under which no child can thrive.

- Adult behavior plays a central role in the development of all protective systems for children.

- As children grow up, they become more able to influence their own level of risk and degree of resiliency.

- Assessments of children need to include competence, assets, strengths, and protective factors along with symptoms, problems, risks, deficiencies, and vulnerabilities.

- Interventions should focus on decreasing an individual's exposure to risk or adversity, increasing the individual's internal resources, and mobilizing protective processes in the social world that surrounds individuals.

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[20]Masten, A. (2000). "Resilience in Children Exposed to Severe Adversity: Models for Research and Action." Paper presented at International Consultation on Children in Adversity. Oxford: Refugee Study Center.

TYPES OF ACTIVITIES

At its most fundamental level, psychosocial programming in crisis situations consists of structured activities designed to advance children's development and to strengthen protective factors that limit the effects of adverse influences. The diversity of psychosocial programming is illustrated by the following sample categories of programming:

- Programs for the tracing and reunification of separated children with their families;
- Programs for the social reintegration of former child soldiers;
- Violence prevention and peace education programs;
- Early stimulation programs for infants;
- Early child development programs;
- Behavioral health programs for children and parents;
- Positive parenting programs;
- Formal and non-formal education, including accelerated learning programs;
- Cultural programs such as celebrations, dance, art, and music;
- Vocational training programs for adolescents;
- Child rights awareness programs;
- Peer networking programs for children, adolescents, youth, and caregivers;
- Training programs for staff in how to work with children and how to address their own stress; and
- Advocacy programs for the greater protection and implementation of children's rights.

In response to the significant disruption of normal routines and a world "turned upside-down," many psychosocial support projects begin with activities to "normalize" daily life. Activities such as formal and non-formal education, recreational sports, and setting up safe play spaces can assist in this initial-stage response, as long as care is taken in the design and implementation of such activities to ensure that no children are marginalized and that staff are well trained in appropriate ways to support and work with children.

Psychosocial programming should not, however, stop at this initial "normalization" phase. It is important to add activities that restore normal developmental opportunities, enhance children's protection, enhance the capacity of families to care for their children, and provide opportunities for children to actively participate in rebuilding their own future.

It may be appropriate to implement different approaches simultaneously as a situation becomes more stable. For instance, an integrated approach to support the generally-affected population may focus on establishing education for all children, including components on peace education and tolerance. At the same time, a stand-alone program may be designed to meet the specific needs of former child soldiers who require alternative or accelerated learning programs. Steps should be taken, however, to bridge the two programs through planning of integrated activities such as sports, games, music, clubs, or other socializing mechanisms.

SC generally uses the following four activities to implement its psychosocial interventions: education, recreation and play, community and peer support, and livelihoods support.

Education

Education, including formal and non-formal activities, is critical to restoring a sense of normalcy and stability for children.[21] As a result, SC works with communities to organize educational activities for their children in the immediate aftermath of displacement. This is a positive development for children and their parents who often view education as an investment in their future recovery. Education is a source of intellectual as well as psychosocial development as children expand their cognitive capacities while learning about sharing, following rules, controlling impulses, and becoming social beings. Scheduled educational activities offer structure and predictability, which contribute to a child's sense of safety and emotional security.

Establishing educational projects for children should take into account the fact that many children may have difficulty concentrating and learning due to the physiological consequences of war experiences.[22] Therefore, curricula and teaching methodologies may need to be adjusted to suit the special needs of children who have witnessed and experienced traumatic events.

The benefits of educational projects can extend to the wider community. In addition to addressing children's developmental and psychosocial needs, educational activities can be a forum for adolescents and adult community members to come together to rebuild their community. Participation of community members in educational programming can foster a positive sense of self-efficacy.

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[21]Refer to the *Field Guide to Education Programs in Emergencies* by C. Triplehorn in this series.

[22]Osofsky, J.D. (1995). "The effects of exposure to violence on young children." <u>American Psychologist</u>. vol. 50, no. 9, pp.782-788.

Recreation and Play

Play is the "work" of childhood and is a cornerstone of healthy psychosocial development.[23] Play is an active learning method that facilitates the development of basic social and physical competencies. Children are curious, and play provides a safe way to explore and learn about their environment. Individual and cooperative playing facilitates neurological growth, fosters the development of physical strength and coordination, enables relaxation, encourages planning, facilitates the processing of symbols, allows the practice of life skills, and engages a child in the process of learning.[24]

Traditional games, dances, songs, and stories provide a sense of stability and continuity during crises, and also help to strengthen children's positive sense of cultural identity. Forced displacement may scatter communities and make it difficult for children to learn songs, stories, dances, and art forms that link generations and provide a sense of belonging to something bigger than oneself. Participation in these types of group activities can rebuild a sense of solidarity and community. Moreover, participation in games can teach positive social behaviors such as cooperation, communication, and non-violent conflict resolution. It is important to note that during times of conflict, activities that promote cultural identity may fuel political tensions. Project planners should be aware of this and seek ways to foster tolerance and reconciliation among groups.

Community Participation and Peer Support

Friendships with peers and relationships with adults outside of the family play a vital part in social and emotional development throughout childhood. The ability to form social relationships and to maintain the ongoing support of close friends is central to building resiliency in children and youth. Conversely, children and adolescents who are isolated or marginalized, especially through rejection and stigmatization, are at an increased risk of developing psychosocial problems that tend to push them even further into isolation.

If one's cultural group has been assaulted, oppressed, or made to feel inferior, the reassertion of cultural values and identity is an integral part of the healing process. Since youth are actors who can contribute positively or negatively to make or break a peace accord, it

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[23]For a discussion of organized play and recreations activities, refer to the *Field Guide to Education Programs in Emergencies* by C. Triplehorn in this series.

[24]Mann, D. (1996). "Serious play." Teachers College Record. vol. 97, pp. 446-467.

is vital to engage them in activities that strengthen positive community identity and efforts toward building tolerance, peace, and reconciliation.[25]

All communities have culturally constructed coping mechanisms for daily challenges such as parenting, and also exceptional challenges created by wars, famines, droughts, and other natural disasters. These cultural resources may include traditional patterns of child rearing, rites of mourning, rituals for healing, norms of caring for children in extended families and by community members outside of the extended family, and "cleansing or forgiveness" ceremonies for returning soldiers to society. Psychosocial programming should identify and support appropriate local leaders, resources, and traditions that disasters and wars frequently disrupt.

While cultural sensitivity is essential in effective programming, all cultures, communities, and local customs should be assessed critically. For example, local communities may have established patterns of hierarchy that tend to become more pronounced during crisis. As occurred in the aftermath of the 1994 Rwandan genocide, particular groups in a refugee camp distributed aid resources unequally and used aid to augment their own power. In many communities, women and children have less access to resources, and their access may decrease further during crises. Effective psychosocial work requires respect for local cultures and communities tempered by ethical sensitivity, and a programmatic commitment to the principles of the Convention on the Rights of the Child.

Livelihoods Support

Economic security contributes tremendously to feelings of safety and well-being for both adults and children. Providing economically for the family increases a caregiver's sense of worth and in turn, positively influences the caregiver's ability to support her/his own child's development. Adults who feel they have no control over life events may become emotionally overwhelmed and gradually less responsive to the needs of their children.

Adolescents and youth often wish to make genuine contributions to support their families. Project strategies that enable adolescents and youth to become active and meaningful participants in the economic life of their community will support their healthy psychosocial development and promote a sense of self-worth and value. SC prioritizes work with families that are particularly vulnerable to economic stresses, especially households headed by children or single-mothers.

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[25]For more discussion on this topic, refer to the *Field Guide to Youth Programs in Emergencies* by Marc Sommers in this series.

PSYCHOSOCIAL PROGRAMMING PRIORITIES

The following summary provides a guiding framework for operationalizing emergency psychosocial programming.[26] These nine priorities are the foundation upon which all psychosocial programming should be built. As a crisis situation stabilizes, additional activities should be added and approaches expanded for a broader reach.

1. **Ensure children's safety and security** to help reduce stress and prevent further threats.
   - Mark landmines as soon as possible. Educate children in landmine/UXO awareness.
   - Talk with girls and boys about where they feel safe so that activities can be organized in the right location.
   - Create a child-friendly space where children and youth can meet to play, relax, and begin structured activities.
   - Train all SC staff in appropriate methods for working with children, including SC's policy on child safety.[27]
   - Train any security personnel on the rights of children and the rights of civilians.
   - Establish a reporting mechanism in which children and adults feel secure in reporting threatening incidents.

2. **Provide information and encourage participation**. In many instances, children and adults who have experienced a crisis feel that they have lost control of their life. It is important to help them feel connected and informed.
   - Ensure that there is accurate information of what help will be provided, by whom, when, and with what limitations. Information is power, and accurate information restores a sense of control.
   - Present messages in both written and verbal forms, through posters, leaflets, drama, radio messages, and announcements at distribution sites and central services such as health posts or registration sites. People under stress may forget things more easily, so information needs to be repeated and presented in a variety of formats.
   - Involve children and adults in decisions. Make them aware of what their options are, even in the early phase of an emergency. Meaningful, general participation is important to build a sense of stability.
   - Involve women and men, girls and boys in group discussions on a regular basis.

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[26]Adapted from the Inter-agency Child Protection Working Group for Iraqi Children. (2002). Save the Children, UNICEF, IRC, World Vision, CCF.

[27]All staff must be made aware of SC's Child Safety Policy and agree to follow these guidelines. The policy is included on the accompanying CD-ROM.
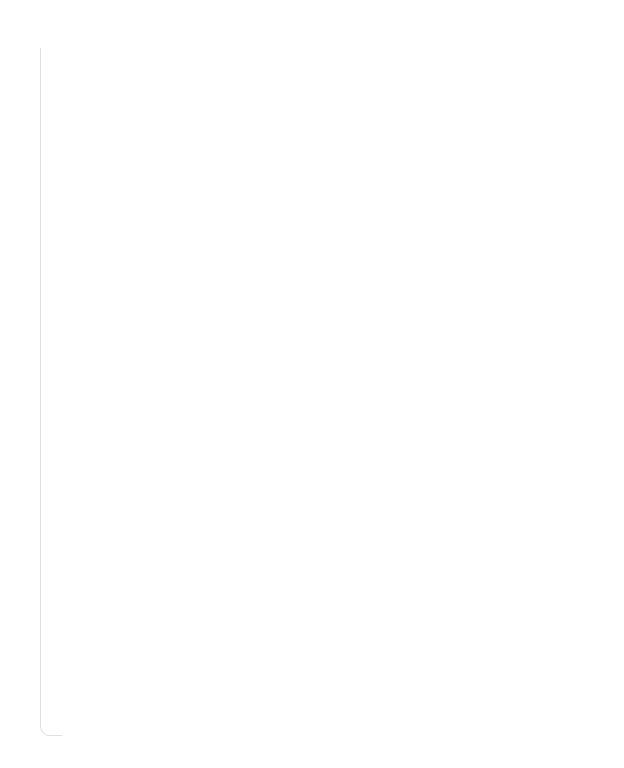
- Make concerted efforts to provide children time and space to express their opinions and to be heard. The participation of children and youth is itself a psychosocial intervention.
- Encourage child-to-child learning and peer youth education. They are valuable ways of not only passing information, but also developing peer support and building children's self esteem.

3. **Recreate "normal" routines.** Schedules and regular activities allow children and families to feel more secure. There may be a need to adapt former activities to the new environment as well as to a situation of ongoing stress. For instance, children may not be able to sleep well at night and may need more periods of rest during the day. It is important for international staff to know as much as possible about daily life and culture before the crisis.
- Prioritize activities that reflect what was good before the crisis, such as education, family routines, and sports activities.
- Organize educational activities quickly, beginning with structured and scheduled times for children to gather and play, learn, and socialize. As the situation becomes more stable, more activities can be added, and formalized learning can be introduced.[28]
- Talk with children and adults about how they have dealt with problems and crises in the past, and try to strengthen those coping mechanisms that are healthy and positive.
- Involve the community in daily activities so that they feel a sense of ownership and routine. Boredom can become a problem when daily life is put on hold during a crisis.

4. **Design activities that support children *and* their families.** If parents are distressed, they do not have the capacity to provide the kind of support their children require. In some cases, parents may not understand why their children are behaving in new ways and may not know how to comfort and care for their child in the new environment.
- Develop parent peer support groups that can be organized while children play or are engaged in other structured activities. Work with parent-teacher associations to develop parent education programs.
- Include good parenting skills and psychosocial support in adult literacy programs.
- Establish day-care facilities for caregivers with small children, so that they have time to look after their own needs.

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[28]For a discussion of activities that can be introduced at early, middle and later stages of an emergency refer to the *Field Guide to Education Programs in Emergencies* by C. Triplehorn in this series.

- Include parents in "safe space" design and activities. Parents who know their children are safe and in a nurturing environment are more likely to allow their children to participate and to take the time to focus on their own needs.

5. **Reassure people.** Children and adults often need reassurance that their reactions to traumatic events are normal reactions to highly abnormal events. Avoid using words like "victim" or "traumatized" in programming operations as these terms are widely mis-used and carry stigma in almost all cultures. Using labels such as these promotes a model of illness (which needs to be cured) as opposed to a model of well-being (in which inherent strengths and resources are enhanced).
   - Choose the name of programs with care, focusing on wellness rather than sickness. "Psychosocial Health" or "Community Support" programs are better named than a "Child Trauma" program.
   - Train staff and community-based volunteers on the effects of stigmatization.

6. **Ensure that programs are designed to be inclusive**. Girls and boys who do not nor-mally participate in organized social activities are among the most vulnerable. These may include girls (of all ages), youth, children who are not attending school, orphans (including those orphaned by AIDS and/or infected with HIV), disabled children, and working children. It is necessary to talk with children and adults about the importance of inclusiveness in the early design phase.
   - Identify activities that will be interesting to adolescent girls and boys.
   - Expand early childhood development and parent education opportunities.
   - Identify children with disabilities and promote their participation through design as well as advocacy.

7. **Identify referral services.** Although the vast majority of the population will be able to adjust to their new situation, a small group of people may be severely affected and require treatment. There will also be individuals who had pre-existing psychological or psychiatric illnesses whose care has been disrupted. It is important to discuss referral mechanisms with health care workers and mental health care workers prior to program implementation.
   - Train staff on how to identify the most serious cases and where to refer them.
   - If a caregiver must be taken to a clinic away from the program site, work within the community to ensure family support during the caregiver's absence.

- Encourage the community to strengthen existing coping mechanisms for stress, such as expression of faith, meeting with friends, establishing normal routines, and exercise.
- Explain the referral process to the community through meetings or posters.

8. **Respect confidentiality and rights.** Children and their families have a right to expect and request that their information, including the stories of their lives, are kept confidential. It is important to disclose this right to beneficiaries as well as to staff.
   - Empower children and families to decline speaking with the media or aid workers about their experiences.
   - Never require children to repeatedly relate their traumatic experiences, as this is not only an invasion of privacy but can have the effect of forcing the child to relive her experience.

9. **Actively network** with other NGOs, Government bodies, and UN agencies. Coordination mechanisms should be put in place to exchange information, agree to basic principles, and ensure coverage of the most needy groups.[29] It is critical to coordinate with:
   - UNICEF and UNHCR for community services, education, and psychosocial health;
   - WHO for secondary and tertiary care, as well as psychiatric referrals;
   - Government ministries charged with health, social services, and education; and
   - International NGOs, local NGOs, and relevant CBOs.

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[29]In Save the Children's psychosocial program in West Bank/Gaza, partners found it useful to draft the "Palestinian Charter for Psychosocial Work," (2001), which sets common principles and guidelines for partners' work. The Charter is attached as Appendix 2, and is included in the accompanying CD-ROM.

V. PROGRAMMING PROCESS

Before a program is designed, the situation on the ground must be assessed to determine the psychosocial needs of the population, priorities for intervention, and how specific activities and interventions can be developed to meet these needs and reach desired outcomes.

This chapter discusses three general aspects of the programming process: assessment, planning, and monitoring and evaluation, noting the particular aspects that must be addressed for effective psychosocial programming.

ASSESSMENT

In all psychosocial assessments, it is important to maintain a focus not only on the needs of the community, but also on their assets and resources. Even during complex emergencies, community and children's needs may be best met through existing community resources. In situations of displacement, normal mechanisms to support children may not be fully functioning; nonetheless, it is important to identify them, assess their capacity, and explore ways in which they can be restored.

In emergency settings, assessments are conducted at various stages, starting with a rapid initial survey. As the situation stabilizes and populations become more established in their locations, a follow-up assessment may be necessary. It is important to note that even in rapid, first-phase assessments it is both possible and essential to include psychosocial concerns. Generally, the purpose of assessments in emergency settings is to:

- Create a broad and immediate picture of children's well-being;
- Identify emergency issues requiring immediate follow up;
- Provide information and recommendations to aid children and their families during the recovery process; and
- Inform the development of appropriate policy and practice.

An assessment, therefore, is not an end-point but rather part of an ongoing process of progressive information collection and dissemination, program development, and advocacy.

It is also important to remember that assessments are not neutral but are "interventions" in themselves. An ethical approach to conducting assessments demands a commitment to:

• Conduct follow-up action, if necessary;
• Refrain from setting up false expectations and taking over situations if communities can cope, unless the community's response violates or ignores children's basic rights;
• Consider potentially negative impacts of the exercise before starting the assessment.

As with programming implementation, assessments should be participatory—that is, they should include beneficiaries, such as children and youth, in the development and use of data collection strategies. Methodologies should be designed and conducted, however, in ways which are sensitive to not stigmatizing children or endangering them in any way.

In any psychosocial assessment, whether in the first emergency phase or in a later phase of programming, the most basic questions include:
• Demographics: What is the household size, and estimated number of children by age and by gender?
• Safety and security: Are there armed groups in the area? Landmines/UXO? Reported abductions of children? Who is providing security at the site?
• Vulnerable groups: Are children on their own? Are there child-headed households? Are there young, unmarried mothers and women on their own? How are they being treated?
• Well-being: What have children experienced? How are they acting now that is different from before? Who do children turn to when they have problems? How do younger and older children spend their days now? Are children putting themselves at greater risk through their activities or are there positive coping mechanisms that could be rein-forced?
• Education: Are there any education activities happening now? Are there teachers in the group?
• Recreation: Observe *where* children play (relative risks, safety, interaction with peers, older youth, supportive or non-supportive adults), *when* they play (amount of time, time of day), and *how* they play (in groups, alone, aggressively, cooperatively, etc.).
• Self-actualization: What do children identify and prioritize as their primary needs and concerns?

Sample assessment forms are presented in Appendices 5 and 6, as well as in the CD-ROM accompanying this field guide. These forms can easily be adapted for either a rapid emergency assessment in a few hours or for an ongoing assessment process as the environment becomes more stable.

Assessments can be conducted in various ways, including observation, individual interviews, and focus group discussions and activities (see *Methods of Data Collection* below). When working with children, it is often helpful to ask children of different ages to map out either a typical day or a specific day from the last week. Through this exercise, they can illustrate how, where, and with whom they spend their days. Questions about where they spend their time should be followed up with a discussion about the purpose and perception of each space, the distance from school and home, and its relative safety. This could also be a way to catalog the time spent per day on particular tasks, including time spent interacting with peers and adults outside the family, and followed up with questions about the type and quality of activity. When an assessment is conducted with girls and boys of different ages, usually 6-12 years and 13-17 years, this exercise quickly highlights potential risks, peer support networks, adult support, children's priorities for activities, and times/locations that would be most appropriate.

When processing information gained from the assessment, it is important that all data be disaggregated by age and gender. In psychosocial programs this is especially critical in order to map trends and identify potential or differing patterns or risks among children.

PROGRAM DESIGN AND PLANNING

The assessment process informs the program design phase by allowing SC program staff to define the target population and identify community needs and assets. A thorough assessment will also encourage staff to confront any underlying assumptions behind the agreed upon interventions to clarify how activities will lead to the desired psychosocial outcomes.

The design of any project is based upon the project's rationale, also known as a logic model, which illustrates the relationships between different steps of the implementation process. The first step in developing a logic model is to clearly identify the key outcomes or intended results and to then work backwards to identify the key inputs and outputs and their relationships to the desired outcomes. The linkages between program activities and

other inputs, their outputs, and intermediate results should be appropriate to the situation and clearly understood by the various stakeholders. Graphics, such as flowcharts or lines that connect the various inputs, outputs, intervention activities, and outcomes are useful to illustrate these pathways and relationships. The process of creating the logic model will help to articulate assumptions behind the model as well as intended project results.

A series of considerations can help guide the development and articulation of a project's logic model:

1. What is the project meant to accomplish? What are the *objectives* or changes expected as a result of the project intervention?
   • At the individual level?
   • At the family level?
   • At the community level?
   • At the population level?

2. Given the available resources and capacities, where will the intervention have the most effective and positive impact? Which target group should be chosen? Should it be an integrated or stand-alone approach? Service-based or through community mobilization?

3. Next to each *objective*, list all the *intermediate results* that will help achieve these objectives at the individual, family and/or community.

EXAMPLE AT THE INDIVIDUAL LEVEL:

OBJECTIVE: Improved psychosocial well-being among children separated from families or orphaned.
What would this look like?
• Children display a desired level of pro-social behavior as defined by/within the local culture
• Children display a desired level of cognitive/emotional functioning as defined by/within the local culture
• Children achieve a desired level of performance in school
• Children report a positive degree of coping as defined by/within the local culture
• Children report a positive degree of self-esteem and agency

4. How are the intermediate results and outputs linked to the objectives or outcomes? Are there any gaps and how can they be closed?
   • Think about identifying a chain of results, or other types of linkages or pathways;
   • Identify gaps;
   • Determine additional intermediate steps or linkages necessary to fill in any gaps.

5. What does the project need to accomplish before achieving the next step?
   • Identify all the activities needed to achieve each intermediate result or step along the pathway.
   • Identify all the inputs and anticipated outputs for each activity to achieve each intermediate result.
   • Identify any underlying assumptions about why and how certain activities lead to desired outcomes, and why and how particular intermediate results are linked to other results.
   • Determine whether these assumptions need to be tested. Assess whether they have been proven elsewhere or whether you need to evaluate the validity of an assumption.
   • Identify other factors that could influence the project's ability or inability to achieve the desired outcomes.

6. Now revisit the logic model to see if any linkages have been left out. Remember to think about causal links between activities and outcomes, and between the intermediate results and the end outcomes or project objectives. Logic models and logic frameworks

are useful tools to illustrate and categorize indicators, activities, outcomes, project purposes and goals. It provides a format in which the logic between project components can be represented and clearly evaluated.[30]

MONITORING IMPLEMENTATION AND EVALUATING RESULTS

The logic model serves as both a planning tool and as an outline for monitoring implementation and evaluating results (i.e., achievement of objectives). Once the critical linkages and intermediate results along the pathway toward a project's final outcomes have been identified, the next task is to design a system to monitor the achievement of steps along the way. Simple checklists or tallies of scheduled activities, participants, trainings, or meetings should be designed for use by program staff and community volunteers. A system for periodically gathering and reporting monitoring information should be designed so that it is not burdensome, but can be easily reported to the program manager (or to a monitoring and evaluation officer, for collating and reporting to the manager). A mechanism for feeding back information on activities and progress toward objectives to the community should also be developed. This may involve participatory assessment meetings in which monitoring data are discussed and further action plans discussed.

At the same time that a monitoring system is developed, it is also important to consider how success will be evaluated. Evaluation is critical because it helps determine not only if the activities have been completed but also whether project objectives have been achieved. In order to measure achievement, "indicators" for key results and outcomes must be identified and a way to compare change or progress developed.

Indicators

Too often, there is a great deal of anxiety in developing indicators, especially in psychosocial programming. This is understandable because determining adequate and reliable indicators can be a difficult process which demands focused attention. Indicators are, however, nothing more than measures—like a ruler or yardstick—to tell us how we are doing. *Indicators do not drive project planning*. Rather, they are a tool to measure project output, results, and particular outcomes, such as the presence, absence, level, or degree of a social or behavioral condition within a target population.

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[30]Refer to Appendix 4 for an example of the logic framework (logframe) from SC's Psychosocial Support Program in Afghanistan.

To be useful for this purpose, indicators should be valid, reliable, and sensitive to the output, status, or outcome of interest:

- *Validity* implies that the indicator is a valid or true measure of the behavior, status, knowledge, attitude, or other feature it is supposed to measure.
- *Reliability* means measuring the same thing more than once using the same indicator and getting the same response; the results do not change according to unpredictable factors.
- *Sensitivity* implies that the measure is responsive to change in our outcome, status, or behavior of interest.

Indicators fall into two basic categories: quantitative and qualitative. Quantitative indicators can be measured using numbers or percentages that can be compared during different stages of implementation. Qualitative indicators are based on observations, interviews, and the perceptions of those affected by programming.

EXAMPLES OF INDICATORS FOR SPECIFIC PSYCHOSOCIAL OBJECTIVES/OUTCOMES:[31]

Objective: Improved psychosocial well-being among separated or orphaned children as defined by pro-social behavior, cognitive/emotional functioning, and positive coping.

Indicators:
- Change in the proportion of affected children displaying culturally defined pro-social behaviors.
- Change in the proportion of affected children able to express fears or concerns and seek care from others during stress.
- Change in the proportion of affected children using positive coping strategies.

Objective: Increased capacity of families/households, community organizations and service providers to support separated or orphaned children and cope with stress/trauma.

Indicators:
- Change in the percentage of families/households, community organizations or services providers using positive coping strategies during times of stress.
- Change in the proportion of local services providers with capacity to provide for separated/orphaned children.
- Change in proportion of community leaders and/or community groups with an adequate [desirable/optimal] level of knowledge and understanding regarding psychosocial needs of separated/orphaned children and the elements of appropriate community responses.

Objective: Enhanced environment for child protection and social integration, through increased awareness among local authorities, NGOs, communities and community leaders of protection principles and rights, risks and appropriate psychosocial responses to separated/orphaned children.

Indicators:
• Change in the number of protection, rights and advocacy groups formally registered in community.
• Change in the percent of knowledge improvement among local authorities, NGOs, communities and community leaders, in protection principles, rights and risks faced by children.
• Change in the number of response mechanisms (i.e., community action plans, interventions, information sharing) to address protection, rights and risk issues initiated by local authorities, NGOs or community groups.
• Change in children's level of perceived safety or security.

For examples of other indicators related to psychosocial programs, refer to Appendix 4 which includes the logical framework for SC's psychosocial support program in Afghanistan. The sample includes objectively verifiable indicators for the goal, purpose, outcomes and activities of the program.

METHODS OF DATA COLLECTION

Once the indicator or measure has been decided, a tool is needed to gather the required information on a regular basis. Various tools may be more useful depending upon the type of indicator. With quantitative (numeric) indicators, for example, survey questionnaires may be most useful to interview individual youth or the adults with whom they interact. With qualitative (descriptive) indicators, however, focus group discussion guides or individual and group exercises with children may be most appropriate.

Data can be collected, therefore, in a variety of ways depending upon what is intended to be measured. Interviews, observation, and participatory appraisal are the most common.

Interviews

Different interview methodologies are available for data collection in emergencies and include:
- Structured interviews
- Unstructured/semi-structured interviews
- Self-report
- Key informants
- Focus groups

Structured interviews are often in questionnaire format and are designed either for qualitative (open-ended questions) or quantitative responses (yes/no, or a scale from 1 to 5). The development of quantitative questionnaires is not as simple as asking a direct question. For example, asking someone if they "feel safe" may not result in as valid a measure as a set of questions or ranked responses to perceived danger or risk associated with specific places, activities, times of the day, or proximity to particular individuals.

Unstructured or *semi-structured interviewing* allows for maximum flexibility in the direction and structure of responses. More time may be required for such an interview, but the benefit is that the respondent (or group) him/herself is able to order and structure the response rather than reflecting an order imposed by the interviewer. Question guidelines and possible probes to encourage a respondent to elaborate further on a given question are often included in the interview guidelines.

Self-reports are easily administered to literate populations and provide systematic data; however, there are some disadvantages. Data collected from a self-report questionnaire is indicative of a person's *own perception* of his/her behaviors or feelings and may not be factual or consistent with behavioral manifestations of observed attitudes and interactions. A self-report methodology may be less effective with young children who are unable to recognize, characterize, or explain clearly their own patterns of behavior, especially over time. Social desirability, self-selection of participants (not everyone who receives a questionnaire responds to it), or an unwillingness to answer candidly (due to embarrassment or other reasons) may skew the results of a self-report questionnaire.

Key informants are people in the community who are in a position to have greater depth of knowledge on a particular subject. They can provide valuable information quickly;

however, key informants may not always be representative of the community as a whole. The information shared may represent an individual informant's personal experience or a culturally-sanctioned representation of a topic.

Focus group interviews allow the interviewer to explore a variety of topics in a systematic way while giving the various beneficiary or interest groups the opportunity to articulate their own thoughts. While they provide rich data, focus group discussions must be designed in such a way that the opinions gathered are representative of the variety of views held by the target population. It is necessary to identify several different focus groups to respond to the same interview questions or discussion guidelines, and encourage those who are not used to speaking out to air their opinions as well. Social practices regarding privacy, open discussion, and the expression of opinions need to be taken into consideration when opting for a focus group methodology.

Observations

Observational methods can be time-consuming and require fieldwork over time; however, they provide rich ethnographic data on how people see their own experience and communicate that experience through various expressive channels.

Common methods include:
• Systematic observation
• Direct observation
• Unobtrusive observation

Systematic observation often quantifies data by utilizing checklists, a scoring system, or categorization of observed behaviors, interactions, and events. When making observations of behaviors, careful planning is needed. The observer should attempt to observe or measure each participant under similar conditions. For example, when observing social interactions of children, it would be useful to observe all of the children at approximately the same time of day and under similar conditions (e.g., during an afternoon free play session) such that any difference in play behaviors observed in children are not due to time, location, or other factors.

Direct observation is used to detect behaviors of interest at a particular time and place, as they occur naturally. Observations can be made by project staff or by caregivers, teachers, and peers. A broad range of information about a child in different settings (e.g., home, school, play) and from the perspective of different role-players in a child's social network can be collected. Observed behavior can be recorded through narratives, event records or interval recording. Narrative may be written or spoken observations of everything observed and can provide a rich array of details on events, activities, and interactions. Because the data recorded are dependant on an individual observer's interests and skills, the quality of the data will vary from one observer to another.

Unobtrusive observations have the added value of not influencing an observed behavior or event by the mere presence or actions of an observer.[32] Such measures are more difficult to construct and may not be available in all instances. The wear that particular areas of a playground or particular sports equipment and games show, for example, are potential indicators of a certain quality and/or quantity of children's play behavior.

Participatory Methods

Participatory methods, often used in community mobilization and rural agricultural development projects, include a culturally sensitive methodology called Participatory Rural Appraisal (PRA).[33] This method of inquiry places an emphasis on local knowledge and experience, and empowers local people to make their own assessment, analysis, and action plans. Group animation and mapping exercises are used to facilitate information sharing, analysis, and action among stakeholders, and include such methodology as semi-structured interviews, focus group discussions, preference ranking/wealth ranking, mapping and modeling, timelines, and seasonal and historical diagramming to gather data. When applied to psychosocial program objectives, methods of measurement might include asking leaders in a refugee camp to draw a diagram of the protection risks women face while carrying out their daily tasks (e.g., gathering firewood, collecting water, picking up food rations) or encouraging various community members to outline draw a pie-chart and then analyze the time youth typically spend in the company of adults, peers, or in situations that might put them at increased risk.

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[32]For a valuable discussion on unobtrusive, alternative and complementary measures, see: Webb, E., Campbell, D., Schwartz, R., and Sechrest, L. (2000). Unobtrusive Measures (revised edition) Thousand Oaks, CA: Sage Publications, Inc.

[33]Freire, P. (1972). Pedagogy of the Oppressed. Harmondsworth: Penguin.; and Chambers, R. (1992). Rural Appraisal: Rapid, Relaxed, and Participatory. Institute of Development Studies Discussion Paper 311. Sussex: HELP.

EVALUATION DESIGN

Information on indicators is usually collected both prior to (pre-) and after (post-) the imple-mentation activities in order to see if the program has resulted in the desired positive change in the psychosocial well-being of children. There are many different project evaluation designs, each with greater or lesser degrees of statistical power, contextual relevance, adaptability, and associated costs. Numerous texts on project evaluation design exist,[34] which can guide program managers and evaluators in identifying an appropriate evaluation strategy. Briefly, the strongest evaluation design is one that can compare change pre- and post-implementation between those who received an intervention (or participated in proj-ect activities) and those who did not.[35] See the following diagrams for an illustration of this evaluation modeling:

- Simple pre-test and post-test; indicators are recorded (observed) in the beneficiary pop-ulation both before and after project implementation.

O_1	X	O_2
Observation at Time 1	*Intervention activities*	*Observation at Time 2*

- Pre-test and post-test comparison group design; the same indicators are recorded in both the beneficiary population and a control group, before and after project imple-mentation.

O_{1a}	X	O_{2a}
Observation at Time 1 among participants	*Intervention activities*	*Observation at Time 2 among participants*
O_{1b}		O_{2b}
Observation at Time 1 among control group		*Observation at Time 2 among control group*

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[34]*See in particular:* W.K. Kellogg Foundation. (2000). Evaluation Handbook. Battle Creek, MI: W.K. Kellogg Foundation available in PDF format: http://www.wkkf.org/Programming/Overview.aspx?CID=281); Patton, Michael Quinn. (1986). Utilization-Focused Evaluation. Newbury Park, CA: Sage Publications, Inc.; and Rossi, P., H. Freedman, and M. Lipsey. (1999). Evaluation: A Systematic Approach. Newbury Park, CA and London: Sage Publications, Inc.

[35]Because most project activities in war or crisis situations attempt full coverage, it is difficult to randomly assign children into an intervention group or a "control" group (i.e., a group that does not participate). Therefore, most project evaluation designs will not have the statistical power to attribute a change in psychosocial status to a particular set of activities. Nonetheless, it is possible to evaluate success with reasonable assurance through various designs and the triangulation of data (that is, getting at the information from three or more different methods). If a program is phased in, control groups of children who participate at different levels or at delayed start times can make up comparison groups. For our purposes here, a simple comparison of measures, pre- and post-implementa-tion (collected among participants and a comparison group if possible) will suffice.

ETHICAL AND SENSITIVE PROJECT EVALUATION

In addition to being methodologically sound, the evaluation process for psychosocial programming requires cultural awareness and sensitivity. Specifically, evaluations should be:

- Culturally grounded;
- Participatory;
- Realized through informed consent and feedback;
- Confidential; and
- Sensitive to consequences.

Just as project development must be appropriate to a particular setting, methods of monitoring and evaluating projects should also be culturally grounded and respectful of different ways of "knowing." By including beneficiaries, local healers, traditional specialists, educators, and others in aspects of a project's monitoring and evaluation, a sense of local ownership and empowerment is strengthened, thereby also promoting the success and sustainability of the project.

Children often have the least say in actions that affect them and it is doubly important that informed consent be obtained before asking questions or engaging children in activities designed to provide us with information for evaluating the success of our project. All participants, regardless of age, have a right to know about the risks and benefits of an evaluation in which they are being asked to participate; in some cases this may require more effort or time, especially with children. Additionally, consent of a child's parents, caregivers, or local authority should be obtained before collecting information. Participants should understand that whether they decide to participate or not has no impact on their continued receipt of project services. Participants should receive specific information on how the information will be used, what the process will entail, what level of confidentiality will exist, and what kind of reports will be written based on these data. Another point to keep in mind in designing an evaluation methodology is if and how feedback will be provided to participants. Participants often have questions about the purpose of the evaluation, use of the data, and results of the evaluation.

Interview data should be kept confidential and accessible only to a limited number of designated staff. A cover sheet on a questionnaire, for example, may have a respondent's name—this is useful for purposes of locating the same person again for any follow-up

questions—but this should be filed separately from the rest of the questionnaire, with identity codes for matching question response sheets and individuals, if necessary.

As noted, one important aspect of respecting children's confidentiality and rights is to avoid requiring children to repeatedly relate their traumatic experiences. Similarly, there can be negative consequences to asking probing questions about emotionally sensitive events. In order to minimize this risk, ask the following information before the interview is conducted.
• Does the interviewer have experience in interviewing children?
• Is enough time allowed for the discussion of issues that may be raised during the interview?
• Is the interview going to occur in a place that is private?
• Will the identity of the child be protected?
• If deep wounds are brought to the surface during the evaluation process, how will this be handled? Is an appropriate resource available to help the respondent?

It is better to not ask questions than to ask them irresponsibly. Even though informed consent carries with it the option to discontinue an interview at any time, children may not feel empowered to stop an interview when distressed, so interviewers must be sensitized in order to recognize children's signs of distress.

Since some interview questions may make respondents uncomfortable or cause distress, it is highly advisable to pre-arrange a follow-up service if needed with another agency which provides one-on-one counseling, a social worker, or a trusted community member, so that respondents are not abandoned following the interview.

VI. CONCLUSION

SC works in many parts of the world where war, conflict, and disasters have created complex emergencies that have a sustained psychosocial impact on children's development. Children are often deliberately targeted during these conflicts and experience the heavy emotional, social, and spiritual burdens associated with death, separation from and loss of parents, attack and victimization, destruction of homes and communities, sexual assault, economic ruin, and the disruption of organized patterns of living. SC is committed to ensuring that its humanitarian assistance programs include focused attention on children's psychosocial well-being by developing programs that help children, families, and communities recover from these events.

The goal of SC's psychosocial programs is to promote the well-being of children by:
• Restoring the normal flow of development;
• Protecting children from the accumulation of distressful and harmful events;
• Enhancing the capacity of families to care for their children; and
• Enabling children to be active agents in rebuilding communities and in actualizing positive futures.

The majority of conflict-affected populations will be able to recover from these events and experiences once their security is restored. Establishing safety and security promotes a sense of normalcy and enhances the psychosocial well-being of children and adolescents.

The following elements are priorities in psychosocial programming in emergencies and must be considered as part of any programming response:[36]

• Prioritize the prevention of further harm, with action focused on minimizing situations that could lead to potential neglect, exploitation or abuse. The majority of children and adults will recover once their safety and security are assured.

• Prioritize family unity and reunification. Maintaining primary attachments and assuring continuity of caregiver is critically important, especially for young children.

• Establish activities quickly that reinforce what was positive and comforting before the crisis. For children and adolescents, the re-establishment of trust begins with a sense of predictability, and is aided by the comfort of familiar routines, tasks and structured activities.

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[36]Adapted from: Action for the Rights of Children (ARC). (2002). Working with Children. Geneva: Save the Children and UNHCR.

- Promote socializing activities for children, adolescents and youth such as non-formal education, recreation, clubs, music, dance, and drama. These activities help children build support networks, social competence, and positive self-identity.

- Promote normal family and community life so as to reinforce a child's natural resilience.

- Promote meaningful participation by children and adults in programming. Such participation is in itself a psychosocial intervention, as it helps individuals reassert a sense of control over their lives after a crisis. Children can actively participate in the assessment, design, review, and evaluation of projects.

- Adopt a community-based approach that encourages self-help and builds on local culture, realities and perceptions of child development. Children need to feel connected to their community and believe that they are part of a larger social whole.

- Re-establish normal developmental opportunities for children. Children not only have the right to access these opportunities, but it is also essential to their psychosocial recovery. Cognitive, emotional, and spiritual development are important, as is livelihoods security for parents and youth.

- Establish education and recreation activities as a priority in first-phase emergency response. Such activities promote structured routines, pro-social behavior, and allow staff to identify children who may require more targeted assistance in psychosocial recovery.

- Provide support and training for personnel who care for children.

- Ensure that all SC staff and volunteers have clarity on the ethical issues particular to working with children in emergencies. All SC staff and volunteers must be familiar with and understand SC's Child Safety policy. Managers should create an environment in which ethical concerns may be addressed in a confidential setting.

- Advocate for children's rights. Ultimately, psychosocial programming advances and protects children's rights, which provide benchmarks for assessing children's well-being. Accordingly, the objectives of effective psychosocial programming follow the human rights framework of the UN Convention on the Rights of the Child.

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APPENDIX 2: SAMPLE CHARTER FOR PSYCHOSOCIAL WORK

Palestine, 10 July, 2001
Committee comprised of: NPA Secretariat for Children, SCF/US, CIDA, UNRWA and UNICEF.

INTRODUCTION

Psychosocial interventions have become increasingly common in the Palestinian society over the previous two decades. As with any society in transition, there is a ongoing need for programs that promote psychosocial well-being. Particularly as a result of the wide-spread psychological distress among the population during and after the first *intifada*, the number and scope of psychosocial programs increased rapidly.

Since the beginning of the Israeli-Palestinian crisis on 28 September 2000, psychosocial needs and programs have again become prominent. Violence permeates all parts of the West Bank and the Gaza Strip, and affects virtually all Palestinian communities, schools, families and children. Wounds are physical and psychological. Fear and panic for the younger children, frustration, anger and loss of trust and confidence for the older ones are the most commonly expressed signs of the psychological distress of Palestinian children.

Eager to help Palestinian children overcome their psychosocial distress, many Palestinian institutions have provided services and implemented interventions to alleviate the psychological sufferings of children and adolescents, often with the financial support of the international community. All agree that the crisis will leave some scars on children, unless interventions are put in place. At the same time there is a general consensus that inappropriate interventions can do more harm to children. This crisis has highlighted the need to ensure the quality of such programs.

The psychosocial work in Palestine needs therefore to (1) be framed within norms established in accordance with the Palestinian cultural and social context, needs and resources, and agreed upon by all actors in psychosocial; and (2) follow necessary minimum standards of quality to be adhered to by all actors in psychosocial work in Palestine. This to effectively promote psychosocial well-being among Palestinian children.

The adoption of a Palestinian Charter for Psychosocial Work in West Bank and Gaza, is an important step towards this goal. The principles of this charter will be implemented by organizations and individuals, including psychologists, social workers, psychiatrists, counselors, teachers, public health and rehabilitation workers—the primary audience for the Charter.

PSYCHOSOCIAL COMPETENCIES

We affirm that psychosocial interventions should promote healthy emotional, cognitive, behavioral and social development. Specifically, they should promote the following 12 key competencies and outcomes among children and adolescents:

1. **Secure attachment with caregivers:** Child feels safe and cared for by supportive adult caregivers.

2. **Meaningful peer attachments and social competence:** Child has the capacity to create and maintain meaningful relationships with peers and adults. Feels he or she is able to effectively navigate his or her social world.

3. **Trust in others:** Child has a belief that he or she can rely on others in his/her community for nurturance, help and advice. Child feels that he or she will not be hurt by others in his/her community.

4. **Sense of Belonging:** Child is socially connected to a community and feels he or she is part of a larger social whole. Child adopts some key values, norms, and traditions of his or her community.

5. **Self-esteem:** Child has a self-concept of worthiness and instrumentality. Child has a sense of being valued. Shows a trust in the self.

6. **Empowerment:** Child has a sense of empowerment and has the capacity to participate in decisions affecting his or her life and to form independent opinions.

7. **Ability to access to opportunities:** Child has the ability to access and/or create opportunities for cognitive, emotional, and spiritual development and economic security.

8. Hopefulness or optimism about the future: Child feels confident that the world offers positive outcomes, that things are, or are likely to be, fine. Child has a realistic sense of the future and is able to plan for the future.

9. Responsibility: The child understands the implications of his or her actions, demonstrates a concern for the impact of his or her action on others, and assumes responsibility for his or her actions.

10. Empathy: The child demonstrates the ability to understand and empathize with the needs, rights and feelings of others.

11. Creativity: The child is able to be creative and to imagine different alternatives and options in a given situation.

12. Adaptability: The child is able to adjust to new situations. The child is able to acknowledge and evaluate new information, make appropriate and timely decisions and adjust his or her thinking and behavior to new situations. The child is able to deal with uncertainty.

OVERARCHING PRINCIPLES

Psychosocial programs and interventions should be based on the Convention on the Rights of the Child and promote the following principles and values:

• **Children's right to life, survival, and development:** the overall objective of psychosocial interventions is to re-establish a state of well-being that is necessary for and promotes the healthy development of the child. This also means that where children are facing life-threatening situations, psychosocial interventions should consider what practical steps can be taken to protect the children from further harm and exposure to violence.

• **Respect for the views of the child:** psychosocial interventions must ensure that children's views are acknowledged and respected so that they participate in their own healing and development, and so that their dignity is preserved.

- **Best interests of the child:** in all decisions affecting the psychological and social well-being of the child, primary consideration should be given to the child's healthy development. Psychosocial programs and their outcomes should not be used for any purpose other than the psychosocial development of the children – in particular, such activities should not be used for political, media, economic or social gain for the implementing organization or individual. The long-term development of the child and the indirect consequences of any short-term intervention should be taken into account when implementing programs. For instance, short-term interventions that undermine the trust between the children and their caregivers or that make children more aware of their problems without helping them to find solutions for these problems can be harmful for the children.

- **Non-discrimination of any kind:** including on the basis of sex, age, religion, socio-economic status, ethnicity, and disability status (particularly regarding availability and appropriateness of services). Psychosocial workers should also minimize the positive or negative stereotyping of children who have experienced psychological or social distress or been exposed to or involved in violence.

- **Confidentiality:** psychosocial assessments and interventions should respect confidentiality, including when the interventions are undertaken in groups; psychosocial institutions should protect this confidentiality and ensure anonymity when communicating about their interventions.

- **Honesty and objectivity:** Psychosocial workers must not mislead the beneficiaries, and must tell them the truth in an age-appropriate manner and to the degree to which it contributes to their long-term development. Institutions and individuals should also be honest and recognize their own limits and be able to refer cases beyond their area of competency;

- **Responsibility:** Interveners must be take responsibility for the impact of their interventions. This means they must make an accurate assessment of the risk involved, and choose the appropriate methodology for optimum benefits and minimal risks for the beneficiaries. They are responsible for closely monitoring the implementation and impact of the intervention. To the degree that is feasible, they are also responsible for providing assistance, including follow-up or referral, for any beneficiaries who can not be adequately assisted through the intervention;

- **Non-violence in all its forms:** children should be protected from all forms of violence by their family and community, including political violence, violence at school, family violence, violence among peers, and representations of violence including in the media. Psychosocial interventions should be free from all forms of violence against or in the presence of children. Where it is absolutely necessary to encourage or allow the child to express his/her experience of violence as part of a healing process, this should be done using the safest form of expression (e.g. drawing rather than acting), and should happen in a confidential, supportive setting involving only those who directly experienced the violence. It should occur as soon as possible after the occurrence of the event as part of a continuum of interventions that help the child to develop positive and constructive behavior.

- **Informed consent:** prior to undertaking psychosocial interventions, consent should be obtained from children and their family with full knowledge of what will happen and the probable effects on the child;

- **Inclusivity:** as much as possible, psychosocial institutions should promote the inclusion of disadvantaged children in their activities;

PROGRAMMING PRINCIPLES

Scope: Psychosocial interventions may cover the promotion of psychosocial well-being, prevention, treatment (particularly detection of early signs of distress) and rehabilitation of psychological distress. Interventions should focus primarily on the promotion of psychological well-being, and the prevention of psychological distress. This can be achieved indirectly through the promotion of protective factors, such as quality health care, nutrition, developmentally-appropriate education, better parenting and family support, effective social participation, and reduction of poverty. It can also be achieved through specific psychosocial interventions, which should, as much as possible, be integrated within existing health, education and social services. Such interventions include counseling, individual and family psychotherapy, self-expression and support programs, and life skills training.

Where possible, long-term continuous programs are more effective than short-term intermittent programs. During times of crisis, long-term programs promoting psychological well-being should be maintained, in addition to the initiation of emergency programs to

deal with psychological and social distress resulting from the crisis. Emergency programs should focus on the strengthening of the resilience of the beneficiaries through promotion of appropriate coping mechanisms and the strengthening of protective factors for 'at risk' groups.

All interventions should give special attention to at risk groups, such as:
• Children living close to conflict zones;
• Children living in families whose members have been killed, injured, tortured and/or detained;
• Children living in families who suffered property losses;
• Children living in acute poverty;
• Abused and/or neglected children;
• Children who have been injured;
• Children living with other individuals who are physically and/or mentally disturbed, abusing drugs, or suffering from a life threatening illness.

Assistance should be provided as long as is necessary, with appropriate follow-up to ensure rehabilitation.

Participation: Interventions should utilize, build upon and strengthen existing familiar, social and community networks, relations and resources. All psychosocial programs should be designed and implemented with the active participation of the beneficiaries, utilizing their knowledge and skills, and should strengthen their capacity to be key actors in the promotion of their own psychosocial well-being, and the promotion of the psychosocial well-being of others in their community. Programs should avoid victimizing and stigmatizing individuals in psychological or social distress.

Relevance: Interventions should be developmentally appropriate and differentiated according needs and psychological status (particularly level and kind of psychological distress) of the beneficiaries. Individual differences between children in terms of experience, environment, competencies, knowledge and values, and their impact on the child's development, should be taken into account in the programs. Interventions should build upon the strengths, knowledge and values of the beneficiaries. They should also serve to create and reinforce positive familial and social dynamics, and to help the child maintain and develop their social relations. Interventions should be appropriate to the local conditions and culture.

Partnerships: Partnerships among psychosocial institutions should be based on careful assessment of respective expertise and capacity and promote geographical and technical complementarities. At the policy level, organizations should work together to identify best practices, agree upon key psychosocial competencies, indicators and messages and ensure program quality. At the community level, coordination mechanisms should be put in place to foster partnerships, avoid overlapping and ensure coverage of the most needy.

Monitoring: Psychosocial programs must be rigorously and regularly monitored. Performance and progress should be assessed against competencies and outcomes as defined above.

Human resources: Professionals working in psychosocial interventions must have competence in child and adolescent development, causes of and risk and protective factors for psychosocial problems, methods of promotion of psychosocial well-being, and prevention, treatment and rehabilitation of psychosocial distress.

Psychosocial professionals must have adequate academic and supervised practical experience, with continuous in-service training. They must possess, at minimum, 3 years of higher education in human sciences (psychology, sociology, counseling, education, rehabilitation, nursing, community work) plus 1 year supervised practical training. In addition, they require a recommendation from two professional specialists (that is, a professional meeting the above requirements with at least five years professional practical experience). Professionals possessing a BA in another field, need to complete, in addition to the above mentioned requirements, diploma in one of the above fields of at least 24 credit hours from a registered organization or educational institute working in this field. Professionals must be committed to in-service professional training, at minimum attending one professional training per year. They must also be committed to self-development, particularly in developing their awareness of the strengths and limitations.

Non-professionals and volunteers, after appropriate training and under intensive professional supervision, may conduct particular activities that promote psychosocial well-being, such as recreational activities, or peer facilitation of group discussions. Such non-professionals must not conduct individual or group counseling.

All psychosocial workers must be fully aware of their limits and take appropriate action to refer children to appropriate institutions and experts, when confronted to problems beyond

their own capacity. Psychosocial workers must function as a team, utilizing a holistic, multi-disciplinary approach that clearly identifies roles and responsibilities, and allows sharing of experience and complimentarily of skills for the benefit of the children and family.

Quality Assurance: Adequate supervision of psychosocial providers, both professionals and non-professionals is a key strategy to ensure quality of services. Accreditation mechanisms need to be put in place to ensure adherence to the above principles by institutions and individual practitioners specializing in psychology, psychiatry and social work. Licenses to these organizations should be temporarily granted based on regular assessments and evaluations of the services provided.

RIGHTS OF THE BENEFICIARIES

We affirm the right of the beneficiaries to choose a psychosocial program or service, and affirm that the services offered must fulfill the above standards. Beneficiaries have the right to seek recourse for any intentional or unintentional harm or unprofessional services resulting in participation in such programs. Beneficiaries have the right to address their complaint directly to the implementing organization and where the complaint is justified, the organization must take appropriate action to redress any injustice, and to ensure other beneficiaries are protected from similar practices. If the beneficiary does not receive a satisfactory response form the organization, they have the right to seek legal recourse. We recognize the need to further develop the legal protection for beneficiaries of psychosocial programs.

IMPLEMENTING THE CHARTER

Policies: Institutions delivering and funding psychosocial services will incorporate these principles in their mission statements and own policies. Necessary decrees will be issued to set up an appropriate quality assurance system.

Dissemination: The Charter will be disseminated among the professional circles and funding institutions, as well as to the public through media. Psychosocial institutions will display the Charter in their own facilities.

APPENDIX 3: CHILD AND ADOLESCENT DEVELOPMENT

The following summary provides indications of developmental stages for children from infancy through adolescence. Although it is common to define children by their chrono-logical age and their biological differences, child development is much more complex as it is also due to cultural and social contexts. The information below is intended only as a schematic guide to those some elements of child development which have been noted across different cultures and different environments. The summary will be useful in ensur-ing that child-centered programming is designed to be appropriate and that child partici-pation is meaningful.

EARLY CHILDHOOD (18 MONTHS-5 YEARS)

This is a period of rapid mental and physical growth. Movement becomes progressively more coordinated: at 18 months the child can drop things intentionally, at two years a ball can be thrown in a specific direction, and at five years the ball can be bounced on the ground and caught with both hands. Language development is marked. In all cultures, a relationship between walking and speech is evident. The utterance of recognizable words coincides with the child's first steps. In most cases, the basics of grammar and the ability to talk in sentences will have been acquired by the age of three.

From three to five years of age, playing increasingly includes "pretending" and "make believe." These games of the imagination let children overcome fears and anxiety. In the game, frightening events can be safely re-enacted; or the child's version can replace actu-al events and experiences.

In contrast to younger children who will be frightened by loud, unexpected noises, unfa-miliar people or animals, the four to five year old will also be frightened of imaginary dangers. At this age nightmares become increasingly common. Children of this age also often find new or unfamiliar surroundings a cause for apprehension, especially if they are not accompanied by their parents.

Through parental discipline and interaction with other family members, the child begins to acquire knowledge of right and wrong, and to be able to exercise self-control. Appropriate behavior is reinforced by the child's identification with the parent, his social role model.

MIDDLE CHILDHOOD (6-11 YEARS)

Children gradually develop the capacity for logical thought and can see things in "relational" terms. He is able to see the reverse of things and put himself in the place of others. Between 6 and 8 years of age children are able to understand the idea of death in relation to their parents or themselves.

The learning process is begun, through teachers at school (reading and writing) or through other adults in the community (e.g. practical skills required in the community to earn a living or to make a home). People outside the family become important: other adults as social and cultural role models, and peers for self-esteem (the child assesses his successes and failures by comparison with his fellows). Stable family and adult-child relationships are critical factors for healthy development during this period. Feelings of self-esteem are not only related to personal achievements and failures but to the perceptions of the family. Conditions in the home may lead to a sense of pride for the family, or feelings of shame and embarrassment. Attitudes to work, the community, social roles and responsibilities also begin to be learned and reinforced at this stage.

ADOLESCENCE (12-18 YEARS)

In early adolescence rapid growth and major changes in body and appearance can lead to strong, conflicting emotions, and feelings of insecurity and self-consciousness. The adolescent's sense of identity (the sum of his childhood experiences) is consolidated during this period. The sense of identity is bound up with relationships (positive and negative) with others; family history and traditions; religious beliefs, political ideas, social/cultural values and standards; role choices; physical and mental well-being.

Personal identity gives the adolescent a strong sense of who he is, what he believes, what he can or cannot do. If no coherent idea of the self evolves, the resulting confusion may give rise to anti-social behavior that reflects their continuing self-doubt. The process of

separation from the family begun in adolescence is a gradual one. Peer relationships become more important as family bonds are loosened. Yet, while the adolescent may be capable of independent thought, of taking responsibility for his own actions and making choices, he will tend to continue to rely for some time on his parents for advice, security and material support.

SUMMARY

0-1 month   reacts to temperature (warm and cold fingers); if the baby is held upright on a firm surface, it makes "walking" movements; recognizes its mother's voice.

3-4 months   plays with its fingers and things that hang; can support itself on its fore-arms; can stretch out its hand and take an object and also begin to let it go; babbles and plays with sound; smiles at other people; can follow an object with its eyes from side to side, up and down and in a circle.

5-6 months   investigates things with both its mouth and fingers; plays with toes; can hold a large object with both hands; can move an object from one hand to the other; imitates and repeats its own sounds.

8-9 months   crawls on its stomach and can stand if supported; enjoys experiencing the world; wants to be carried; can play "give-take" games; can have an object in each hand and hit them against one another; imitates sounds it hears and understands separate words.

12 months   can play with chalk, pen and paper; begins assisting with dressing.

12-18 months   stands and walks by itself with its legs apart; squats on its heels and gets up again.

18 months   can drop things intentionally; points at things it wants; no longer drib-bles.

2 years	walks sideways; can throw a ball in a specific direction; can distinguish a form that looks similar to the one the adult is holding.
3 years	can sort out objects according to shape in different piles; understands "give one to every child"; jumps with both feet together.
4 years	runs well; balances along a thickly drawn line; sits still and concentrates; can feel different weights; can imitate movements with its body; can pour water into a mug with one hand.
5 years	can talk about a previous occurrence; can see totalities (that a half-finished house is to be a house); able to bounce a ball against the ground and catch it with both hands; can make itself stiff-limp; can stand on one leg without support.
6 years	can sort objects according to length; can differentiate surfaces (different types of sand, cloth and such); can put the thumb against the finger tips; has a dominant hand; stands on one leg 8-10 seconds with eyes closed.
7 years	can tie a bow; able to explain the difference between two things; can catch a small ball; can control facial muscles like closing one eye, looking glad, angry or sad; can do somersaults.
3-7 years	the child begins to use words and images to think about reality. He tends to think he is the center of the world and has difficulty imagining himself in the place of another.
7-12 years	the child begins logical thought and can see things in 'relational' terms; he is able to see the reverse of things and put himself in the place of others.
12+ years	the child can think in abstract terms, reason by hypothesis and generalize; becomes interested in ideas, the future, and political, religious and social problems.

APPENDIX 4: AFGHANISTAN FRAMEWORK FOR PSYCHOSOCIAL SUPPORT[38]

	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	RISKS/ASSUMPTIONS
GOAL:			
Capacities of children, families and communities re-enforced to establish nurturing and protective environments for children in the context of the CRC			• No outbreak of violence in Kabul. • No major influx of IDP's. • No expelling of international staff/ agencies.
PURPOSE: Strategy developed to provide psychosocial support to war affected communities with a focus on disabled children and their families.	• Strategy identified and documented. • Plan for duplication of strategy in other parts of the city.	• Project documents	
OUTPUTS:			
1. Situation Analysis through participatory action research imple-mented to establish base-line and identify needs of vulnerable children and their families in two com-munities in Kabul City.	• Baseline and needs identified.	• Baseline report • Project documents	• No major restrictions on home based action research. • Free movement of SC staff.
2. Access to key services improved for vulnerable children and their families.	• Increased level of awareness among key service providers. • # of vulnerable children/families using the improved services.	• Baseline data versus post evaluation. • Project documents.	• No restrictions on cer-tain people making use of certain services (i.e. women not allowed to come to service unac-companied).

[38]Save the Children with the NGO Consortium for the Psychosocial Care and Protection of Children. (2002). Child Protection & Psychosocial Support for Afghan Children and Youth Proposal.

	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	RISKS/ASSUMPTIONS
OUTPUTS:			
3. Community structures promoting psychosocial support improved for vulnerable children and their families in two locations.	• # and type of needs related to psychosocial support reduced/changed. • # of activities implemented for vulnerable children/families. • # of vulnerable children/families participating in the activities.	• Baseline data versus post evaluation. • Project documents. • Minutes of meetings.	• No restrictions on community structures to be formed and active.
4. Support structure for vulnerable children and their families through the Ministry of Social Welfare improved.	• # of MoSW staff trained and active in program. • MoSW adopts CBR program and has a plan for duplication.	• Project documents	• MoSW allows female staff to work in communities.
ACTIVITIES:			
1.1. Identify 2 communities in Kabul city for implementation of the project.	• Criteria for identification identified. • Locations identified justified.	• Project documents	
1.2. Develop and implement a situational analysis through participatory action research.	• Situational analysis implemented and documented.	• Situation analysis report.	
1.3. Disseminate the results to all stakeholders.	• Results accessible and disseminated to different stakeholders. • # of workshops/meetings implemented. • # and type of participants.	• Situation analysis report for different stakeholders (including illiterate women and children). • Project documents.	

	OBJECTIVELY VERIFIABLE INDICATORS	**MEANS OF VERIFICATION**	**RISKS/ASSUMPTIONS**
ACTIVITIES:			
2.1. Identify key services for vulnerable children.	• Criteria for identification identified. • Key service providers identified justified.	• Project documents	
2.2. Raise awareness on the needs of vulnerable children and their families among key service providers.	• # of awareness raising activities implemented. • # and type of participants.	• Project documents	
2.3. Identify with the service providers and users barriers to access these services.	• # and type of barriers identified. • # and type of participants involved in identification of barriers.	• Project documents	
2.4. Develop and implement strategies to reduce the identified barriers.	• # and type of strategies identified and implemented to reduce barriers. • Level of satisfaction with improved services by users. • # of people making use of service.	• Project documents • Baseline data versus post evaluation.	
3.1. Identify representative community structures in the community and raise their awareness on vulnerable children and their families.	• # of participants in awareness raising activities. • # of structures adapting their activities to include vulnerable children/ families. • Level of satisfaction of users.	• Project documents • Baseline data versus post evaluation.	

	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	RISKS/ASSUMPTIONS
ACTIVITIES:			
3.2. Identify community members who have an interest in forming a group to provide support for vulnerable children and their families (adults and youth).	• # and type of participants in group(s).		
3.3. Train the established groups and identify activities to be undertaking to provide support, both to individuals and to the community as a whole.	• # of participants in training. • # and type of activities identified, planned.	• Project documents.	
3.4. Implement activities aiming at vulnerable children/families.*	• # and type of activities implemented. • # of children/ families reached. • Level of satisfaction of participants.	• Project documents. • Baseline data versus post evaluation	
3.5. Implement activities aiming at the community at large (awareness raising).	• # and type of activities implemented. • # and type of participants. • # and type of awareness materials developed. • Level of awareness of community members	• Project documents. • Baseline data versus post evaluation	
4.1. Form partnership with the Ministry of Social Welfare, agree and sign a protocol.	• Protocol signed.	• Project documents.	

*Among them could be a space for people to meet (children, mothers of disabled children etc.), play areas, training for income generating activities, revolving funds for income generating projects for women, etc.

	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	RISKS/ASSUMPTIONS
ACTIVITIES:			
4.2. Develop with CDAP an appropriate training curriculum.	• Appropriate curriculum developed.	• Curriculum document.	
4.3. Identify and train staff of the partner organization as Middle Level Rehabilitation Workers.	• # of MoSW staff trained.	• Project documents. • CDAP report.	
4.4. Develop and implement a psychosocial support program based on the CBR approach.	• # of staff active in program. • # and type of activities done. • # of family trainers trained and active. • # of vulnerable children/ families with reduced needs. • # of children/ families with increased social mobility.	• Project documents. • Baseline data versus post evaluation.	
4.5. Build the capacity of the MoSW in managing the home visiting program.	• # of trainings implemented. • # of participants. • Plan for duplication developed.	• Project documents.	

APPENDIX 5: AFGHANISTAN CHILD PROTECTION QUICK ASSESSMENT

Location: _____ Person doing the assessment: _____

General Situation
How many children are there at this location/village? _____
Adults, men _____ Adults, women _____
Approximate number of households: _____
Approximate number of female-headed households: _____

Are people at this location displaced from their original homes? If so, give details.

Did people stay in this location for the past 6 months or have they moved?
If so, from where?

What is the community view of female-headed households?

What is their general economic and social status?

What are the principal concerns of children and families?

How do children spend their time generally?

How has life changed in the past 3 months?

Community Networks
Which community members have the most influence in children's lives?

What kind of social groups exist among children and among adults?

Separated children

Are there unaccompanied children (children with no adults) at this location?

Are there children at this location who are separated from their primary caregivers?

If so, how have these children been separated?

How are they being cared for?

Are there concerns about how these children are being cared for?

Are these concerns different for boys and girls? Give details.

Are there child-headed households? Give details.

How are these households supported? What additional support is needed?

Recruitment

Are there reports that children under 18 years have been recruited to fight, have left to join the fighting, or have returned after fighting?

How does the community view these children?

How does recruitment take place?

Are children joining militarized madrassas?

Disappearances

Are there reports of children disappearing from the area for long periods of time? If so, give details.

What information is available about what has happened to these children?

Sexual Abuse
Do you hear or observe any report of sexual abuse among children? Give details.

Child Labor
What kinds of work are children involved in?

How old are they?

Is the work considered dangerous or is it exploitative? Give details.

What support is there among working children?

Education
What education opportunities do children have?

How old are the children participating in these activities?

Which children participate in these activities?

Which children do not participate and why?

Recreation
What recreation opportunities do children have?

What is the difference in access for boys and girls?

What age of children participate in these activities?

Why do children not participate?

Youth

How do adolescent boys and girls spend their time?

Do they have access to education and recreation activities?

What do adolescents see as the most important issues for them?

Children with Special Needs

Are there children with special needs at this location?

Do they have access to education/recreation opportunities?

How are these children being supported within the community?

Health

Do children and their families have access to health care?

What problems exist in accessing this care?

APPENDIX 6: IRAQ CHILD PROTECTION INTER-AGENCY ASSESSMENT METHODOLOGY FRAMEWORK[39]

ASSESSMENTS ARE NOT NEUTRAL BUT ARE "INTERVENTIONS" IN THEMSELVES.

An ethical approach to conducting assessments demands:

- A commitment to follow-up action, if required;
- Refraining from taking over if communities can cope, unless the community's response violates the basic rights of children;
- Foresight regarding potentially negative impact of the exercise: avoid methodologies that risk stigmatising children, endangering them in any way, or increasing family separation. In extreme cases, assessments may even endanger the safety of these children, for example, by attracting the attention of groups that prey on defenceless children.
- Refraining from setting up false expectations.

Adapted from S. Uppard Save UK, PROTECTION notes for assessment.doc

Protection consists of ensuring the fulfillment of basic human rights and enabling human well-being, particularly in regard to vulnerable people such as women, children, and displaced people. Protection includes reducing physical, emotional, and social risks; supporting emotional and social well-being; providing equal access to basic services; and promoting the rights and dignity of individuals, families, groups, and communities.[40] The following elements are essential to operationalizing this definition:

- Integration of protection activities for women and children across humanitarian delivery sectors.
- Helping to foster a secure and stable environment for displaced people, women, children, and other vulnerable groups.
- Support for community-driven processes and networks of protection that activate and build on local groups and resources.
- Making rights a reality through programming, education, advocacy, capacity building, and influencing policies and practices.
- Support for full participation in protection activities by vulnerable people, particularly women and children.

[39]This Appendix is adapted from the Iraq Child Protection Inter-Agency Assessment Methodology Framework. The Inter-Agency group was comprised of Save the Children US, Save the Children UK, CCF, IRC, World Vision and UNICEF. The complete Framework is included on the accompanying CD-ROM.

[40]Definition taken from the InterAction Protection Working Group, in which SC actively participates.

The **objective** of this child-focused assessment is to provide a situation analysis and needs assessment that analyzes children's situation, maps key risks and child protection issues, and identifies particularly vulnerable groups, coping skills and mechanisms and local assets for supporting children. The purposes of the assessment and agreed methodologies for participatory assessment are:

• To build a broad and immediate picture of child protection and well-being;
• To identify emergency issues requiring immediate follow up;
• To provide information and recommendations to help inform or guide practices and programming aimed at addressing critical issues affecting children and their families during the process of recovery and societal rebuilding;
• To inform the development of longer-term recommendations on policy and practice.

The assessment, therefore, is not an end-point but is part of an ongoing process of progressive information collection and sharing, program development, and advocacy in a region that will likely continue to undergo many rapid and complex changes.

KEY REMINDER

All data should be disaggregated by age and gender to facilitate the mapping of trends and to identify potential or differing patterns or risks among children.

The assessment will collect quantitative as well as qualitative data. The use of multiple methods is recommended. For example: structured and semi-structured interviews with key informants and randomly selected groups of women, children and gender segregated adolescents; smaller focus group discussions with elders, women, parents, children and young people; transect walks; observations and descriptions of local conditions, and case studies.

GENERAL PSYCHOSOCIAL OR EMOTIONAL AND SOCIAL WELL BEING INFORMATION

• Coping Mechanisms
• Support Networks
• Play
• Local Terms For Children & Emotions, Etc.

• Roles
• Changes/Effects Due To Recent Conflict
• Community Roles/Attitudes

Knowledge, attitudes, and practices (KAP) are pivotal to assessment information collection and intervention design and implementation. An intervention or assessment that identifies needs or takes care of the technical issues but does not take KAP into account is unlikely to achieve optimal impact. Good KAP information is critical to understanding why people do what they do, and to involving people in designing acceptable interventions. KAP is not a data collection method; it is an area of enquiry, to be approached by means of various methods. (Save the Children, UK)

- How do boys of different ages spend their time?
  Under 6 years
  Ages 6-12
  Ages 13-18

- How do girls of different ages spend their time?
  Under 6 years
  Ages 6-12
  Ages 13-18

- Do children in this location have time to play?
  If yes, what are the most common games?
  Are there places/spaces in this location for children to play?

- Are there lots of boys or girls between the ages of 12-18 with nothing to do?

- What are the local terms for 'sad' or 'unhappy' or 'depressed'?
  Are there children in this location who are sad?

- Have relations between parents and children recently changed?
  If yes, in what way?

- Has the behavior of children recently changed? If so how?
  Do children have difficulty sleeping?
  Do they have nightmares?
  Are there children who fight more or are more aggressive?
  Do any children have trouble leaving their parent's constant company?
  Are there children who spend most of their time alone?
  Are there children who are more fearful or afraid? Anxious?

- What are parent's definition of what constitutes a 'good child'?
  What are children and youth's definition of what constitutes a good child?
  What do parents do to raise 'good children'?
  Are there other adults who help children learn good behavior?

- Who do children go to for support or if they have problems?

- How do parents or other adults discipline children?

- What are the most common worries of children and adolescents?
  What are the most common or highest risks for children or adolescents

ask children and adults and compare answers

- What do children usually dream about at night? *(Only ask children themselves)*

YOUTH

- Past and present roles & status in society
- Key risks & concerns
- Sexual health knowledge & practices
- How youth envision their future
- Youth activities/opportunities in the community & how they spend their time

- Relationships to adults & children
- Involvement in risky behavior
- Opportunities for employment & education
- Do they have a voice in decisions
- Community recognition of youth as separate category of development having special needs

- Are there any youth represented in decision making or leadership structures?
  Is yes, how many and what is there role(s)? If no, how do youth have issues of
  concern addressed?
  Are there any youth groups? If yes, how many and what do they do?

- Have there been changes in the roles of youth or how they spend their time?
  Have there been any changes in relations between youth and adults?
  Have adults noticed any recent changes in youth's behavior? If so, what or in what
  way?

- Are there any youth engaging in risk behavior including unprotected sex and drug
  usage? If yes, how many (age and gender breakdown)?

- What services/ activities exist in the community for young people?

- What are some of the problems or risks faced by youth in this community?
  (ask both youth and adults and compare the answers)

- At what age do girls in the community generally get married?
  Has this age changed recently? If so, what has been the change and why?

- Have there been any classes or instruction offered to youth on sexual or reproductive
  health or on parenting skills? If so, when and by whom?
  Who is usually instructs a teenage girl on such matters? Who instructs teenage boys?
  Has this recently changed? If so, how or in what way?

- What are youth's main concerns or worries for the future?
  What if any do youth see as opportunities for their future?

- When someone dies what are the local ritual and mourning practices?
  Have these changed or are they still being practiced?
  Do children participate?
  If yes, how?

- What are some of the bad things that have happened in the past that have affected the community?
  What did people do or what practices helped?

- What are some of the good things that have happened in the past that have been positive for the community?

- Are there key people (spiritual, traditional healers, etc.) people turn to in this location for help?

- Are there any rites of passage, cleansing, or spiritual practices specific to children?

- How do children become adults? (Are there any practices or stages they have to do through?)
  Has this recently changed? If yes, how and why?

- When a child is raped or has killed someone are there any special rituals or practices that need to be done?
  Has this recently changed? If yes, how and why?

- Are there other situations in which special rituals for children are performed?
  Has this recently changed? If yes, how and why?

- Seek out information on different local or traditional beliefs related to child health practices

- Has the role of the family or family members recently changed? If so how or in what way?

Some questions related to issues set out in the following two categories are included in other sections. It is recommended, however, that similar or related questions are included in multiple sections or are posed to various groups for the purposes of comparing answers and to triangulate information.

Resources and/or Assets: agencies, local government, community structures/groups etc. present in the area

Host Communities: in areas where IDPs/refugees are living in communities questions to host communities about attitudes, concerns, relations etc.

Repatriation or resettlement issues

Sectors: Discrimination in access to basic services, etc.
(depth & scope of questions to be discussed by group)
    Health & Nutrition
    Shelter
    Food Security
    Water and Sanitation
    Education—formal & non-formal/vocational
    Economic/Livelihoods
    Non-food items

Demographics: general population information and on above categories

Children: specific age and gender statistical information relevant to children, particularly vulnerable groups

Current and previous community structures: community committees; tribal/religious leaders; women, youth or children's groups; PVOs, local NGOs, etc.

Government structures/Ministries involved in Children's issues: who, doing what, previous/current role